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Brisbane, Australia December 2021

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INTRODUCTION

This book provides some useful information on the human condition.

The author is a psychiatrist with many years of experience.

Three Layers of the Human Mind

You are reading and understanding these words with your conscious mind. And you remember what a long process it was to learn the English language.

When you go to sleep at night your unconscious mind entertains you with dreams while paralysing your body so you can't kick out and wave your arms while these images are playing out in your dreams.

And al the time, your unconscious mind is efficiently running all your internal organs, without your conscious knowledge.

But when you are wide awake and thoughtful, somehow knowing things you haven't learnt. or recognising people you've never met, you become aware of a third deeper layer of your mind, that we might call your inner self. Or your deeper self, or your true identity.

Admittedly there are people educated in universities who believe the mind is only the brain working, and that your idea of who you are depends on some part of the brain we haven't discovered as yet.

But most people believe that who we are is intimately associated with how we came into being and who created us.

Some people seeking advice on how to live better will need their conscious mind re-educating. For example, some people have been wrongly taught you can only be happy if you're a winner. "Winners are grinners". Now that they have decided they're losers, they're miserable.

Others need to learn they have a mysterious unconscious mind with its own language and logic, that causes them to experience body symptoms that don't seem to make sense as part of medical illness.

And other people who are born highly sensitive, may feel disturbed about the world they're living in and are contemplating ending it all.

Find out more about Highly Sensitive people by Googling Dr Elaine Aron's website The Highly Sensitive Person)

To be helpful to these sensitive people who make up about 20% of our population, we need to respect two separate beliefs:

Firstly, that each human being is unique, a one-only, and actually is an immortal soul.

Secondly, that we were created by an invisible spirit that we have absolutely no understanding of, and that each soul is individually loved and guided throughout life.

A person seeking to be a counsellor, but who has no religious beliefs, no concept of a soul or spirit, no thoughts on how we came into being, will be limited in those people he or she can help.

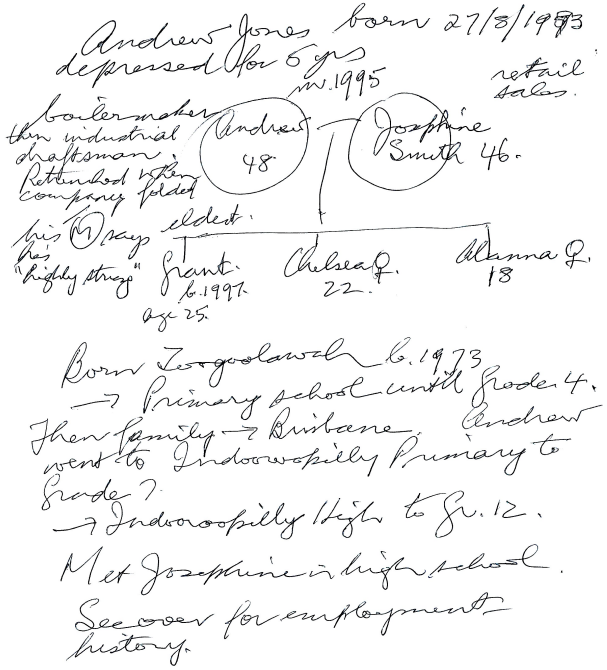
If you are that person, and you want to be a counsellor who can help people cope with a wide range of human suffering, I suggest you might postpone your counselling course until you have learned something about the human soul.

CHAPTER ONE

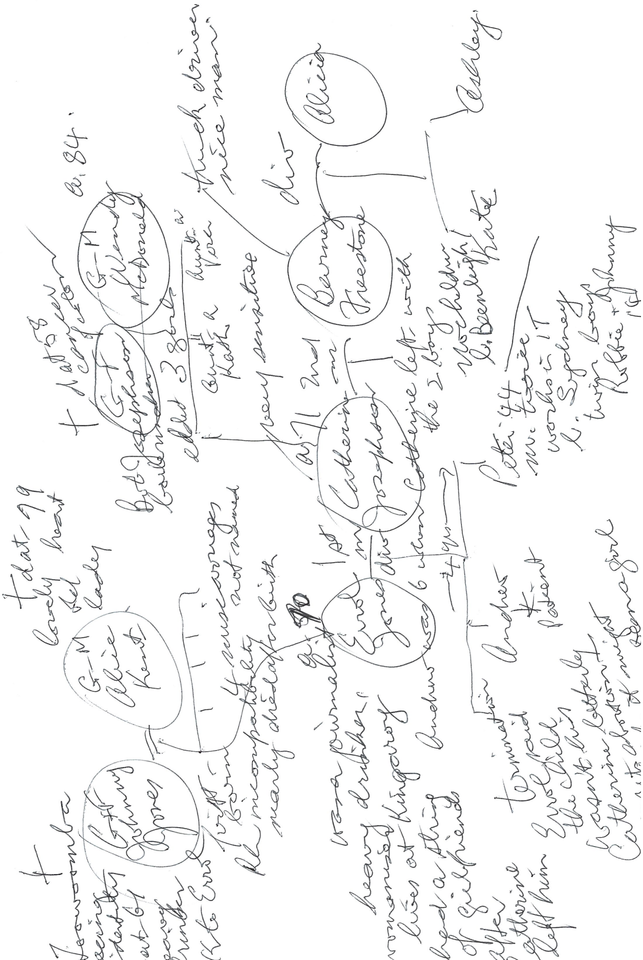
Taking a good history

To help people sort out their emotional problems, we need to know who they are and what caused their problems. A good history is essential.

I find it easier to record the family history in diagram form.



Born Toowoomba 6.1973
→ Primary school until Grade 4.
Then family → Brisbane. Andrew went to Indooroopilly Primary to Grade 7.
→ Indooroopilly High to Yr. 12.
Met Josephine in high school.
See over for employment history.



Therapists usually find their own way of recording a family history that they are comfortable with.

Looking back at the family history of my client

While human babies are born in a physically helpless state, they come equipped with an ability to communicate with their mothers in several ways:

- They respond to touch and being cuddled
- They cry loudly when they need anything whatsoever
- They smile at faces
- They respond to songs and certain tones in human speech

Each of these communications require the presence of a mother ready to respond to the baby and to provide everything the baby needs.

A baby is physically helpless, but is a consummate communicator with a brain that learns and remembers at an astonishing rate.

The asymmetrical tonic neck reflex

Watch a baby in a crib, with an adoring adult trying to interest the baby in a rattle. The adult moves the object into the baby's field of vision, and the baby visually fixes on the object. As the object moves towards the lateral limit of the baby's visual field, the tracking of the baby's eyes initiates a reflex that turns the head in that direction.

As the baby's head nears the limit of its range of movement to right or left, the asymmetrical tonic neck reflex is triggered.

This causes the arm on that side to extend, while the arm on the other side is flexed. It looks a little like a fencer making a lunge with one arm while the other is flexed upwards in an arc.

What is happening is simply the triggering of reflex movements by firstly the movement of the eyes and then by the movement of the head. But it looks like the baby is trying to reach for the object.

The adoring adult will then promptly respond by placing the object in the hand of the baby and calling it a name and providing a description of it. "He wants it! That's a rattle! See, if you shake it, it makes a noise!"

When this is repeated over and over the baby begins to realize he has a marvellous tool at his disposal. Point to something, or make a move towards it, and someone will either give it to you or give it a name and tell you about it.

This pointing activity that never was a purposeful act at the beginning, is what a baby will use to learn language and to understand what is going on in the world.

But it always requires another person to be there. As we grow and mature, we will still need affirmation by

another person before we can be sure of our own perception of reality.

And learning usually requires the presence (or the virtual presence) of another person.

Stages of child development

We can consistently identify several stages in human development.

Up to the age of two years, the infant is totally enmeshed with the mother, who is the provider of everything the infant needs, the source of the infant's self-concept, self-confidence and happiness.

At about age two, the child discovers the words "No!" and "I won't!" as a means of differentiating himself from his mother, and becoming a separate being. This is the stage of the "Terrible Twos".

If the mother doesn't over-react or feel her authority is being threatened by her two-year old seemingly becoming a mindless rebel, the child succeeds in establishing that he is a separate person.

Having satisfied himself of this new status, having established that he has the right to poo when and where he wants, he may choose to retreat a little and becomes intent on forming an alliance with Mum.

Making friends with Mum identifies the stage of the "Trusting Threes". The child discovers what it is like to have one's own opinions while keeping close to the person you trust to give you whatever you need.

Then it is time to find out how much power you have as you enter the stage of the "Frightful Fours". Maybe if you scream and roll on the floor near the lolly counter at the supermarket long enough, Mum will give in finally and give you what you want.

At this stage, the four-year old becomes preoccupied with power and ownership, and begins to learn about the use of aggression in getting what you want. The four year old begins to behave like a wild animal that needs to be tamed.

At age five, most children are busily learning skills towards becoming independent, learning how to tie up shoe laces, adjust the taps in the bath, tidy up etc.

If you visit a kindergarten and observe the behaviour of these pre-school children, you will notice that mostly they are all behaving as miniature Mums and Dads.

By watching these children, one can often gain a good impression of how their mothers and fathers behave at home. These children seem to have internalised as their own, the behaviour of their parents.

At age 6, when Australian children start primary school, we tend to see a transition between children being miniature adults, and children being kids.

But at age 7, when most children are in Grade 2 at primary school, they are definitely kids, and this is the beginning of an identification with the peer group that will last for many years.

Primary school children have games at school that bear little or no relationship to current reality in the world of adults. They sing songs and play games like "Oranges and lemons, the bells of St Clements, you owe me three farthings say the bells of St Martins…" This is a rhyme about the churches in London, ending with "here comes the chopper to chop off your head!" Referring to the Tower of London.

Another favourite, still going strong is "Ring a ring a rosy, a pocketful of posies….a tishoo a tishoo, we all fall down!" This is about the Great Plague.

Another one: "Constantinople is a very big word, how do you spell it?" The answer is "it". But there is no Constantinople on the map. It lives only in history.

The peer group has faithfully preserved these rhymes and games in spite of the passage of hundreds of years.

While significant trauma affecting a pre-school child may have a lasting effect on their relationships with significant authority figures, trauma affecting a child of

seven or more may show up more in relationships with peers.

If a child enjoys good relationships with other children at school, this may tend to soften the effects of emotional trauma arising from the home. And the opposite is true- a child being bullied and humiliated by other children may survive relatively unscathed if the child has good supportive relationships at home.

Children who have bad experiences both at home and at school are very likely to be permanently emotionally damaged, unless they are rescued through psychotherapy.

Internalizations and judgments

Preschool children internalise the behaviour and the attitudes of their parents or those parenting them, to become the basic internal structure of their own self-control mechanism. In a happy loving family a child will develop an internal Dad and an internal Mum.

This internal structure within their personality will have three parts to it. There is the way Dad does things, gets his own way and negotiates with people. There is the way Mum does things, gets her own way, and negotiates with people. And there is a third element in this self-control mechanism, the way that Dad and Mum settle their differences. This will become the way the developing child will deal with the differences between the internal Dad and the internal Mum.

Let's take for example, a Dad who is a relatively aggressive man who states clearly what he wants and who expects others to cooperate; and Mum is a soft, forgiving person who fits in with agendas set by others. But Dad and Mum get along well by respecting each other's roles in the family.

Dad insists on having his own way in choosing the family car, working in the garden and doing odd jobs around the house. Mum has the say on the furniture and the electrical appliances in the house and all the soft furnishings.

When Dad and Mum disagree, Dad might get angry but only briefly, then he apologises and does what Mum wants.

This is a loving and effective family. The child will grow up with an assertiveness internalised from Dad's behaviour, but when this doesn't work with the schoolteacher, the child can easily switch to diplomacy as Mum does.

When confronted with the fact that the child has switched from a confronting to a cooperating strategy, there is no anxiety about it. It feels natural for the child, because it was natural for the parents.

The child grows into adult life with an inbuilt super-ego derived from internalising both parents and the way the parents settled their differences.

Judgments

Let us now look at the situation in a dysfunctional family, where Dad is aggressive and abusive and Mum is submissive and intimidated by Dad threatening violence if he doesn't get his way. Eventually Mum gets up enough courage to leave Dad.

The son will have internalised an aggressive Dad, and has learned to be able to switch to a timid approach like Mum uses. But there is no Dad-Mum integration package.

As the boy gets to age 7 or so, he rejects Dad's behaviour. "Don't tell me I'm like my father!" Likewise he rejects Mum's behaviour- "My mother's a wimp!" He decides he is not like either, but in fact he really is like both. He can readily switch from being timid and scared to being nasty and threatening.

But because of his judgments on both parents this boy is not aware of being like them. He can even grow up with the self-concept that he is totally unlike either parent. But then he doesn't know who he really is.

In my clinical practice, in taking life histories I always ask my patients to describe their father and mother and their siblings, long before I would ever ask these clients to describe their own personality.

Patients will usually provide a fairly accurate description of others in their family, but when they describe

themselves are more likely to offer the therapist what the client wants to believe about himself, or sometimes what the client thinks the therapist wants to hear. And having provided an honest appraisal of their relatives, patients are more likely to provide an honest description of those personal characteristics that run in the family.

The "Law of Judgment"

Therapists who work in this area, identifying patterns of internalizations (introjects) and judgments, soon learn that a person making strong judgments against some family trait, will be highly likely to repeat the same mistakes that they have judged harshly.

Alice, the daughter of an alcoholic father and a co-dependent mother makes a vow "I vow and declare that I will never ever marry an alcoholic!" Of all the boyfriends Alice has, she marries Henry because he is the one who will do whatever she wants, whenever she wants.

She doesn't want Henry to drink, and he wouldn't dare go near alcohol. But at the work Christmas party someone spikes the punch, and Henry gets a good dose of vodka. Suddenly, he's not scared any more of anything. When he gets home, he loudly criticises Alice for the kids leaving their toys in the lounge room.

Years later at an Al-Anon meeting, Alice tells the group she had inadvertently chosen for a husband a man who had all the pre-conditions for alcoholism. She says she

would have done better to marry a man who could stand up to her without the need of alcohol.

The “law of judgment” states that we are very likely to repeat a pattern of behaviour that we have made strong judgments against.

The early teen years

Puberty unleashes powerful sexual drives in people who are still children. Many parents describe the care of teenage children in terms of a daily holding operation, protecting them from their own urges until their emotional development can catch up with their physical development.

In the transition from child to adult, many occasions arise where teenagers demand to be given the privileges of adulthood while still enjoying a lifestyle free of adult responsibility.

This transition has some elements in common with the period of life from age two to four, where a similar transition has occurred from dependency to autonomy. Therefore it is not unexpected when 13 year olds begin behaving like two year olds again.

Just as in the “terrible two” stage, it is very important for parents to allow teenagers some freedom to experiment with negative statements.

Thirteen year olds can suddenly become slovenly in their speech, think it's funny to insult their friends and relatives and use bad language. They will expect their parents to attempt to discipline and control this teenage rebelliousness, and will be prepared to play the victim.

However, intelligent parents who want to get this phase over as soon as possible, respond to their 13 year olds the same way they did when the children were two, by encouraging them to be independent. When the parents' response is to encourage them to assume responsibility for their own pocket money, homework and bedtime, these teenage rebels may not need to persist with their experiments in non-cooperation and bad language.

The child's history

When we find that in early childhood a client has experienced the pain of their parents' divorce, domestic violence and severe inappropriate punishment, we will know that without effective therapy and counselling, this person will bear the behavioural scars for decades.

Usually a child will discover a way of living that reduces the pain of maternal rejection, paternal violence or a large number of unfortunate and painful events that impact an innocent child.

The problem to be dealt with later, is that the grown up child will continue with the behaviour that they learned

in childhood would reduce the probability of their being hurt.

And the behaviour that was useful in their early life is now causing problems later, particularly in relating to their own children.

If you bash a child, they will learn to bash children. If you humiliate a child, this child will grow up to humiliate children.

A lot of human learning is less like copying, and more like programming a computer.

Confidentiality

Your client's secrets belong to them. Increasingly lawyers demand access to psychiatrists' confidential notes, and they will soon be doing the same with counsellors. I suggest that you provide a satchel where your client can keep the notes you have made, along with family photos and documents such as school reports.

The client should bring the satchel containing their photographs and documents as well as your confidential notes with them to each interview.

So no lawyer or government agency can demand from you any confidential information without the client's permission.

Lawyers will even obtain a court subpoena to demand your notes, but if all you have on the client's file is basic information, dates of interviews and billing, they will not succeed in gaining access to your clients' secrets.

When my patient and I are discussing secrets, I usually write down only the date in my notes. I have a good memory. This has infuriated investigators from the Queensland Medical Board. They ask "What if you get run over by a bus and another doctor needs to take over the case?"

My answer is that confidential information belongs to my patient, not me. If my patients have to see another doctor, they can decide for themselves what they want to confide to the other doctor.

This explanation is usually not good enough for the Medical Board.

Counsellors need to ensure their clients' privacy.

CHAPTER TWO

Understanding what anxiety is

Anxiety is a sudden vague urgent feeling of unease or dread, and as you feel it, you notice your body is "jumpy" or "up tight".

In fact your body, as you experience the feeling of anxiety, is being prepared to run away or fight.

What causes it? Anxiety is simply an alarm signal that tells you that your nervous system is having difficulty processing your current situation. Such as:

Trying to do too many things at once, or

Trying to something that is too hard for you

Or

- **Waiting, when you don't know how long**
- **Being in a no-win situation, where a negative outcome is associated with every choice**
- **Having to switch directions or attitudes to the exact opposite and back again, a number of times**

Why? Human beings have lived on planet Earth for a very long time, and we have survived to the extent of being a dominant species. Yet we have no claws, no fangs, no fur, no camouflage. But we're really smart,

and when something seems to be going wrong and we don't quite know what it is, the safest thing to is to run away and hide. Or if we know what it is, we get 10 men armed with a stout stick each and we kill the damn thing.

Here is a **poem to remind you of the common causes of anxiety:**

I'm feeling nervy, perhaps it's that I'm
Doing too many jobs at the one time,
Or do I need help for this problem of mine?

No, the work's not excessive. My processing's slow.
Have I had enough sleep? Is my blood glucose low?
Or is there something wrong, I should know?
Is the booze wearing off, or is it the pills?
Too much tea or coffee, I hope I'm not ill?"

If my little poem gives you a clue,
Stop what you're doing for a minute or two,
And think without panicking what you should do.

You're feeling so dreadful but it's just an alarm,
Being anxious feels awful, but does you no harm.
But if you're terribly scared you'll fall in a heap,
Here's a little advice I hope that you'll keep,
Get some rest from the stress and a great deal more sleep.

Ask yourself these questions

Are you trying to do too many things at once? Women seem to be able to do a number of tasks at the same time. Many men, on the other hand, may have difficulty with more than one task at a time.

If you are anxious and you are not doing too many things at once, is what you are trying to do, too difficult? There are three situations the human brain has great difficulty with:

1. Waiting. Waiting for something to happen, when you don't know how long you will need to wait, always makes us anxious. Some people can train themselves to tolerate waiting by entering a self-induced hypnotic trance. Others feel they must occupy themselves with some task, like reading. When we cannot entertain ourselves enough or the waiting is too long, human beings may become distressed.

2. Having to adapt to rapidly changing circumstances. People become anxious when they have to adapt to situations which continually reverse themselves, for example, if someone keeps changing the place where you are supposed to pick them up in heavy traffic. Or if you are a receptionist having to explain to the public why what was wrong last week is now preferred policy, and the word comes down they have changed it all back again.

3. Being in a no-win situation. When we are forced to choose between two equally unacceptable alternatives we may experience anxiety. There are many jobs in which a day's work is a series of no-win situations. Police work, for example. When a police officer charges somebody with an offence, someone accuses him of victimization. If he fails to charge that person, he is accused of corruption by someone else. Similarly, the role of parent or teacher having to exert discipline, provides an endless stream of no-win situations.

> **Perhaps my anxiety is not caused by excessive load. Have I had enough sleep?**

Have you had enough sleep? If you use an alarm clock to wake you up in the morning, you are probably not getting enough sleep. When you are getting sufficient sleep, you will wake up before the alarm goes off.

Although we all know from our own experience how important it is to get sufficient sleep, science still hasn't fully explained what sleep does. We know it is necessary to keep the brain from becoming over-stimulated, and we know that a certain level and amount of deep sleep is necessary for restoration and repair of muscles and ligaments.

Deep sleep is also essential in keeping up normal numbers of the body's white blood cells, which protect us against invaders and destroy cancer cells. We know also that dreaming sleep is useful in helping us deal with traumatic situations. But in spite of all we already

know, research on sleep is still discovering new facts and posing new questions.

I would like to affirm William Shakespeare's description of sleep, from Macbeth Act II, where he has Macbeth describing:

> *Sleep that knits up the ravelled sleeve of care,*
> *The death of each day's life, sore labour's bath,*
> *Balm of hurt minds, great nature's second course,*
> *Chief nourisher in life's feast-"*

Nutritional state

While other body organs can use nutrients other than glucose as fuel, the brain cannot. So when the level of glucose in the blood drops, brain function is impaired, and an anxiety reaction occurs immediately. Adrenalin released into the bloodstream causes glycogen in the liver to break down into glucose, fairly rapidly restoring the blood glucose level to normal. This glycogen-breakdown mechanism takes about 20-30 minutes.

Hypoglycemia (low blood glucose) is a common occurrence in the lives of diabetic patients treated with insulin. The sudden onset of anxiety is a useful warning of low blood glucose, giving the patient time to take some extra glucose.

At that time, the nervous system will become inefficient and trigger off an anxiety reaction.

Pills, alcohol or marijuana wearing off?

Withdrawal of sedative drugs, such as alcohol and the benzodiazepine drugs with names ending in "azepam" or "azolam", (such as diazepam and alprazolam). can produce an agitation indistinguishable from anxiety.

In general, most people know about hangovers from drinking alcohol, but they may not realize that sedative drugs prescribed for anxiety will leave a vague agitation when the sedation wears off.

This agitation usually persists for about four times as long as the duration of the sedative action of the drug.

Thus, a person may be suffering from feelings of anxiety due simply to withdrawal of the sedative action of a drug, leaving the agitation.

Marijuana withdrawal also causes anxiety symptoms, but because this drug is slowly excreted from the body, the resulting agitation has a slower onset and is more prolonged.

Too much tea, coffee or cola drinks?

Another common cause of feeling agitated is the consumption of excessive amounts of tea, coffee, and cola drinks containing caffeine. The caffeine and other drugs in these drinks cause stimulation by release of noradrenalin in the body. Excessive amounts of

stimulants can produce a state indistinguishable from anxiety.

Do I need to see a doctor?

Conditions such as an overactive thyroid gland, a low level of calcium in the blood, and acute virus and bacterial infections can cause feelings or anxiety.

Being anxious about being anxious can cause a panic attack

If body feelings of anxiety are unexpected and unexplained, the fact of feeling anxious can then become something frightening in itself. What's wrong with me? Am I having a heart attack? Am I going insane?

The person becomes worried about being worried, frightened of being frightened, panicky about feeling panicky. The result is then worsened by the fact of over-breathing, where the anxious person's breathing rate has become too fast and is taking too much carbon dioxide out of the blood and altering the blood's acidity.

When the blood's acidity changes, the longer nerve fibres begin to malfunction, and the person experiences tingling, "pins and needles" and numbness in the hands and feet and around the mouth.

The conscious mind does not recognize these feelings for what they are, and fires off yet another alarm signal,

causing the panic reaction to worsen. At this point, the person needs to breathe in and out of a paper bag to bring the blood's carbon dioxide back to normal.

Late teens and personal commitment

Teenagers getting little sleep, seeking emotional stimulation and eating junk food irregularly, tend to experience anxiety symptoms.

Young people in their late teens and early twenties often spend sleepless nights worried about committing themselves to a particular person, course of study or professional career. The effects of decisions being made at this time may last a lifetime, and some of these decisions are made too quickly, based on too little information.

It is important for parents to recognize that anxiety caused by unavoidable stress accounts for much of the behaviour we often label as adolescent. Sometimes the most appropriate answer to teenage moodiness and rebellion is as simple as a good night's sleep.

Will Power and "Don't" Power

The body chemicals that give us the ability to "get up and go" are noradrenalin and adrenalin. (In the USA they say "norepinephrine" and "epinephrine") These are just different ways of saying "on top of the kidneys."

Sitting on top of our kidneys are the adrenal glands that release adrenalin and noradrenalin when we need to give ourselves a push to get out of bed, start a job, or make that telephone call.

Adrenalin and noradrenalin make the heart pump faster, increase the blood pressure, and break down glycogen in the liver to increase the blood glucose to feed our muscles.

Our nervous system reacts immediately we encounter a threat or obstacle by releasing adrenalin. If our job is just that - dealing with obstacles, there might be too much adrenalin stimulating the heart to beat and the muscles to contract.

So your doctor might prescribe a drug called a “beta blocker” that reduces the stimulatory action of adrenalin on the heart. Some of the symptoms of anxiety, like rapid heartbeat and shaky hands, are caused by release of these chemicals.

If you have to carry on working when you’re worn out, you can run out of adrenalin and noradrenalin stores, and this might then be called a state of adrenal exhaustion. You feel weak, can’t get started, and your blood pressure drops when you stand up.

However. much of what we have to put up with, in 21st century cities, often requires us to use our “don’t” power rather than our will power. Serotonin (also a sleep transmitter) is the chemical that allows us to stop

complaining, keep our objections to ourselves and look calm when we're seething inside.

And we can run out of serotonin reserves, if the stress in our chosen occupations involves tolerating intolerable behaviour or taking risks.

When we run down our serotonin reserves we have difficulty staying asleep (serotonin is a sleep neurotransmitter), and we feel as though we're on a knife-edge, about to break down any moment.

CHAPTER THREE

Two types of depression

Almost everyone knows what it feels like to withdraw from the fear of having your heart broken again. "I'm not going out, I'll just stay here in the gloom and mope."

We call this *reactive depression*. If this is a reaction to a severe loss, we call it a *grief reaction*. The symptoms are a combination of sadness from loss, plus symptoms of anxiety.

The best treatment for reactive depression is counselling.

Grief

Human beings tend to become emotionally attached to people, places and objects, and when we are parted from them, we suffer the pain of loss.

Some people try to dull the pain of loss by convincing themselves the lost object was of little value. However, devaluing a lost object merely devalues our own feelings. A woman who described her deserting husband as "no good anyway" then said, "I was a complete fool for marrying him!"

Devaluing a lost object never helps with the pain of loss. Only grieving does this. Grieving is a process through which we disengage emotionally from a valued lost

object. At the end of this process, the object is still valuable to us, but we no longer feel the pain of its absence from our lives.

When significant losses occur in our lives, we experience all over again the pain of previous losses that we did not adequately deal with at the time.

Sometimes a person may appear to fall into a profound grief reaction to a minor loss, when in reality, this person is experiencing all over again, the pain of a former loss that was not worked through.

Three stages in a normal healthy grief reaction.

1**. A stage of numbness of disbelief.** We can't believe it has happened. We're numb. We've been told our father has been struck by a car and killed, but we expect him to come in the door any minute, saying it was all a mistake or a big joke. In this stage, bereaved people can look very calm, and other people may wrongly conclude we're taking the loss very well. It's just that the loss at this point hasn't really sunk in.

2. A stage of protest or anger. After the first stage has passed, and we are painfully aware that the loss is real, we feel the emotional pain acutely. We weep, we wail, we protest, we get angry, we blame ourselves for not warning him not to trust the walk sign on the traffic lights, we blame the person who ran over him, we blame the ambulance for not getting there fast enough, and the doctors for not saving him at the hospital.

As this stage progresses, our anger may be directed towards friends and relatives who have not suffered the loss. We accuse them of being callous and unfeeling. "You couldn't care less about me! You're not the slightest bit interested in the way I'm feeling, you're so callous!"

3. **Acceptance that initially resembles depression.** As we cease blaming ourselves and others, and stop complaining that they don't care about our feelings, we begin to accept the loss.

At first it may appear that we're becoming depressed. "What's the use of complaining and carrying on, he's gone, all the tears in the world won't bring him back."

The next statement will reveal whether the bereaved person is going to develop a reactive depression or is going to recover normally from the loss.

For example, the next statement might be: "A good man killed for nothing, dead and gone forever! What's the use of trying, what's the use of caring?"

This bereaved person may well develop a pattern of self-protective withdrawal that might cause an ongoing depression.

Or the next statement might be: "He's gone, we have to accept it. We'll just have to live the best way we can.

He certainly wouldn't want us to sit around moping for the rest of our lives!"

In this case, the grief reaction is coming to an end. The lost father will be highly valued, always remembered with deep affection, but the pain of separation and loss will lessen with time.

By five years after the accidental death, we should be able to remember our father without bursting into tears.

Normal patterns for our society

Where there was a good relationship with a lost person, the protest or angry phase may last 6 months to a year. For older people, the protest or angry phase can last two years and still be regarded as normal. Normally, we can remember the lost person without weeping, about five years after their loss.

If the mention of a lost person causes tears more than five years after the loss, then something has delayed the normal resolution of the grieving process.

Unusual patterns of grief

Grief reactions occur with the loss of any significant object. While most of us are well aware that a person suffering the loss of a loved one will normally go through a grief reaction, we are less prepared for this when the loss is a body part, a role or position of

authority, a cherished belief or an assumption of inviolability. In fact some of the behaviour of a person going through a grief reaction to one of these losses, can appear quite odd.

For example, a woman who had had a breast removed for cancer was stuck in a stage of disbelief for a week following the operation, in which she steadfastly claimed that the breast was still there, although it was quite obviously missing.

Another example is a profound grief reaction following a burglary where the only object stolen was a video player with an intermittent fault. The insurance company would replace the video with one that worked.

However, a profound grief reaction to the burglary followed, not to the loss of the object, but to the loss of the feeling of safety. This person previously believed his possessions were safe and secure, now he feels he can't just lock up and feel safe.

Prolonged grief

Prolonged grief, often referred to as pathological grief, can last for decades. There is a concept known as grief work, referring to the observation that if we do a lot of grieving we get it over more quickly, and if we do less grieving it takes longer.

Prolonged grief occurs in patterns, depending on which stage is prolonged.

Prolonged stage of disbelief

When the initial stage of grief is prolonged, the bereaved people are functioning abnormally, and their health will inevitably suffer. One father and daughter did not move any of the furniture after the mother died, for eight years. Some families will leave a room formerly occupied by the lost person, just as it was when that person died.

This is particularly likely when a child has died. A woman continued to set a place at the table for her dead husband.

Another man used to buy two seats at the movies, one for him and one for his dead wife, and would not allow anyone else to sit in the seat next to him.

While such behaviour might appeal to our romantic sentiments, it is quite destructive to physical, emotional and mental health. The people who pretend the dead person is still with them, need help to accept the reality of the loss.

In my experience, the main reason is that they did not have a good relationship with the lost person.

Often there was a dependent or co-dependent relationship, and what is required is an honest dialogue about this former relationship with the lost person.

Prolonged angry or protest stage

We can suspect that someone we know is suffering from prolonged grief if they are continual complainers, and their regular complaints are how much they do for people who don't acknowledge it, how nobody is there for them, how nobody cares about what they're feeling.

Usually, chronic complainers do not realize they have not finished their grieving.

They may even sing the praises of the lost person. For example, a woman continued to blame herself for the death of her husband, whom she described in glowing terms. She felt guilty that she wasn't a good enough wife.

It became obvious that this woman's alcoholic, selfish, mean-mouthed husband had never treated her well, but there was a loss in her early childhood that prevented her from dealing adequately with the loss of her husband.

Eventually she was able to describe truthfully his behaviour towards her and she moved on to resolve her grief.

Reactive depression

I have already mentioned that at the end of the protest phase of grief, a bereaved person might develop a depressive illness, caused originally by a self-protective withdrawal.

The bereaved person decides not to become attached to anything again, for fear of disappointment, and withdraws from involvement in life, like a snail retreating into its shell.

The longer this person lives apart from what is going on around him, the more self-confidence is lost, social skills and community awareness are lost, and the depression deepens.

How to help a grieving person

Grieving people are not helped by suggestions they go away on a cruise or a trip to get away from the painful reminders of the object they lost. Leaving the scene simply means that the grieving process is put on hold until they come back, and they usually don't enjoy the break.

The grieving person should stay home, where the memories are strongest, where friends and relatives are close by. The more intensively the person grieves, the sooner the grieving process can come to an end.

Major Depression

There is another type of depression we call "major depression" that was once called "endogenous depression" because it comes from within the body's chemistry.

This illness runs a course, and the sufferer will recover eventually even if nothing is done to treat it. It may take 7 to 11 months to recover spontaneously, and the patient is then perfectly normal.

But a decision to allow a patient to recover spontaneously is a dangerous one, because these sufferers are always in danger of suicide.

The symptoms of this type of depression are:

- A sleep disturbance, usually difficulty staying asleep rather than getting to sleep, such as occurs in anxiety and reactive depression.
- Loss of appetite for food, sex and enjoyments generally.
- Feeling worse at a particular time of day, usually in the mornings.
- Loss of weight, constipation.
- A feeling of sadness that does not lift at all.
- Sometimes delusions of sin, poverty and disease
- Sometimes hallucinations, usually voices accusing and trying to humiliate the sufferer.
- The sufferer often contemplates suicide.

Counsellors need to know that clients suffering from these symptoms do not improve with counselling. They need antidepressant drugs, and if these drugs don't work, TMS (transcranial magnetic stimulation) or ECT (electro-convulsive therapy).

Sometimes people who suffer from this type of depression can experience periods of perhaps 6 months of what seems to be the opposite of depression. We call this **mania.** The mood is elevated, manic people expend a lot of energy, lose the ability to think rationally and may become deluded and experience hallucinations, always of a grandiose kind.

Many sufferers, however, have a mood disturbance that is less than mania, where their main problems are disturbed sleep and accelerated thought processes, and this is called hypomania.

The manic phase shares some of the characteristics of endogenous depression. They have the same sleep disturbance, inability to stay asleep. And sometimes we see a picture that we describe as mixed depression. The patient may present as grandiose but is at the same time suicidal.

A manic mood swing is always a medical emergency. Manic patients can make silly financial decisions, or get into trouble with gambling and sexual affairs.

When a counsellor suspects a client is either manic or severely depressed, it is always necessary to get medical attention. These patients usually need admission to a psychiatric hospital.

CHAPTER FOUR

Bipolar Disorder

Bipolar disorder is a serious illness where the mood is either abnormally elevated or lowered, and where thinking and behaviour are altered in keeping with the elevated or depressed mood. In between periods of highs and the lows, the person appears normal.

This illness cannot be treated by psychotherapy, because it is not psychological in nature. However, patients who suffer from these recurring severe mood swings and disturbed behaviour certainly benefit from counselling support.

Individuals who suffer from bipolar disorder, previously called Manic-Depressive Psychosis, may experience mainly episodes of lowered mood with an occasional high, or mainly episodes of mania with an occasional depressed mood swing, or may tend to alternate between highs and lows.

The prevalence rate varies throughout the world.

(Reported in http://www.news-medical.net on 7th March 2011) Kathleen Merikangas of the National Institute of Mental Health in Bethesda, Maryland and colleagues reported in the Archives of General Psychiatry 2011;68(3):241-251. doi:10.1001/archgenpsychiatry.2011.12

"The team conducted surveys of adults in the United States, Mexico, Brazil, Colombia, Bulgaria, Romania, China, India,

Japan, Lebanon and New Zealand. The United States has the highest lifetime rate of bipolar disorder at 4.4%, and India the lowest, with 0.1%. Japan had a lifetime prevalence of 0.7%. Colombia, a lower-income nation, also deviated from the trend with a relatively high prevalence of 2.6%."

In bipolar disorder, episodes of depression tend to last longer than episodes of mania, depression averaging perhaps 9 to 12 months (sometimes up to 18 months) and manic mood swings averaging 3 to 6 months.

The duration of the mood swings varies from patient to patient. But the mood always returns to normal, even in the absence of any treatment intervention.

However, apart from cases where the mood is only mildly elevated, it is usually too dangerous to adopt a strategy of waiting for spontaneous recovery. Bipolar depression carries a high risk of suicide, and the tendency to transgress personal boundaries in untreated bipolar mania can get the patient into serious financial and moral trouble.

Rapidly changing moods that last a few days at the most, feeling high when things are going well, and feeling miserable when things are going badly, is not bipolar disorder, but is characteristic of people whose identity and self esteem are too much defined by their successes and failures.

Bipolar Disorder seems to have been with us for all of our recorded history. In 400BC, Hippocrates wrote that

the mood disorders were more common in spring and autumn.

The extensive literature on **Seasonal Affective Disorder** shows that an episode of depression can be triggered by the shortening of daylight that occurs in the winter months in cold countries.

Exposing the patient to artificial light for an extra two hours a day can often cause the depression to lift.

There is an obvious connection between the behaviour of bears that hibernate in the depth of winter, sleeping soundly at low body temperatures in order to survive the cold, and human beings in their log cabins in the snow, sleeping a lot, not moving much, not eating much, too depressed to interact with each other.

We know that hibernation helps animals survive the worst of winter. And we also know that if human beings don't stay within their four walls when it is freezing outside, they will run the risk of being frozen to death, or of becoming ill and dying of lung infections.

Survival skills of people in cold countries

In northern Canada and Siberia it is essential to stay inside for the coldest part of the winter. It helps people to survive if they enter into a torpid winter state, sleeping a lot, interacting little, eating little and doing very little physical activity. This state is often described as "cabin fever".

When the snow thaws and the rain starts in spring, it is very helpful if the same people suddenly become very active, working hard to repair fences and farm machines, planting their crops and looking after their animals. This state of elevated energy is often described as “spring fever”.

The people who switch from a winter depression into a spring mania have a great advantage over those who don’t. Their elevated mood with the extra energy and the ability to do without sleep is very useful when people are planting and then harvesting their crops and storing them away for the winter, drying and preserving meat and fish and fruit.

It seems obvious that a bipolar pattern of activity, if it were coordinated with changes in the seasons, would be of great benefit in helping human beings survive in those countries furthest away from the equator.

Did bipolar disorder help us survive the ice ages?

It appears that many of our ancestors had to adapt to survive our planet's successive ice ages. If this involved a genetic change, then perhaps a gene that helps us survive cold winters, if inappropriately switched on, might trigger inappropriate mania or inappropriate depression.

The 2011 finding that the prevalence rate for bipolar disorder in India is very low (0.1%) compared with the rate for the United States (4.4%) is consistent with the

fact that the ancestors of Indian people did not need the bipolar mood swings to survive in cold countries, whereas the ancestors of Europeans definitely did.

Mania

When patients are either manic or suffering from bipolar depression, trying to talk them out of feeling the way they do, is totally useless. Once a manic mood swing begins, it will run a course and then the mood will eventually return to normal.

In mild manic mood swings, where the patient is just a little over-talkative and has more energy than usual, it may not be necessary to do anything other than advise the patient not to enter into any contractual obligations while manic, that they would regret when their mood returns to normal.

In fact, there are many people who seem to benefit from mild fluctuations in mood. Some famous writers have been bipolar, writing furiously and sleeping little while they are manic, and then editing carefully what they have written when the mood returns to normal.

The major fear is that manic people left untreated could waste all their money or get involved in sexual or other misadventures that they will deeply regret when their mood returns to normal.

If the manic person has become psychotic (usually because of lack of sleep) delusions will have a

grandiose quality. Often by the time the manic person gets to see a psychiatrist, he has been talking so much his voice is hoarse.

Bipolar depression

The main concern with bipolar depression is that the patient may commit suicide.

It is as useless trying to talk a patient with bipolar depression out of feeling depressed than it is to talk a manic person out of being manic.

Sometimes it requires experience to diagnose that the patient has bipolar depression because the patient may deny feeling sad. Sometimes they will admit to being bad but not being sad.

However, they usually have the following symptoms:

Sleep disturbance - most commonly being able to get to sleep but then waking after two hours or less, and then sleeping fitfully during the remainder of the night, being awake earlier in the morning than is their usual pattern

Feeling worst in the mornings with their mood improving after midday.

Loss of appetite for food, loss of sex drive

Constipation - possibly because of eating less

Lack of energy and motivation

Feeling of sadness or uselessness and often feeling guilty for no particular reason

Psychotic depression

When the patient with bipolar depression is found to be suffering from delusions, this situation is very dangerous and the patient needs hospital admission urgently. This condition is usually called Psychotic Depression.

A delusion is a false idea that the patient cannot be talked out of. Delusions in psychotic depression may include delusions of sin, poverty and disease.

The depressed patient may claim to have committed an unpardonable sin, or claim to be poor when they are not. Some will claim to be rotting away from venereal disease when there is no evidence for this at all.

Hallucinations in psychotic depression may include nasty voices insisting the patient commit suicide, and smells of rotting human flesh when other people can smell nothing unusual.

It is usually not difficult to get a patient with psychotic depression into hospital. They may need electro-convulsive therapy, but they usually don't mind this either.

Usually the person afflicted with psychotic depression is so certain he is hopelessly diseased or damned for all

time that he has little interest in the risks of any treatment procedure he is being offered.

The most important thing to remember about patients suffering from psychotic depression is that they can be quite determined to kill themselves, and need to be supervised carefully until they are safely in hospital.

Another danger is that they may kill their children in the deluded belief that it is better for a child to die than to have to grow up without a parent.

CHAPTER FIVE

Understanding the Unconscious Mind

Most of us are aware that we have an unconscious mind. While the conscious mind is asleep, the unconscious mind is playing out in images, dreams related to some aspect of the previous day's happenings.

We can be driving the car while talking to our passenger and we suddenly become aware that we can't remember driving the last 5 kilometres. All we can remember is the conversation we had. Was the unconscious mind doing the driving?

While your conscious mind is reading these words, your unconscious mind has set up your body to hold your head still without your even being aware of it. And at the same time your unconscious mind is controlling perfectly your heart and blood vessels and your internal organs.

Most of the time, we are only partly aware of the functioning of our internal organs, and we usually take notice only when there is some disturbance. Perhaps you drank too many cups of coffee and you can feel your heart beating, perhaps you ate something that produces too much gas and you can feel your colon is distended.

Under normal circumstances, when we're eating proper food, drinking clean water and getting the right amount of sleep and exercise, the unconscious mind is quietly able to do its job.

The job of the unconscious mind is to keep everything the same, keeping the blood's acidity at the right level, keeping the body temperature steady at 37 degrees Celsius, keeping the resting heart rate near 76 beats per minute and our breathing rate one fourth of the pulse rate.

Keeping everything steady, repairing damage and fighting off invaders are the primary responsibilities of the unconscious mind.

And if we willingly and knowingly do something to disturb the body's inner peace, the unconscious mind is willing to trigger pain signals to punish us.

By contrast the conscious mind is oriented towards the exterior, the world around us. It brings in images from the outside world, classifies them and thinks about them. It wants to understand the outside world.

When the conscious mind goes to sleep, it hands over to the world of dreams, the incredible stories presented by the unconscious mind, using its odd rules and its strange logic.

The autonomic nervous system

The unconscious mind operates the autonomic nervous system. This is a system of nerve fibres and collections of nerve cells that operates separately from the central nervous system.

The autonomic nervous system does not sleep. While the conscious mind is asleep, the autonomic nervous system is busy repairing any damage that was done during the previous day.

During a surgical operation under general anaesthesia while the conscious mind is sound asleep, the autonomic nerves are wide awake and actively reporting the damage of tissues being cut and stitched.

In recognition of this, modern surgeons use local anaesthetic when operating, even though the patient may be deeply asleep, and they take great care to handle our inner organs and tissues very gently.

Other symbolic body symptoms - "organ language"

When we come to consider other ways in which symbolism might produce body symptoms, we need to consider organ language.

People sometimes express their emotions and feelings by using words appropriate to the function of organs in the body.

When I was a resident medical officer, I saw an adolescent girl in the hospital casualty department complaining of painful red areas on the sides of the neck. This girl was very tense and irritable. She said, "My mother is a pain in the neck! Whatever I do is wrong, I can't win, and I'm sick of it!" We might say that this girl was "hot under the collar".

Other people complain that someone "makes me sick in the stomach!", thereby giving some clue to the cause of symptoms of nausea and diarrhea.

Some people adopt a "stiff-necked" approach to criticism by others, refusing to respond to it, holding their heads up with pride, and perhaps suffering from neck pain. The critic is "a pain in the neck".

Another common example of organ language is the development of the "feeling" of a lump in the throat, which does not in any way interfere with the person's ability to swallow- called "globus hystericus".

This is often associated with the thought "I am not going to swallow that!"- meaning "I am not going to naively accept what you are trying to ram down my throat!" To the unconscious mind, swallowing and believing can be the same, hence people who are easy to convince are called "gullible", a word derived from gullet, or oesophagus.

The library of ancient stories or archetypes

The word **archetype** is from the Greek, describing an "original model" from which others may be patterned or emulated.

The unconscious mind has a number of built-in archetypes and stories about the outside world that appear to have been inherited via the family tree, and some of these archetypes are very old indeed.

"We'll wake you up when summer comes."

For example, if the conscious mind reports that there is a serious persistent threat to survival, the unconscious mind may read this situation as a long cold winter, and it may move to put the body into a hibernation cycle. This is the archetypal story called "You go to sleep; we'll wake you up when everything's OK again".

However the threat might be a threat of dismissal from one's job, in which case the unconscious mind's response in reducing the body's temperature and metabolic rate and making the person sleepy, will not prove helpful at all.

"You can't afford to bleed to death"

Another example: if the conscious mind reports that there is a conflict about to break out that may cause the person to be harmed in some way, the unconscious

mind will respond by preparing to quickly stop the bleeding when an inevitable injury occurs.

Arteries are made ready to shut down quickly and blood made ready to clot as soon as blood loss occurs.

Regardless of whether the conflict is a battle over holding down one's job, or defending one's personal integrity against a verbal attack by a political enemy, the unconscious mind will still make the same preparations, as if there are likely to be wounds and loss of blood.

Unfortunately, these preparations to minimize possible blood loss may provoke blood clots in a coronary or cerebral artery or a leg vein, leading to a heart attack or a stroke, or a deep vein thrombosis.

"You can't ram that junk down my throat!"

The word "gullible" comes from the word "gullet" for food tube or esophagus. And the unconscious mind can get mixed up about the old story "I Believe." When you'll believe something ridiculous, you'll "swallow anything."

A related story is "You can't ram that junk down my throat!" in which the esophagus absolutely refuses to accept a belief that it thinks is wrong, and it pretends there is something blocking the esophageal tube, when in actual fact there is no blockage.

The person in whom this is taking place may complain of a feeling of a lump in the throat that feels like the person cannot swallow, although in fact they are perfectly capable of swallowing. This condition is known medically as globus hystericus.

Sigh

Some of the stories in the unconscious mind's library have groups of organs or areas of the body acting collectively, for example the heart, the diaphragm and the breathing muscles, playing the leading parts in "Sigh"- a story of separation from the loved one or the loved place.

In this story the group players (heart, diaphragm and chest wall muscles) demonstrate their claim they cannot stay alive if separated from the loved one or the loved place, by acting out not being able to breathe. The person experiences sighing, heart palpitations and a feeling of not getting enough oxygen, until the longed-for reconciliation. This condition was described in the 1930s by Max Herz as **phrenocardia.**

"We'll pay you back for abusing us!"

Sometimes a group of muscles and tendons, for example in forearm, upper arm and shoulder, will cobble together a story called "We hate you for doing this to us!" and will punish with continuing severe pain the Rubik's Cube fanatic or the computer mouse over-user.

This is the basis of the complex regional pain syndrome described as repetitive strain injury or RSI.

"She's a real pain in the neck and she's sure getting me hot under the collar!"

When I was a young resident medical officer, I saw an adolescent girl in the hospital casualty department complaining of painful red areas on the sides of her neck. This girl was very tense and irritable. She said, "My mother is a pain in the neck! Whatever I do is wrong, I can't win, and I'm sick of it!" She was obviously living out the story called "Hot under the collar".

Some people adopt a "stiff-necked" approach to criticism by others, refusing to respond to it, holding their heads up with pride, and perhaps suffering from neck pain. We often describe a constant critic as "a pain in the neck".

Lower back pain. (Can you stand up to it?) When we're standing up straight and unaided, the centre of gravity passes through the area where the spine joins onto the pelvis at the sacrum. Anxiety over whether one is able to stand alone, to be able to stand up and be counted, is often associated with pain and aching in the area of the lower back and hips.

When this person makes a decision to ask for help to overcome their problems they were trying to deal with on their own, the symptoms may be relieved.

Upper back pain. (They're getting my back up!) Pain between the shoulder blades and stiffness of the spine in the upper back is often associated with the body being put into a state of readiness for a fist fight.

The admonition "Don't get your back up!" meaning "don't be so defensive" draws our attention to the fact that upper back pain and stiffness is often associated with situations where we have to be prepared to defend ourselves against the unreasonable aggression of other people.

Dyspepsia, feeling sick in the stomach. (He makes me sick!) The autonomic nervous system controlling the functions of the stomach is always ready to reject anything by vomiting it up, of something we have taken in, that is considered dangerous to the body. This is usually a fairly quick response, where something that looks and smells good, is found to be instantly corrosive soon after it is swallowed.

We often find that a chronic state of feeling as though vomiting is imminent, is associated with being forced to accept beliefs, attitudes and behaviour that are deeply repugnant to us.

Diarrhoea. (He gives me the shits!) If there is something (a food or a belief) we have swallowed, and we were foolish enough to accept it as though it were harmless, and then we find out it is really dangerous to the tissues of the body or the integrity of the

personality, the autonomic nervous system will get rid of it by washing it through the intestines to get rid of it quickly through diarrhoea.

A common situation is that someone has accepted as real, some false information given to them by someone who was at that time a trusted person. When the person who was deceived becomes aware of the real truth, and realizes the seemingly true information is in reality something harmful, the unconscious mind may react with explosive diarrhea.

Tension (muscle contraction) headache The underlying story here is **"I have to be prepared to deal with the next catastrophe but I don't know when it will happen".**

Most patients I have seen who suffer from a chronic headache that starts when they wake up and is there when they go to bed, are in a chronic state of readiness to deal with the next thing that will go wrong.

But they don't know when this will happen, and so the muscles of the neck and shoulders are holding the head and shoulders rigid all day long, so as to free the arms for immediate action.

"I can't tell my daughter to leave."

The sudden inability to speak was useful to an elderly father whose daughter was living with a man who proved to be violent and dangerous. The daughter had

come home to her father for protection, and now the violent ex-lover was coming around, threatening the father that if the father did not tell the daughter to return to him, he would kill them both.

The elderly man suddenly lost the power to speak. Under hypnosis, he was able to speak normally. The loss of speech was a partial solution to the immediate problem of having to tell the daughter to return to the dangerous lover.

"I couldn't hit my mother!"

In another case, a man living with an elderly mother who had early dementia and was verbally abusive, suddenly lost the use of his right arm. This seeming paralysis prevented him for hitting her in response to her cruel and relentless verbal abuse.

"I don't want to see my mother with another man."

A little girl claimed to have lost her sight, a “blindness” that protected her from seeing her mother having an affair with another man while her father was at work.

Complex patterns of preparedness - the "as if" syndromes

Most of what is happening in our bodies is not under conscious control. We are largely unaware of the unconscious mind as it makes decisions, responds to

problems, nourishes, repairs, supports and prepares us for mental activity that we are conscious of.

There are a number of stress-related illnesses caused by the unconscious mind preparing the body for action. I call these the “as if” syndromes.

"As if" I’m fighting for my life

There was an interesting article in one of the medical journals a few years ago, about the use of onions and garlic to reduce the risk of thrombosis - that is, clotting of blood within veins and arteries. It was based on an old French veterinary remedy for thrombosis in horses, and it sparked off some witty letters to the editor about this proposed method of preventing heart attacks.

An experiment was described where medical students going in to examinations had their blood tested for its clotting ability, with or without a meal of onions. The researchers purported to show that the students without prior onions showed an increased tendency for the blood to clot, as a result of the stress of the examinations.

What interested me more than the onions or their effects on interpersonal relationships, was that the blood of healthy young people should be more ready to clot when they go "to do battle" with the examiners. I have heard that people in "hiring and firing" jobs have a higher risk of heart attack. (Heart attacks are usually

caused by coronary thrombosis - a clot of blood blocking up the coronary artery to the heart).

It is "as if" the person going out to face some conflict has his body made ready to respond to a possible loss of blood. It is said that soldiers sustaining severe wounds in battle, often don't bleed much at all, whereas if a person sustains a severe unexpected wound, as in the case of a butcher severing a femoral artery while boning the ribs of a carcass, there is a real risk of dying immediately from loss of blood. Clearly, readiness for conflict can minimize blood loss.

It is "as if" the body tones up the blood vessels, so they are all ready to shut down the moment they are severed, and the blood made ready to clot at a moment's notice. Unfortunately, if the battle involves a politician under attack from his opposition, having to defend himself against a barrage of criticism at question time in the parliament, then the toned up blood vessels and quick-clotting blood would be of no good use to him at all.

Instead the increased tone of the blood vessels and the extra clotting ability might cause a clot to form in a vein or artery. I remember how the late President Richard Nixon suffered from thrombosis of his leg veins when he was in a beleaguered state prior to his resignation.

"As if" I'm hanging on by the skin of my teeth

There are many patterns of preparedness characterized by chronic contraction of specific muscle groups. A

common pattern is seen in the person who is expecting the worst and has his teeth clenched and head held rigidly in anticipation. This may cause severe pain in the temporo-mandibular joint in front of the ear, as well as headaches and neck pain.

In general, I find that people who are always psychologically bracing themselves for disaster, tend to suffer with stiffness and pain of the extensor muscles of the body. These include not only the muscles at the back of the neck, but those of the shoulders and the lower back, as well.

Manipulating us through pleasure and pain

The unconscious mind rewards us with pleasurable body feelings when we do something the autonomic nervous system wants us to do, like emptying a full rectum or a distended bladder. And there is nothing so delicious as the instant pleasure of cool water in the mouth of a thirsty dehydrated human being.

Likewise the unconscious mind rewards us with feelings of body relaxation from a good deep muscle massage, and we can be manipulated into all sorts of behaviour if it culminates in the ultimate reward of an orgasm.

The unconscious mind also punishes us with pain signals through activating the autonomic nervous system's pain-carrying fibres, if it judges that we have carelessly caused damage to the inner parts of the

body, and this pain is a very disagreeable punishing pain known sometimes as causalgia.

The unconscious mind dislikes indecision and delay

We are born with an unconscious mind that already has a list of conditions or behaviour that it will not tolerate, such as having to wait when you don't know how long you will have to wait, and being unable to decide what to do next. The unconscious mind usually punishes indecision and delay by triggering disagreeable feelings of anxiety or guilt.

Endorphins - the brain's own pain-killers

If you accidentally crack your kneecap on the desk as you sit down in a hurry, you will immediately experience a sharp pain, carried by the large rapid-firing sensory nerve fibres of the peripheral nerves. This sharp pain will be followed by a slow, disagreeable punishing pain carried by smaller slower-firing fibres associated with the autonomic nerves.

You will feel punished, and you may even vocalize your own stupidity in not being careful. This is the unconscious mind punishing you for allowing a part of the body to be damaged.

Fortunately, the conscious mind has a way of calming down the unconscious mind when it is disturbed. The brain releases pain-killing drugs called endorphins.

Endorphins have the same structure and function as the opiate drugs like codeine and morphine, drugs that originate in the milky sap of the poppy plant's unripe seed pod.

Opiate drugs work like endorphins

Opiate pain killers seem to be specific for pain arising in the interior of the body, where the pain is being transmitted by the autonomic nervous system fibres that carry endorphin receptors. This is why, in response to an injury affecting the interior of the body, it is appropriate to use opiate pain-killers immediately.

CHAPTER SIX

Stress Breakdown

Most of us already know that too many worries can strain relationships with workmates, harm our health, and destroy marriages.

What we may not realize is how much damage results from the failure of our communities to understand the behaviour of over-stressed people.

The first sign you are beginning to break down from too much stress is that you suddenly experience free-floating anxiety.

Free floating anxiety is a vague, urgent feeling of unease or dread.

At the same time you may feel tense and easily startled. You may also experience symptoms in various parts of your body, caused by your body being prepared to run away or fight. And in some cases, being prepared to drop to the ground and play dead.

If you stay in the stressful situation, using your will power and your "don't power" and your energy reserves to keep going, you may experience, as well as anxiety, one or both of the two symptoms of the second stage of stress breakdown:

- Loss of the ability to control your emotions. You may flare up suddenly into anger, tears or laughter.

- Loss of the ability to motivate yourself. You cannot force yourself to get back to work. Your "get up and go" will seem to have got up and gone.

If you still cannot find relief from the stressful situation, you may then experience the three symptoms of the third stage of stress breakdown:

- You may suddenly find many forms of stimulation quite disagreeable, and you will tend to withdraw emotionally and avoid sensory stimulation. You may find noise, bright lights, people touching you, tight clothing and loud music, intolerable.

- You may suddenly lose the ability to not react to things you have previously put up with for years. You may become suddenly intolerant of faults and failings in others and in yourself.

- You may appear to others to have undergone a personality change. Important responsibilities now seem to be ignored, while you continue to react normally to unimportant matters.

If you try to continue coping with stress that has caused you to experience these three different groups of stress symptoms, you may become seriously ill, unable to

carry out your normal duties and functions. This illness may take the form of a mental illness, an emotional illness, or a physical illness.

In any case, you will also experience major communication difficulties with your workmates and loved ones. You may even come to believe quite wrongly, that your marriage or love relationship has broken down.

Don't panic! As you learn what causes these stress symptoms, you will find ways of avoiding stress-caused illness and stress-caused relationship breakdown.

Here is a poem to help you remember the three main groups of symptoms we find in stress breakdown:

Poem on stress breakdown

In stress breakdown. the very first sign
Is feeling tense and nervy most of the time.

And if you don't work out what's getting you up tight
And you just go on will power, thinking you'll be all right-

Two things can happen when your battery runs down
You can find yourself just sitting around
Can't get started;

Or flying off the handle, bursting into tears
Getting more emotional than you've been in years.

The family might recognize you're going off your head
And lovingly suggest you spend the day in bed.

There are three stages in stress breakdown,
I've mentioned one and two,
And I won't be surprised at all,
If what I said, you already knew.

But here's the situation that really worries me
Only just a very few can recognize stage three.

Stage three symptoms can't be underestimated-
For many people wrongly think love's just deteriorated.

Suddenly you can't stand noise or any stimulation
You just want to get away from the whole situation.

All your loved one's faults and failings
You never criticize,
Suddenly you just can't stand
They're intolerable in your eyes.

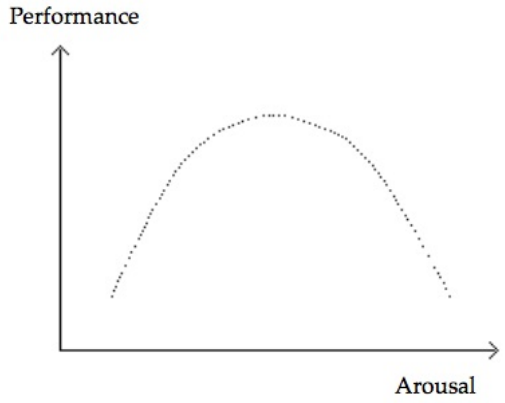
And your reaction pattern changes;
Big problems you don't see
While unimportant details
You treat attentively.

When all these things
Are happening,
That we don't comprehend -
Love relationships are weakened,
On which family life depends.

Explaining stress breakdown.

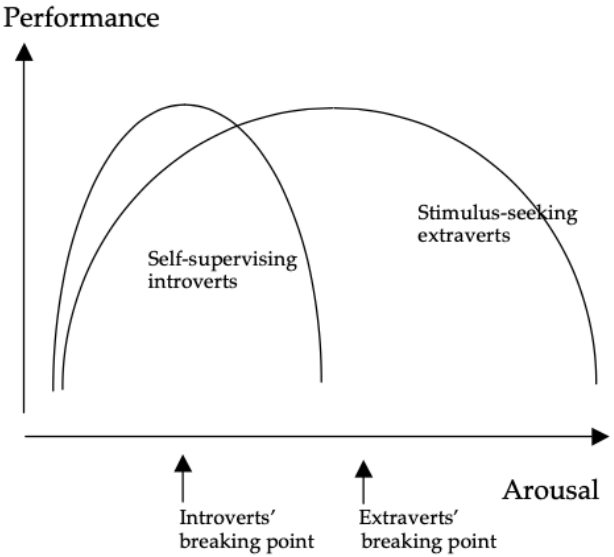
Everyone breaks down under excessive stress. Each of us has a breaking point beyond which we all experience the symptoms of stress breakdown.

If we draw a graph of mental performance in relation to



arousal level or stress level, the result is a curve like an upside down letter U. As stress or arousal level increases, we find performance increases to a peak, and beyond that peak, further arousal or stress just results in a falling-off of performance.

This inverted U curve is also known as the Yerkes-Dodson Law, and has been known to psychologists for many years. The peak of the curve is the breaking point, the point beyond which our performance deteriorates with increasing stress or arousal.



(The research was done in 1970 by Susanne Wilkie at the University of Queensland, using white noise as the stressful stimulus with groups of students identified by the Eysenck scale as highly introverted and highly extraverted respectively.)

If we draw graphs for different personalities, we find that quiet sensitive introverted people tend to break down at a lower level of stress than do the rowdy, stimulus-seeking extraverts. However, the graph also reveals that introverts work more efficiently at lower levels of arousal.

These are the self-supervising people who work best when they are left alone to get on with the job. Extraverts, on the other hand, usually need constant encouragement and supervision for full efficiency.

It might seem from these graphs on the previous page, that it would not be difficult to choose the right personnel for high stress jobs: just choose stimulus-seeking extraverts. However, such attempts at selecting people for high stress jobs on the basis of personality type usually fail.

The main reason is that many high stress jobs in military, police, and emergency services require sensitive perceptive people who can work alone without supervision.

And the people who do these jobs best, often turn out to be the sensitive introverts with a lower threshold for stress breakdown.

It is my experience that children regularly victimized at school are usually self-supervising introverts and the bullies are usually (among other factors) stimulus-seeking extraverts.

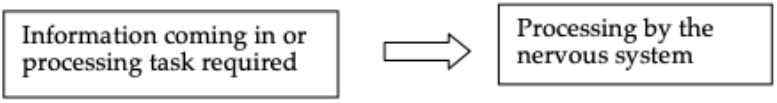
The bullies enjoy the sport and the feeling of power from imposing stress on their sensitive introverted victims sufficient to cause stress breakdown symptoms.

The warning signal of free-floating anxiety

If we are asking the brain to handle more information than it can comfortably process, or carry out some task that is too difficult, a warning signal is fired off, adrenalin is released into the bloodstream, and we will

experience a feeling of unease or dread plus the symptoms of body arousal for fight or flight.

This feeling is called *free-floating anxiety.*



If the brain is unable to process the information properly, an alarm is triggered and adrenalin is released. This causes free-floating anxiety, which is made up of:

- **A warning component**- a vague urgent feeling of unease or dread
- **A preparation component**- the body is made ready to run away or fight.

It is called "free floating" anxiety because it doesn't seem to be attached to anything; unlike for example a fear of spiders, where a feeling of anxiety is attached to the possibility of encountering spiders. With free-floating anxiety, you feel worried or anxious or tense, but you don't know why.

Psychiatrists usually refer to free-floating anxiety simply as anxiety, and anxiety attached to specific objects or situations as phobic or situational anxiety.

Anxiety is basically an alarm signal triggered by the brain when it is having difficulty processing the information being presented to it.

If you are interested in understanding the neurophysiology at the basis of the three stages of stress breakdown, I suggest you read my book "Understanding Stress Breakdown".

Stress breakdown results from stress. The counsellor's role in treating and preventing stress breakdown is very important.

Treating the symptoms of stage two

The two extra symptoms of stress breakdown caused by fatigue and exhaustion of the body's will power and inhibitory controls are:

1. Loss of the capacity for emotional control
2. Loss of the capacity for self-motivation.

As these symptoms are due to exhaustion and depletion of the nervous system's will power reserves, the symptoms will abate when the person is rested and the body's reserves are restored.

I advise putting overstressed people with exhaustion symptoms into bed and feeding them. They should be encouraged to sleep as long as possible.

They should also be given vitamin supplements, particularly the B group vitamins and extra vitamin C, 500 to 1000mg per day.

Treating the symptoms of stage three

- Intolerance of sensory stimulation
- Apparent change in priorities and attitudes.
- Inability to tolerate things previously tolerated

The symptoms of stage three are caused by the operation of the brain's circuit breakers. These symptoms will disappear when the excessive load on the brain is reduced. However, people experiencing third stage stress breakdown usually cannot help themselves because the symptoms themselves interfere with the capacity for insight and self-organization. It is useless just giving advice. A rescuer is required.

Almost invariably, people with third stage stress breakdown symptoms have broken down under a combined load of external and internal stresses. The internal stresses are often a murky web of complex self-contradictory and convoluted demands on the self to look good, not appear vulnerable, and guarantee success.

The rescuer will be most helpful when the approach taken is one that bypasses the internal stresses and simplifies and clarifies the task to be dealt with. Something like: "I know how important it has been for you to make sure everything went well. You've worn yourself out doing this, and we are grateful for the contribution and sacrifices you have made. However, if we are to get this project finished we need to focus on those aspects that you personally are responsible for.

We won't worry about those things you cannot personally do anything about."

Allow the overstressed client to withdraw

It is essential for the person with stage three stress breakdown symptoms to be protected from the added stress of having to explain his unusual behaviour. Quiet places providing minimal stimulation are helpful, the best being a quiet bedroom in one's own home, with no telephone.

Only consider holiday places if they are quiet and require no great effort on the overstressed person's part. If an overstressed person is to be sent on a holiday, someone else will have to do the bookings and make the travel arrangements.

If the person is admitted to a hospital, there should be no visitors except close family, and these only for short visits.

Keep explanations simple, avoid misinterpretations

In third stage stress breakdown, changes in behaviour are almost inevitably going to be misinterpreted. The commonest misinterpretation of the symptoms is that of marriage breakdown. It is essential to explain clearly and simply how the unusual behaviour of the overstressed person is caused by stress breakdown. If people close to the overstressed person refuse to

accept this explanation, they should be kept away until the situation returns to normal.

Rest, relief of stress, and a lot more sleep

The treatment of a person with stage three symptoms should include everything already said about the treatment of stages one and two. Rest and relief of stress are the most important things to insist on.

We know the healing has started when the overstressed person is overcome by the need to sleep. When someone who has demonstrated unusual behaviour in a time of high stress, sleeps the whole weekend (without the aid of drugs) - this is a very good sign.

Stress we cannot avoid

Many people are in situations where stress in unavoidable. The mothers of newborn babies cannot hand over sick children readily to someone else. The same often applies to families with severely handicapped relatives. Police, teachers and ambulance officers find that stress goes with the job.

If stress is unavoidable, it is important to identify stress symptoms for what they are and not to mistake them for symptoms of illness. If you cannot avoid the big problems, let go as many non-essentials as you can. Get as much sleep as possible, even if it is just "forty winks" now and then during the day.

Look after your nutrition. Don't skip meals, or start crash diets. Decide to take a holiday when the stress is over, and do it. The holiday might be going to bed for a few days, or going away to recuperate and be pampered.

New mothers and stress breakdown

Of the many different high stress occupations and situations, I would like to make special mention of the mothers of newborn babies. They often have to cope with stress they cannot avoid, while missing out on sleep. And many new mothers have been weakened nutritionally by the metabolic demands of the growing baby, the effects of the hormones of pregnancy, and sometimes an exhausting labor.

The mothers of newborn babies can suddenly develop serious stress breakdown symptoms, quite often experiencing the three stages at once. This is because their state of health is quite precarious in this post-natal period. The mother of a newborn baby can suddenly deteriorate from seeming quite normal to appearing deeply emotionally and mentally disturbed, unable to respond to the baby's needs, simply as a result of stress breakdown. Many cases of post-natal depression are in fact cases of serious stress breakdown.

It is usually not difficult to differentiate the post-natal stress breakdown cases from true post-natal depression. Stress symptoms disappear with 48 hours rest, while the symptoms of true post-natal depression

persist in spite of rest. It is essential for true post-natal depression to be recognized early because this is a serious illness that requires medical treatment.

I do not agree with the current practice of sending women home from hospital soon after the baby is born. It is sending wrong signals to our society. Hospitals are expensive, noisy and inconsiderate places, and we cannot blame women for wanting to get home to their families as soon as possible. But some women seem to think because they are allowed home they are capable of a normal work load.

Chinese women have the right idea. They have a tradition called "sitting the month"; the mother of a newborn baby does nothing other than breast-feed her baby and attend to her own hygiene for one month after the baby is born. While she is being looked after by her husband and others in the family, she is recuperating her strength. Traditional Chinese belief is that in this post-natal period, women are very vulnerable to all sorts of illnesses because of their weakened condition.

CHAPTER SEVEN

Highly sensitive people

Almost one hundred years ago, (he began writing in 1928) the famous Russian physiologist Ivan Pavlov became aware that some highly sensitive people had nervous systems that actually magnified sensory information coming into the brain.

These people tended to break down more easily under stress with their nervous systems switching on inhibitory nerve networks that provided protective inhibition to overloaded neural networks.

Dr Elaine Aron

In 1991, Dr Elaine Aron began studying "the innate temperament trait of high sensitivity". (see her website "The Highly Sensitive Person" at https://hsperson.com) On her website, Dr Aron states: "If you find you are highly sensitive, or your child is, I'd like you to know the following: (My own comments in brackets)

- **Your trait is normal.** It is found in 15 to 20% of the population.
- **It is innate.** Biologists have found it in over 100 species.

- You are more aware than others of subtleties. This is mainly because your brain processes information and reflects on it more deeply. (Many highly sensitive people are more "spiritual", paying attention to issues often ignored by others)

- You are also more easily overwhelmed. (and more likely to experience symptoms of stress breakdown under prolonged stress)

- This trait is not a new discovery, but it has been misunderstood.

- Sensitivity is valued differently in different cultures. (It is valued by indigenous cultures, such as the Australian Aboriginal people and is highly regarded in Slavic cultures)

Susanne Wilkie's Experience

My wife Susanne Wilkie is a psychologist who has a lot of experience working with children. She often becomes concerned to hear sensitive children or teenagers describe themselves negatively as being “too sensitive” as though this is some defect that they have failed to correct.

Often Susanne is able to reassure sensitive people that they have been born with a significant advantage in being sensitive, creative, and thoughtful, and therefore likely to become successful in certain fields of endeavour.

Sensitive people are often interested in music, singing, drawing, dance and art, and they like having time to themselves so they can think.

Because of their increased sensitivity they tend to react to irritants and pollens in the air, to become allergic to additives in foods, and they are more susceptible to environmental toxins.

Some of the highly sensitive kids in their early childhood have experienced blocked up Eustachian tubes and ear infections that may become chronic.

Some may develop learning problems at school associated with under-development of auditory processes.

Therefore some sensitive children can be disadvantaged by specific learning problems that other non-sensitive children have as well.

But the sensitive ones tend to be teased about their difficulties, they usually blame themselves for having problems, and they tend to withdraw and become anxious about going to school.

In my practice, I see highly sensitive adults already badly damaged by misinformation and being mistreated by teachers and employers. Some highly sensitive adults experience being bullied at work, and these people may have been bullied in the schoolyard as well.

Recent research on highly sensitive people

In the 21st century, new technology is confirming the truth of Pavlov's 20th century findings. From Brain Behav. 2014 Jul; 4(4): 580–594. **The highly sensitive brain: an fMRI study of sensory processing sensitivity and response to others' emotions**

Theory and research suggest that sensory processing sensitivity (SPS), found in roughly 20% of humans and over 100 other species, is a trait associated with greater sensitivity and responsiveness to the environment and to social stimuli. Self-report studies have shown that high-SPS individuals are strongly affected by others' moods, but no previous study has examined neural systems engaged in response to others' emotions. These results provide evidence that awareness and responsiveness are fundamental features of SPS, and show how the brain may mediate these traits.

Unfortunately, not many doctors, psychologists and psychiatrists are aware that about 20% of their clients are by nature highly sensitive, tending to think differently about personal issues, over-reacting to injuries and pain, and suffering from allergic and auto-immune health problems. There has been an unfortunate tendency for highly sensitive children to be wrongly labelled as suffering from "Over-anxious Disorder of Childhood", which in my view does not exist.

Just childhood itself in families of highly sensitive people is scary enough. There is no need to assign erroneous labels of disorder.

In relation to stress breakdown, highly sensitive people should be advised that they will become overwhelmed and anxious before their "average" companions will, they will need more sleep than the others, and they should withdraw from stressful situations early, before they show signs of breaking down.

CHAPTER EIGHT

Post-traumatic stress disorders

People who have survived stressful events or periods in their lives may never be able to forget what happened. They may have nightmares over and over, of the same event. Sometimes a chance stimulus will remind them of the event, and they may instantly react as if it were happening all over again.

They may feel edgy a lot of the time, as though constantly on the look-out for danger. And sometimes they feel numb, alienated from people around them, able to share memories of the event only with others who were there at the time. We call this a post-traumatic stress disorder.

What causes it? It seems that the memory of a stressful event includes a memory of body feelings in just the same way that pleasant memories may be associated with smells or sounds. Recalling the event recalls the complex distressing feelings of stress breakdown which were experienced at the time. And because people don't like feeling anxious and distressed, they will avoid recalling the memory. So it sits there, half-forgotten, like an open wound that has never been closed, or like a bruise that has never healed.

Psychiatrists detect these painful memories during history taking. We notice an emotional reaction when the patient mentions the event. A tear in the eye, a changed expression, a change in facial colour, a tremble of the lip, a quaver in the voice. What is happening is that at that moment the patient is re-experiencing all over again, a sample of the symptoms of stress breakdown endured at the time.

The event might be some form of physical or sexual abuse in childhood, an act of brutality in war, the humiliation of being held hostage by a bank-robber. Any traumatic event which we might describe as outside of everyday human experience can produce a post-traumatic stress disorder (PTSD).

Unfortunately many people working in the helping and caring professions do not realize that the patient has no control over the symptoms of PTSD. When exposed to some stimulus that reminds them of the past trauma, they will automatically begin responding as if that previous trauma were happening again, whether they want to or not.

Below are the criteria that psychiatrists use for diagnosing PTSD. Many practicing psychiatrists consider section A to be too restrictive, as they continue to see patients who are suffering from PTSD as a result of stress which did not actually involve the threat of death or physical injury.

Diagnostic criteria for post traumatic stress disorder (PTSD) from the Diagnostic and Statistical Manual of Mental Disorders 4th edition, published in 1994 by the American Psychiatric Association

A. The person has been exposed to a traumatic event in which both of the following were present:

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

(2) the person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behaviour.

B. The traumatic event is persistently re-experienced in one or more of the following ways:

(1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

(2) recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.

(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific re-enactment may occur.

(4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

(5) physiological activity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
(2) efforts to avoid activities, places or people that arouse recollections of the trauma
(3) inability to recall an important aspect of the trauma
(4) markedly diminished interest or participation in significant activities
(5) feeling of detachment or estrangement from others
(6) restricted range of affect (e.g. unable to have loving feelings)
(7) sense of a foreshortened future (e.g. does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
(1) difficulty falling or staying asleep
(2) irritability or outbursts of anger
(3) difficulty concentrating
(4) hypervigilance
(5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B,C and D) is more than one month.

F. The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

Here are some excerpts from *The Psychobiology of Post Traumatic Stress Disorder* by Bessel A. Van der Kolk, M.D. published with permission from the Journal of Clinical Psychiatry 1997;58 (supplement 91,16-24) Dr Van der Kolk is regarded as an expert in the study of PTSD.

"When Abram Kardiner (1941) first gave detailed descriptions of the effect of war trauma, he noted that sufferers from

"traumatic neuroses" develop an enduring vigilance for and sensitivity to environmental threat. Kardiner stated that the physiologic hyperarousal characteristic of PTSD occurs not only in response to combat sounds: many of his patients also suffered from sensitivity to temperature, pain, and sudden tactile stimuli, as well. "These patients cannot stand being slapped on the back abruptly; they cannot tolerate a misstep or a stumble. From a physiologic point of view, there exists a lowering of the threshold of stimulation, and from a psychological point of view, a state of readiness for fright reactions."'

"PTSD is not an issue of simple conditioning. Most people who have been exposed to a tragedy become distressed when they are reminded of it, whether they develop PTSD or not. Pitman et al. have pointed out that the critical issue in PTSD is that the stimuli that cause people to over-react may not be conditional enough: a variety of triggers not directly related to the traumatic experience may come to precipitate extreme reactions.

The persistence of intrusive thoughts and images, by means of the process of kindling, sets up a chronically disordered pattern of arousal, in which the patient reacts to a host of reminders with a physiologic intensity appropriate to the original trauma."

"In an apparent attempt to compensate for their chronic hyperarousal, traumatized people seem to shut down on a behavioral level, by avoiding stimuli that remind them of the trauma, on a psychobiological level, by emotional numbing, which may extend to both trauma-related and everyday experience.'

Over time, people with chronic PTSD come to suffer from numbing of responsiveness to the environment, intermittent hyperarousal in response to emotionally arousing stimuli, and

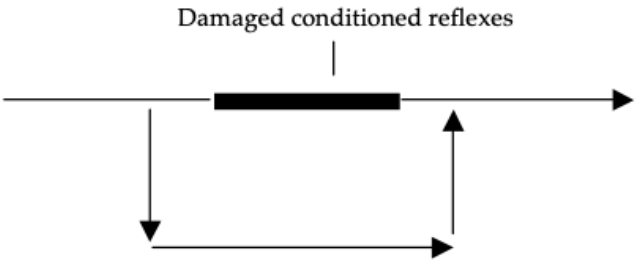
nonspecific hyperarousal to intense but neutral stimuli. Hence, abnormal psychophysiologic reactions in PTSD occur on two different levels:
(1) in response to specific reminders of the trauma and (2) in response to intense, but neutral stimuli, such as loud noises. This indicates that people with PTSD suffer from a loss of stimulus discrimination.

It is clear from the above that severe psychological trauma can produce long term changes in the way that people subsequently react to stress.

Therapy involves setting up new conditioned reflexes that will re-route the circuit around the damaged area

It is important for therapists working with patients suffering from PTSD to recognize that recovery is going to involve a re-education program that will result in the forming of new conditioned reflexes that function normally. This requires skill on the part of the therapist, and the process usually takes about two years of regular psychotherapy sessions.

The process of re-education or reconstruction could be described in electrical terms as though probes are inserted to find the disordered reflexes, and then a nerve cell network detour is constructed to skirt around the damaged area.



Steps in treatment of post traumatic stress disorder

The first step is to give the patient with a post-traumatic stress disorder the status of a damaged person. Thus the abused child is someone who was abused, not a bad person. The child bullied at school is someone who was victimized, not a coward. The worker who has suffered a stress breakdown from being harassed out of his job is an injured worker, eligible for workers' compensation.

The human ego is a self-centering system that tries to put us on center stage. Most people who have broken down as a result of deliberate abuse by others, tend initially to blame themselves for the abuse. The ego would rather believe that the victim is to blame for the abuse heaped on him, because in a sort of cock-eyed upside down logic, there is power in the idea "if I caused it, I can stop it happening again."

This first step in treatment must involve the patient getting beyond self-blame. If a patient suffering from a post traumatic stress disorder continues to blame himself, he will not be able to move on to the next step in treatment.

The second step is to examine the memories of the traumatic events, and try to fit them into some meaningful framework. If the victim can see why the bully acted the way he did, the events begin to make sense. At this stage there is no thought whatsoever of

making excuses for the bullying behaviour, just simply to make sense of it.

A senior lecturer, forced into giving tutorials in a subject he had never been trained for, by superiors intending to force him to resign, felt relieved when a friend overheard some of these people bragging about their dirty tricks campaign. The victimized lecturer was then able to understand why they had behaved as they did.

Reiker and Carmen (1986) pointed out that "confrontations with violence challenge one's most basic assumptions about the self as invulnerable and basically worthy, and about the world as orderly and just. After abuse, the victim's view of self and the world can never be the same again; it must be reconstructed to incorporate the abuse experience."

This reconstructive part of the therapy for post-traumatic stress disorder can be challenging for therapist and patient. A psychiatric nurse had never recovered from the trauma of a patient trying to strangle her. She saw in this man's eyes, sheer hatred, real palpable evil.

A major problem in her rehabilitation was that her psychiatric training had no explanation for evil, misrepresenting malice as either ignorance or mental illness; but she knew the malevolence she saw in his eyes was neither of those. It was evil, and her rehabilitation required her to come to an understanding of what evil is.

The third step in the treatment of post-traumatic stress disorders is to reclaim the ground that has been lost. The person returns to the place, to the role, or to the expectations that existed before the trauma. The bank clerk who has been robbed and held hostage, prepares to return to the job.

The woman who was sexually abused by her step-father accepts his apology. In this third step, the skills of the therapist are really tested. The traumatized person does not want to return to the place where it all happened, and yet knows that unless he does, he our she will always be a victim.

CHAPTER NINE

Bullying

Some cases of PTSD arise from a tragic accident in which there was no intent to emotionally traumatize anyone. Many cases, however, arise from deliberate and repeated bullying aimed at causing someone to break down emotionally, for example:

- Children and adolescents regularly bullied at school to provide some sort of daily entertainment for their tormentors.

- Repeated and habitual violence inflicted on family members by mentally and emotionally disturbed individuals.

- Workers deliberately put under pressure by their supervisors to encourage them to resign, as part of a workplace restructuring plan where the employers want to be spared the expense of offering redundancy payouts to displaced workers.

- "Whistleblowers" subjected to stress with the aim of causing stress breakdown and destroying their credibility after they had exposed corruption or inefficiency.

When people suffer stress breakdown as a result of deliberate bullying, the breakdown is usually severe. The reason is that the victim has usually kept the bullying secret out of embarrassment or fear of reprisal, and therefore there has been no rescuer to help in responding to second and third stage stress breakdown symptoms.

Often it is only when serious stress breakdown symptoms occur and the victim's behaviour becomes obviously abnormal, that the bullying comes to the attention of others. For example, a chronically bullied child at school may suddenly over-react and seriously harm the bully with a weapon. Or a response that is probably more common - the desperate victim attempts suicide.

Where severe stress is continuous and the victim is powerless, stress breakdown is inevitable. And where the victim is prevented from reporting the abuse, there is often nowhere else to express his rage except against himself. This is why depression, self-hatred, self-mutilation and suicide are seen so often in victimized people.

Bullying in organizations

Greg McMahon, National Director of Whistleblowers Australia, has compared four types of school bullying with their counterparts in the workplace. These are the gatekeeper bully, the sandpit bully, the toilet bully, and the king bully.

“The gatekeeper bully at school took up a strategic position, say on stairs, the door to the library, the walkway across the creek, or the like, and decided who could pass.”

“In the organization, gatekeeper bullies deny their subordinates, without reasonable grounds, applications, priority, funds, meetings and/or briefings necessary for the subordinate’s work, training and experience necessary for gaining qualifications, and/or enjoyment of family life.”

“The gatekeeper bully at kindergarten kept other children from entering or leaving the sandpit. The sandpit bully, on the other hand, kept knocking down or otherwise ruining any sandcastles or other structures made by other children in the sandpit.

This open behaviour included forms where the bully would help build the structure only to destroy it before it could be used or admired. More secretive behavioural forms also occurred. Sandpit bullies stole pieces of the jigsaw puzzle others were putting together, threw the cricket ball into the creek, or ruined the display with graffiti.”

“In the organization, sandpit bullies are more proactive than gatekeepers. Sandpit bullies restructure successful teams in order to split them up, assign experts to generalist duties, send achievers on wild goose chases, reassign leaders to tasks without purpose, and personally take over projects when success is assured;

sandpit bullies also cancel holiday leave approvals without substantial cause, deny use of company resources for in-house training courses, refuse relief arrangements while the bullied are away from the office, give officers directions that are ruinous of the relations that the officers have with other staff."

"The most hurtful bullying at school has been largely associated with toilet areas and change sheds. These areas are where the school organization affords the bully the greatest degree of privacy and freedom from supervision and inspection. These most hurtful forms of bullying include head flushing, slanderous graffiti, physical torture, extortion, removal of clothing, king hitting, personal ridicule and open threats."

"The toilet bully in organizations also prefers to operate where inspection by others is most difficult. The privacy of toilet areas and store rooms is not discarded, but with respect to organizational procedures, the "privacy" opportunities utilized by the toilet bully include the one-to-one interview or counseling interview, selection interview and the like.

The area of greatest operation of the toilet tactics, however, is within the "privacy" of the discretionary power afforded to the superior officer by the organization in decision-making affecting the subordinate officer."

"The most developed form of the organizational bully is the king bully. At school the king bully had a gang, and

they 'expelled' the bullied person from the playground; the bullied person had to either join another gang or leave the school. Territories for gangs were defined, and rules were established, both within gangs and across gangs."

"The king bully in an organization 'expels' officers, expels them from locations, from careers, from favored groups, from special projects/collaborations/ committees, and from organizations."

"Within organizations, the king bully is an organizational or location chief or professional head, and operates in the open with apparent impunity. Other king bullies are accommodated, their 'territories' even respected. There is no place, however, in the king bully's domain for independents; only favored officers and hired hands are allowed."

"Expulsions are effected by subordinate bullies in the organizational 'gang', of the sandpit variety (or the toilet variety if the bullied person shows resistance.)"

Our society usually blames the victim

Our society usually tries to blame the victim for the harassment. We send the victims of school bullies off for counselling when they have done nothing wrong. Often the victim is the one who is advised to go to another school. We advise the battered wives it is their own fault for staying with their abusive husbands. We

describe whistleblowers as having personality disorders and accuse them of being misfits in society.

Sadly, the victims usually join in and blame themselves for the abuse they have suffered. They accuse themselves of cowardice, of being weak and allowing the bullies to reduce them to tears.

Victims may blame themselves for wearing glasses, being fat, being thin, being short, being tall, being black, being white, whatever it is they are being relentlessly teased about.

The truth is that bullies pick on you for one reason only. They see you as an easy target, and they think you will not strike back.

This is why the typical victim is a sensitive introverted child who does not belong to a large peer group and whose relatives are not known for exacting revenge.

This sensitive child will develop stress breakdown symptoms at a lower stress level than the stimulus-seeking extraverts who tend to be the bullies.

I usually advise people being bullied:

- Tell as many people as you can.
- Change your response, do the opposite of what you are doing now.
- Harden the target, don't be where the bullies are.

Tell as many people as you can

Bullying and despotism are really the same thing. The best antidote against gang bosses and dictators is a free press. The first step on the road to recovery for a woman who is being regularly bashed by her husband is to tell the neighbour and her doctor the truth about the black eye. The bullied child at school tells his parents and the school principal , even though the bullies have threatened even worse violence if he tells.

Change your response

The bullies are putting you under stress deliberately so that you will react in a way that is entertaining or convenient for them. If you change your response, they may lose the feedback they have been getting, and they may decide to bully someone else.

Harden the target

If the bullies are waiting and ready to bully you, but you're not there, you have avoided the experience of abuse. Make yourself a harder target for the bullies to get at. A school child being relentlessly bullied at lunch time might elect to spend the lunch hour in the library, advising the librarian why he is there.

Why do some people bully others?

South Australian researcher Ken Rigby reported that in a study of 25,000 Australian school children aged 8 to 18

years, 3 out of 5 children reported that they sometimes felt like hurting someone. (Rigby and Slee 1991)

Here are some statements endorsed by a sample of 2,158 boys and 1,884 girls attending Australian secondary schools. Percentages are those agreeing with each statement.

Bullying other students makes you:

- Feel good about yourself (boys 15.4%, girls 9.6%)
- Gets you admired by other children at this school (Boys 23.4%, girls 14.5%)
- Prevents you from being bullied (Boys 35.6%, girls 26.8%)
- Shows them you are tough (Boys 39.3%, girls 31.2%)
- Makes you feel better than them (Boys 47.1%, girls 40.3%)

Psychiatrist the late Dr Shirley Waugh, writing in *Bullying, Causes, Costs and Cures* suggests that the antecedents to bullying arise in a normal stage of child development called infantile omnipotence, well under way by the age of three.

"Infantile omnipotence is an unconscious belief (developed in our earliest babyhood) that there is someone, either oneself or another (mother in the first instance) who has all power and all knowledge, immortality and invulnerability, and that this God-like person never ever makes any mistakes. Allied with this is a belief in the absolute uniqueness of that person."

"Nina Coltart, a British psychoanalyst, says that living life is like walking a tight rope, very difficult, and one is

sure to 'fall off' at times. If you fall on one side of the tight rope, unconsciously you feel you are unique, all-knowing, and that everyone else is dust beneath your feet.

If you fall off the other side of the tight rope, then unconsciously you feel that you are the lowest dustiest dust beneath others' feet, and then the people whom you look up to as having knowledge or power are idealized, 'put on a pedestal' to an unreal extent."

"I think we have to accept that the precursors of bullying are there in humans, are part of normal development, and are well developed by the age of 3 years.

These precursors are allied to infantile omnipotence, to the wish to be all powerful, and also to the subsequent wish to project the despised vulnerable powerless parts of oneself on to another, who is then the despised one."

Extraverts and introverts

About fifteen per cent of our population could be described as highly sensitive. These are the self-supervising introverts - quiet, inwardly focused people who need time alone. At the other end of the spectrum are the stimulus-seeking extraverts.

Research at the University of Iowa has revealed major differences in PET brain scans between introverts and extraverts. Debra Johnson, Ph.D., from the University

of Iowa reported in the February 1999 issue of the American Journal of Psychiatry that researchers had found that introverts have more activity in the frontal lobes of the brain and the anterior part of the thalamus. These areas are activated when a person's brain takes on internal processing such as remembering, problem solving and planning.

By contrast, extraverts exhibit more activity in the anterior cingulate gyrus, temporal lobes and posterior thalamus. These areas are typically thought to be more involved in sensory processing such as listening, watching or driving.

The differences in cognitive style and sensory-processing relate to the qualities associated with introversion and extraversion. True introverts are quiet, inwardly focused and reclusive. Extraverts are gregarious, socially active and sensation seeking.

"Introverts get more of their stimulation internally, whereas extraverts seek outside sources," Johnson said. "Extremely introverted and extraverted personalities are two ends of a continuum, with most people falling somewhere in between."

Because there are such structural differences between introverts and extraverts, it is unlikely that extraverts will ever be able to see the world the way introverts do, and vice versa.

Introverts tend to develop stress breakdown symptoms at stress levels where others, especially extraverts, may be quite comfortable.

Therefore in a group of people subjected to some common stress, the introverts may be breaking down while the extraverts may be unaffected. Attention will be drawn to the stress-caused behavioural changes in the introverts, and the extraverts will appear superior and strong while the introverts may appear inferior and weak.

This is why introverts are more likely to be the victims of bullying and extraverts are more likely to be the bullies.

Schools bring together students who differ greatly in their size and strength and levels of maturation, providing a suitable milieu for the more robust children to bully the more sensitive or smaller children. Thus many highly sensitive children will experience their school days as highly stressful, and many will carry the scars of post traumatic stress symptoms into adult life.

Unfortunately for our society, many of these highly sensitive people will become the scientists, the musicians, the movie producers, and the therapists. Unfortunate because the sensitive intuitive people we will rely upon to solve problems will be people who have been mindlessly traumatized during their formative years.

Dr Elaine Aron has written an important book The Highly Sensitive Person that describes highly sensitive people and offers these people some valuable insights into the difficulties they face in extraverted cultures like the United States and Australia.

CHAPTER TEN

Identity and dissociative identity disorder

We can identify people in two different ways:

- Through the groups they belong to
- How they differ from other people

We can identify Henry Smith as one of the people who live in Australia, one of the Australians who lives in Melbourne, one of the Melbournites who lives in Preston, one of the Prestonites who served overseas in World War Two, one of the War veterans who lost a leg, one of the legless veterans who attends Dr Jones' psychiatric clinic, one of Dr Jones' one-legged patients who always comes 25 minutes early for his appointments.

And seeing there's only one of them, we have identified Henry Smith by virtue of his membership of a number of overlapping groups. This is the oneness or belonging dimension.

Or we could identify someone by how they differ from everyone else – the fattest kid in the class, the fastest 400 metres runner in the world, the brightest kid in the school, and so on. This is the separateness dimension.

These two characteristics – belonging to a group and wanting to be a separate individual, are both built into the unconscious mind's library of archetypal stories.

Affirmation in oneness and separateness dimensions

We all seek affirmation of our identity in relation to both of these alternatives – our oneness dimension and our separateness dimension. When you're sitting in a group of your fellow students from the graduating class of 1967, and it's now 40 years later, the feeling of belonging is a feeling of inner peace, inner silence, inner quiet.

But if you have just broken the world record for the 100 metres sprint in the Olympic Games or won a major competition in tennis or golf, the feeling is one of exhilaration. You're high for up to 12 hours, and then this exhilaration is followed by a lowered mood for a little longer than the high.

The conversation then goes something like "I'm the fastest man on the planet right now, but when you're on top there's only one place to go, and that's down. I'll have to keep in training because there's always someone faster coming along."

It is fairly common these days where everyone wants to play psychiatry and label each other's behaviour, for people to claim that they have bipolar disorder because they often experience an elevated mood when things

are going well and will feel depressed when things don't go as they expected.

In most of these cases, they have been operating on a separateness dimension, comparing themselves with other people. When they feel they are as good as or better than someone else they feel happy, and when they feel they have failed to live up to the standards of others, they feel sad.

Multiple personality / dissociative identity disorder

Most people have a single ego or self that they have had all their lives. Although they watch their bodies changing year by year, they still feel they are the same person inside. Some older people are shocked when they look in the mirror and see how old their body has become, because the person on the inside does not feel like a person of that age.

In most people the awareness of self or ego is so strong that they would regard as highly unusual the situation where someone appears to have a number of different egos of differing ages. Where a person seems to have a number of different selves or egos that switch places and cause chaos in that person's life, we refer to this condition as dissociative identity disorder or multiple personality disorder.

Dissociative identity disorder is a type of post traumatic stress disorder.

Soldiers who have experienced great fear in a specific battle and who develop a post traumatic stress disorder, often experience “flashbacks” where some chance environmental stimulus like the sound of a helicopter flying overhead can trigger a re-experiencing of that battle all over again.

For a few moments, the war veteran behaves as he did during the actual battle, not recognizing his actual surroundings. He may be embarrassed and ashamed of his behaviour when he “wakes up” to where he actually is.

Dissociative identity disorder is somewhat the same, but in this case an environmental stimulus triggers the switching on of another personality that may appear very different and inappropriate. For example, a mature woman may suddenly switch into speaking and acting as if she is four years old.

Both the war veteran and the person suffering from dissociative identity disorder have no control over these sudden switchings. The war veteran, however, usually knows that the re-experiencing has taken place, while the person suffering from a dissociative identity disorder often does not.

A woman suffering from a dissociative identity disorder or multiple personality disorder was unexpectedly taking up to three hours just getting the shopping done at her local shopping centre. She would be unable to say where she had been and why she was so late. It

was discovered later that in the shopping centre a new shop had opened for business, a fairy shop that sold items related to fairies and angels and butterflies and all sorts of marvellous things that appealed to little children.

This mature woman walking past the fairy shop, would suddenly become a four year old and was lingering for an hour or two in the fairy shop. Eventually the adult personality reappeared and she wondered what she was doing in a shop for children. She would then drive home, mystified by how long she had taken to do the shopping.

This woman had experienced severe ongoing trauma from age four to six, and an inner child personality had developed. However, the woman herself was unaware of the existence of this child personality. It was in her unconscious mind. Like most patients suffering from a dissociative identity disorder, there were several other personalities, each seemingly originating as a result of a specific period of trauma.

These “personalities” become archetypal stories in the unconscious mind and function in exactly the same way as do other archetypes. In most cases of dissociative identity disorder, there is usually a tough, robust personality that tends to appear when the person is under some type of threat. Where another personality develops in a time period where a little girl has to endure ongoing trauma that she cannot avoid, it would

certainly be an advantage if that personality was tougher and more resilient, able to fight back.

What causes dissociative identity disorder? We know that it seems to result from prolonged emotional trauma in a child, prolonged stress that the child has no intellectual resources to cope with.

In our own recollections of our childhood, we recognize that the places and buildings of our childhood loom very large in our memory. We remember these places in sizes that would be relatively large to a child, but when we revisit these places and buildings as adults, we see them for the modest edifices they really are.

Dissociative identity disorder has something to do with the way a child perceives the world.

The hippocampus time lapse camera

There is a brain structure at the tip of the temporal lobe of the brain that is called the hippocampus because someone thought it superficially resembled a mythological monster with a horse's head and a coiled fishlike body.

This brain structure is involved in memory, and it has been likened to a camera that takes a photographic "snapshot" of current happenings at regular intervals.

The nerve cells and fibres in the hippocampus are set up in such a way that memories can be replayed at a

set rate, in exactly the same way that a movie projector works. Recalling memories involves replaying the time lapse snapshots at a particular rate so that motion is simulated.

The hippocampus apparently works just like a combined time lapse camera and playback device.

We have all experienced how time seems to go slowly when we're bored and how it seems to speed up when we're having fun. The hippocampus is responsible for these perceptions. And it has another very useful function: in times of peril, for short periods, the hippocampus can speed up its snapshot-taking just like a camera operating in slow-motion mode.

Most of us have heard of people reporting how when they were in danger, (for example where people were in a car rolling over) everything seemed to go very slowly, and they actually had time to do something they would not otherwise have had.

A bus is coming round a curve on a slight hill. The driver has caught sight of a car speeding towards a road junction and is watching the speeding car that looks like it won't stop in time. Meanwhile a small child has walked out onto the road chasing a balloon. A bystander sees instantly that the bus driver has not seen the child, he is looking at the speeding car. Everything slows right down.

The bystander has plenty of time to run onto the road, grab the child by the arm and whisk the child to safety as the bus goes past. Horrified spectators saw the bystander move at great speed to rescue the child. The bystander said everything was moving so slowly he had plenty of time.

In times of peril, the hippocampus slows down perceived time. We also know that times of peril can cause a post traumatic stress disorder where memories of the traumatic events may never be erased. The hippocampus in involved in these processes.

Let us ask ourselves what would happen if the hippocampus continued to speed up its snapshot-taking to a point where there is virtually no period of time between each snapshot, like a camera where the lens stays open. The perception of time would be greatly affected and the passage of time might appear to cease.

The author is unaware if any scientist has been able to predict what a human being would perceive as happening if the hippocampus' snapshot taking was speeded up to its limit. The most likely outcome would seem to be that everything would freeze just like a freeze-frame option on a DVD player or a videotape.

Perhaps some function of the hippocampus brings into being the other egos or other personalities in a dissociative identity disorder. Perhaps during a period of prolonged stress at a particular time in a person's life,

the hippocampus has recorded a frozen action memory involving all aspects of functioning of the person at that particular time period, and that frozen action snapshot is put immediately into the unconscious mind as an archetypal story.

We know that this archetypal story is in the unconscious mind, because the conscious mind usually has no control over the process. And usually people suffering from a dissociative identity disorder have no conscious recollection of what they did while acting like another personality.

Diagnosis of dissociative identity disorder

This switching into what appears to be a different person can seem very dramatic to someone observing a sudden transformations from a grown woman into one of a number of other people, and it may even appear to be deliberate and contrived.

Early in the diagnostic process the therapist will need to consider whether this is a case of deliberate fraud, multiple personality, or the altered behaviour of a person who is possessed by an evil spirit.

There are signs well known to experienced clergy that will point to the presence of an evil spirit, and a therapist usually has no difficulty in differentiating between a dissociative state and a possession state.

Information from family and close friends will help to reveal if the perceived personality switching is deliberate and contrived. There have been cases where criminals have feigned multiple personality disorder to excuse criminal behavior. "It wasn't me who robbed the bank, it was my evil alter ego".

In multiple personalities, the behaviour of the patient in one of these personalities is consistent with the usual behaviour of a human being at that age.

Where one of the alleged alter egos or personalities seeks to destroy the adult person or another of the personalities, the therapist must examine the destructive entity.

Sometimes it is found that a destructive evil spirit has been able to gain access to the multiplicity of personalities and has been able to hide amongst them, like someone hiding amongst the trees of a forest. As soon as the therapist identifies a destructive spiritual entity, it is to be named and expelled. These destructive entities are never tolerated by the therapist.

It needs to be remembered that people suffering from a dissociative identity disorder are not enjoying the episodes of suddenly switching into another personality. They are often perplexed and frightened by the fact that they have no memory for the time they were behaving out of character.

They tend to seek treatment often at the request of a worried and confused spouse or another relative. Usually the adult who seeks professional help has no memory of the traumatic events that caused so much suffering. Instead there are long periods during their childhood for which they claim to have no memory whatsoever.

The unconscious mind appears to have been deliberately blocking access of the conscious mind to memories of these events, because it knows the conscious mind at that time does not have the life skills to accept and integrate these events into the person's overall identity.

Later, when the unconscious mind is convinced that the conscious mind has developed the ability to cope with memories of the trauma, it will allow the conscious mind to begin recalling these unhappy events.

In cases of multiple personality, the therapist proceeds with a knowledge gained through experience, that while the conscious mind cannot recall the happenings in childhood that have caused long term suffering, the unconscious mind knows and remembers full well those traumatic events. The art of psychotherapy is not to overburden the conscious mind with information the therapist has gained from speaking to the "children".

There may be many sessions when a "child" will tell the therapist some significant information, but towards the end of the session when the adult has to reappear (the

"child" is not going to be able to drive home after the session or negotiate public transport), the adult cannot remember much of the session, and may even complain, "I just got here, and now I've got to go home again, and we've hardly talked!"

Psychotherapy for dissociative identity disorder

In therapy, the therapist needs to form a long-term relationship of friendliness and trust with each of the different personalities as well as the adult person who is seeking help.

The different "children" may test the therapist's sincerity and tolerance before settling down and becoming part of an integrated identity who can remember the traumatic events and can understand their impact on the person's whole of life experiences.

Psychotherapy for dissociative identity disorder is always long term. Some inexperienced therapists may attempt to create some "fusion" of the different personalities, but this is always counter-productive. There are no living beings that willingly agree to their own destruction, and the idea of encouraging the merging of personalities feels like murder to the one who won't be heard from again.

Instead the experienced therapist will neither encourage or discourage the different personalities from appearing in the psychotherapy sessions. The experienced therapist will allow the different personalities to tell

about the traumatic life experiences that they were involved in.

It is best to put off revealing these facts to the adult personality who usually has no knowledge of these other personalities and of the information they have provided to the therapist.

The therapist will expect a shock reaction from the adult personality when the facts are eventually revealed and the therapist will need to be available to reassure and support the adult personality.

CHAPTER ELEVEN

So-called Personality Disorders

What we call personality disorders are actually post traumatic stress disorders where the original battleground was decided by personality traits.

For example, if a fussy, controlling mother frequently lost her temper in arguments with her two year old over potty training, the whole question of who is the boss, who can make you do what they want instead of what you want, becomes fixed in the child's development.

And because this battle of wills occurred so early in the child's life, it becomes generalized to many areas of functioning as the child grows up. Someone later labels this person as having an Obsessive-Compulsive Personality.

Another example: a child's mother has an illness that takes her away far too often from looking after her baby daughter.

Often the mother is just not there when the child is distressed and the child cries herself to sleep. The trauma here is in the area of basic trust. How can I know if the people who say they care about me will be there when I need them?

The child grows up with a feeling of uncertainty about others, and she learns how to test them out, whenever she experiences the anxiety of separation. Someone later appends a label of Borderline Personality Disorder.

Sometimes the pattern of behaviour that decides the battleground where the trauma occurred is a personality trait that is inherited. For example, people prone to paranoia are usually extraverts, who see their problems as having been caused by other people.

Intuitive introverts, on the other hand, internalize their concerns and are prone to feeling self-critical and depressed when subjected to unwarranted criticism.

People who are highly sensitive by nature may develop a pattern of avoiding excess stimulation. They quickly feel emotionally overwhelmed when in a noisy environment, and have to withdraw.

People who misunderstand this self-protective withdrawal and wrongly label it as arrogant disdain for the noisy crowd, may follow up on the withdrawal of the highly sensitive person with increasing criticism that makes the sensitive person withdraw still further.

Personality Types

Each one of us is unique, with our own fingerprints and our own specific personality. And yet enough personality traits seem to occur in clusters for us to be able to describe different personality types. There are

obsessive people, introverted people, histrionic people, dependent people, aggressive people, and so on.

Each set of personality characteristics provides at the same time, an advantage and a disadvantage, a gift and a weakness. Your major gift always turns out to be your major weakness. For example:

Gifts versus Weaknesses

Gift	Weakness
• Warm personality that breaks down barriers	• Breaks down safety fences, gets too involved.
• Steadfast, loyal	• Rigid, unbending
• Makes clear decisions easily	• Judgmental
• Accepting of others	• Indecisive
• Meticulous, clean	• Fussy, obsessive
• Able to keep a secret	• Can't express inner feelings
• Analyses situations	• Paranoid

Complementary personalities

It is not difficult to decide if a person's personality characteristics are personality gifts or symptoms of some form of emotional illness, once a detailed family tree history has been recorded. True personality types will usually be found along with complementary personality types in the family tree. For example, assertive extraverts are often happily married to submissive introverts, and their children may be one or

the other. You will find easy-going dreamers alongside fussy manager types, and totally calm, unflappable people happily married to people whose emotions fluctuate wildly.

The personality is not disordered

People are said to have a personality disorder when the personality characteristics they have displayed since childhood regularly get them into conflict with others, and significantly affect their happiness.

For example, an obsessive or compulsive person may make himself very unpopular trying to force other people to submit to his over-fussy rules, and to undertake his compulsive checking and cleaning rituals.

Or a young person who is naturally curious and adventurous may continually go too far and break the law.

In reality the people described as having personality disorders are people whose personality traits determine the way they will interact with others in a disordered way.

For example, the dominating obsessive person is someone who has been allowed to get his own way, a control addict. The obsessions and compulsions are simply the battleground where he tries to control others to deal with his fears of inadequacy.

The so-called sociopath is an adventurous person difficult to discipline, who has learned how to defeat the containment skills of his parents, and now satisfies his ego by being uncontrollable.

In each case of personality disorder, the tendency to make others suffer is not derived from the personality traits themselves, but from other skills, like bullying, lying, and emotional blackmail.

Treatment, therefore, should not involve trying to alter personality traits, but should be aimed at countering the methods by which this person infringes the rights or comfort of others.

The treatment of personality disorder

While the term personality disorder is quite misleading, those people said to suffer from a personality disorder definitely need psychotherapy. A series of therapy sessions would:

- Outline the true personality characteristics of the patient, with the gift and weakness aspects clearly set out, and encourage the patient to use these gifts in a positive way.

- Focus on early trauma in childhood, hopefully involving other members of the family if possible to identify problem areas.

- Diagnose the abnormal processes operating to cause this person to behave in a socially disordered way. For example, perhaps rejection by a parent leads this person to try to form relationships with authority figures and then test them to see if they can be trusted.

- Design specific therapy goals to overcome the abnormal processes, faulty learning and false expectations, once these have been clearly identified and understood by both patient and therapist.

Post Traumatic Stress Disorder IS a disorder

People who have survived stressful events or periods in their lives may never be able to forget what happened. They may have nightmares over and over, of the same event. Sometimes a chance stimulus will remind them of the event, and they may instantly react as if it were happening all over again.

They may feel edgy a lot of the time, as though constantly on the lookout for danger. And sometimes they feel numb, alienated from people around them, able to share memories of the event only with others who were there at the time. We call this a post-traumatic stress disorder (PTSD).

Post-traumatic stress disorders may last an entire lifetime, in stubborn opposition to the old saying that time heals all wounds. Why does it do this? We now

understand that every time a person suffers a flashback episode, recalling the stressful event and experiencing the same feelings as if the event were happening all over again, the person is re-traumatised.

The woman who has lost her children in a horrifying accident has been traumatised by a chance remark by another woman at church who did not know about the tragedy and made an innocent enquiry about how the children are getting on at school.

The woman with the PTSD then begins to experience anxiety at the thought of being in groups of other women talking about their own children. The original post-traumatic stress disorder has been augmented by a secondary PTSD now associated with groups of mothers.

What causes post-traumatic stress disorder? It seems that the memory of a stressful event includes a memory of body feelings, in just the same way that pleasant memories may be associated with smells or sounds.

Recalling the event recalls the complex distressing feelings of stress breakdown which were experienced at the time.

And because people don't like feeling anxious and distressed, they will avoid recalling the memory. So it sits there, half-forgotten, like an open wound that has never been closed, like a fracture that has never healed.

Psychiatrists detect these painful memories during history taking. We notice an emotional reaction when the patient mentions the event. A tear in the eye, a changed expression, a change in facial colour, a tremble of the lip, a quaver in the voice.

What is happening is that at that moment the patient is re-experiencing all over again, a sample of the symptoms of stress breakdown endured at the time.

The event might be some form of physical or sexual abuse in childhood, an act of brutality in war, the humiliation of being held hostage by a bank-robber. Any traumatic event that we might describe as outside of everyday human experience can produce a post-traumatic stress disorder (PTSD).

Post traumatic stress disorders in children

The most important aspect of post traumatic stress disorders in children is that the symptoms of the PTSD can become permanently fixed and may wrongly appear to represent personality traits.

For example, the state of constant readiness for flight reactions described by Bessel Van der Kolk can cause a traumatised child to appear to be innately highly sensitive.

Van der Kolk Bessel A. M.D. The Psychobiology of Posttraumatic Stress Disorder J Clin Psychiatry 1997;58 [suppl 91.,16-24)

Likewise the appearance of being behaviourally shut down and numb and avoidant of external stimulation, can make a traumatised child appear to be autistic or psychotic.

When a child's behaviour is dominated by post traumatic reactions, the adults responding to that child will behave differently towards that child. And this adult behaviour may become internalised by the child to represent the behaviour that the child will expect from all adults.

This is why emotional trauma affecting a child will tend to cause the child's reactions to be more widely generalised than in the case of emotional trauma affecting an adult.

The younger the child, the more generalised will be the response to emotional trauma.

This is why it is crucial that our children should be protected from stress as much as possible.

CHAPTER TWELVE

Schizophrenia

Schizophrenia is a disorder of brain function that mainly affects sensitive young people. It is characterized by delusions, auditory hallucinations and problems with selective attention and mental concentration, as well as an inappropriateness of the emotional display that does not fit with the significance of the topic being discussed.

In the previous chapter, I described behavioural changes occurring under conditions of excessive environmental stress or overstimulation. In highly sensitive people, these changes in behaviour associated with over-loaded nerve cell networks shutting down, can be abrupt, unexpected and catastrophic.

In schizophrenia, the primary system failure is in the selective attention mechanism that malfunctions under excessively high stimulus levels.

This is why the characteristic symptom of schizophrenia is inappropriate-ness or incongruity. The patient may appear to be blandly indifferent about important matters or overly concerned about trivia.

Dopamine is an important neurotransmitter chemical involved in the firing of nerve cell networks that decide the importance or the relevance of incoming stimuli.

The mainstay of the medical treatment of schizophrenia has been to use drugs that reduce levels of dopamine, in order to reduce the level of overstimulation in the selective attention cell networks.

See **Trends in Cognitive Sciences** Volume 15, Issue 12, December 2011, Pages 585–591 **The role of neuromodulators in selective attention** Behrad Noudoost, Tirin Moore

Unfortunately the reduction in dopamine can cause symptoms similar to those of Parkinson's Disease, long known to be caused by a loss of dopamine producing cells in the lower brain centres.

Many drugs that help to bring the symptoms of schizophrenia under control can cause tremors and involuntary motor movements if used in high doses for prolonged periods.

The brain's selective attention mechanism

When we start watching a movie on a small television set, the figures on the screen are initially quite small in relation to the objects in the room that we can see on either side of the TV. As we become absorbed in the story, the lower centres of the brain tell the brain surface to ignore the objects in the room around the TV set, and

to magnify what we see on the screen. Soon we become oblivious of the small size of the screen.

Another common example of how the brain magnifies what we want to see and diminishes what we want to ignore can be easily seen when reading a book with a small print size. Once you begin to concentrate on what you are reading, the print seems to get larger. If you quickly look at the opposite page you will notice the print on that page seems smaller, for the short time it takes your brain to adjust.

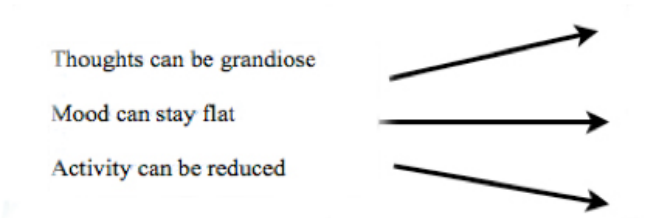
This selective attention mechanism malfunctions in people who develop a schizophrenic illness. At low stress levels, the patient can function normally, but under conditions of stress or excess noise, the selective attention mechanism fails to reduce the unwanted peripheral input (the noise) while the wanted input (the signal) is being enhanced. The relationship between the noise and the signal is referred to as the signal-to-noise ratio and is abnormal in schizophrenia.

See Trends in Neurosciences Volume 27, Issue 11, November 2004, pages 683-690 Genes, dopamine and cortical signal-to-noise ratio in schizophrenia Georg Winterer and Daniel R. Weinberger "Dopamine, long implicated in psychosis and in antipsychotic drug effects, is crucial in optimizing signal-to-noise ratio of local cortical microcircuits." "In schizophrenia, an abnormal cortical dopamine D1/D2 activation ratio – in concert with, and in part related to, altered GABA and glutamate transmission – appears to interfere crucially with this process."

The brain surface trying to process incoming information under conditions of stress or excess noise becomes widely overstimulated because the dopamine system has not reduced the peripheral noise while enhancing the signal strength. The surface brain cells therefore have no option other than to shut down the nerve cell networks that are being overloaded.

The sudden shutting down of these overloaded nerve cell networks causes thought block, one of the symptoms common to schizophrenia and stress breakdown. The stream of thoughts can suddenly stop as though turned off by some external controlling entity. Patients suffering from schizophrenia may claim that their thoughts are being switched off deliberately by someone operating a new form of technology.

The failure of the selective attention mechanism is responsible for the the apparent “splintering-away” of the normally parallel relationships of thoughts, mood and activity that gives this condition its name of schizophrenia. (schizo = splitting and phrenia = mind).



In depression, thoughts are gloomy, mood is lowered and physical activity is diminished. In mania, the

opposite is true. In schizophrenia, the patient may have grandiose delusions, while the mood is flat and inappropriate for the grandiose thoughts, while physical and mental activity can be diminished.

Description of a schizophrenic breakdown

Acute schizophrenia results from a stress-caused malfunction of the brain's ability to focus attention on a task. The capacity to maintain a normal signal to noise ratio is impaired in people who develop a schizophrenic illness.

Whenever these people try to focus on a task, the lower centres of the brain simply over-stimulate the entire brain surface.

For example, if I were having a schizophrenic breakdown as I am writing this, the lower centres of my brain would not only be stimulating the part of my brain concerned with looking at my computer screen, it would be stimulating the entire brain surface.

So the more I wanted to concentrate on what I am doing, the more I would become distracted by the squeak of my office chair, the feel of the breeze from the electric fan on my skin, the sound of people next door, the discomfort from my aches and pains etc.

Furthermore, previously unconscious dream activity could become conscious and I might start experiencing strange "knowings" and perhaps start hearing voices.

The auditory hallucinations, the "voices" in schizophrenia are typically those of a running commentary

If you watch little children at play you may overhear an ongoing prattle of incessant talk–"Now Dolly, you say hello to Clown, now Clown why didn't you say hello to Dolly? Oh dear Dolly fell over! Oh dear! Oh well pick Dolly up. Oh dear Clown fell over. Pick Clown up!"

The French psychologist Piaget thought that this ongoing prattle of early childhood just disappears, but the Russian psychologist Vygotsky claimed that this ongoing speech becomes sub-vocal, and continues on in adult life as ongoing sub-vocal instructions to ourselves.

For example when you're getting out of your car on a wet day and saying to yourself under your breath "Now where's your umbrella? Careful now! Don't leave the keys in the car. Watch out you don't slip over.."

We know that if we perform electromyography tests of electrical activity in the muscles of the tongue and larynx in schizophrenic patients experiencing auditory hallucinations, we will see that at the same time as the patient is hearing the voices, the electromyogram is picking up evidence of muscles being stimulated, the pattern of sub-vocal speech.

In an acute schizophrenic breakdown the brain is so overstimulated that these sub-vocal speech patterns

can seem quite loud, as though real people are speaking in your ear.

At the same time, overstimulation of the brain makes dream activity seem as if it is real. This is where the primary delusions of schizophrenia come from. The patient with schizophrenia is having a vivid dream while wide-awake, and getting all the dream activity confused with what is going on in the outside world.

This pattern is not limited to schizophrenia. Delusions can occur in mania and also in conditions such as delirium tremens where overstimulation of the brain is caused by withdrawal from a sedative agent such as alcohol or benzodiazepine drugs.

The treatment of schizophrenia

Because a schizophrenic breakdown arises from an overstimulated brain in a highly sensitive person, reduction of stress is the first and most important step to consider.

Acutely psychotic patients are invariably fearful of the fact that they seem to be falling apart and losing control of their lives. If they seem arrogant, it is because they are afraid. It is best to answer hostility and apparent arrogance in an acutely disturbed schizophrenic patient, with supportive reassurance.

Nurses, doctors and other health professionals should never joke with a disturbed psychotic patient. There is

a lot of aggression in humour, and psychotic people out of touch with reality will invariably misunderstand the intentions of someone who simply wants to settle the patient down by having a laugh with them.

The psychotic patient will misread the joke as a criticism directed at him.

The second step in the treatment of acute schizophrenia is the use of specific antipsychotic drugs. Preferably these should be given by mouth so as not to alarm the patient, but may have to be given by injection in the early phase of treatment.

The patient must always be treated with respect and consideration.

Where possible, patients should be consulted and involved as far as possible in the adjustment of their medication dosages.

Unfortunately, the diagnosis of schizophrenia, particularly if the patient has been forced to accept hospital treatment against his will, is socially embarrassing and therefore stressful.

If we look carefully at the way people are treated after they have been given a diagnosis of schizophrenia, we will see that almost everything that happens to them following this diagnosis, just increases the amount of environmental stress they have to cope with.

Prevention of schizophrenia

If we lived in a society that valued sensitivity and thoughtfulness in our children, there would be less people suffering from schizophrenia. Unfortunately, many educators wrongly regard introverted children who tend to avoid noisy activities, as children lacking social skills.

Many sensitive school children are forced into rowdy competition with other children in the mistaken belief that these activities are teaching social skills. Too often, such intervention by teachers becomes a further stress to be endured by a quiet child.

If our health professionals were trained to identify the symptoms of stress breakdown occurring in highly sensitive individuals, our psychiatric treatment of patients with schizophrenia would make them better, and not worse, as is too often the case today.

It is known that people who suffer an acute schizophrenic breakdown in “third-world” developing countries are more likely to recover completely than people suffering an acute schizophrenic breakdown in a wealthy western nation.

"Third world" societies are often much more aware of spiritual realities, more likely to value sensitivity and less likely to regard sensitive people as defective.

CHAPTER THIRTEEN

Alcoholism and Drug Dependence

Inexperienced therapists may wrongly view alcoholism and drug dependence as an increased appetite for emotion-altering drugs plus a failure of self-control. In treatment, inexperienced therapists may encourage the patient to gain and maintain conscious self control, while using various methods to reduce the patient's appetite for drugs of dependence.

One way to reduce the patient's appetite for the offending drug is to prescribe other drugs for the patient to take in place of the offending drug. Although the concept of "the pharmacological treatment of drug dependence" seems like an oxymoron to the general public, it might be lucrative for drug companies to produce drugs to be prescribed in place of drugs of dependence.

Experienced therapists tend to view alcoholism and drug dependence as an increased appetite for emotion-altering drugs plus an obsession with self-control. The addicting drug or behaviour, in the distorted perception of the addict, offers a means of achieving self-control.

Alcohol and sedative drugs reduce fear and anxiety, while the out-of-reality experience brought about by opiate drugs relieves boredom. The accelerated mood resulting from amphetamines allows users to cross over

the boundaries of social appropriateness and take risks they wouldn't normally take.

Usually, alcoholics don't drink for the purpose of getting drunk, although this usually happens when they begin to drink. Alcoholics usually drink because alcohol makes them initially feel calm and happy, more in control of their worries.

After a few hours drinking, when they can become agitated and aggressive, alcoholics usually don't recognize the connection between their drinking and the negative change in their behaviour.

While alcoholics wrongly think that alcohol is keeping them going and helping them cope, their relatives can see that alcohol is weakening their nervous system and keeping them sick.

In the treatment of alcoholism and drug dependence, effective therapy helps patients let go of their obsessive concerns with controlling the way they feel, and their obsessive concerns with shaping the way their lives will proceed.

The addicted person usually comes to see that their addiction to various drugs and behaviours is actually a distorted way of trying to gain certainty in an uncertain world.

The most effective method of treating alcoholism and other types of addictions is the Twelve Steps program that began with Alcoholics Anonymous.

1. *We admitted we were powerless over alcohol - that our lives had become unmanageable.*
2. *We came to believe that a Power greater than ourselves could restore us to sanity.*
3. *We made a decision to turn our will and our lives over to the care of God as we understood Him.*
4. *We made a searching and fearless moral inventory of ourselves.*
5. *We admitted to God, to ourselves and to another human being the exact nature of our wrongs.*
6. *We were entirely ready to have God remove all these defects of character.*
7. *We humbly asked Him to remove our shortcomings.*
8. *We made a list of all persons we had harmed, and became willing to make amends to them all.*
9. *We made direct amends to such people wherever possible, except when to do so would injure them or others.*
10. *We continued to take personal inventory and when we were wrong promptly admitted it.*
11. *We sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.*
12. *Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.*

address other problems, or in any other non-A.A. context, does not imply otherwise. Additionally, while A.A. is a spiritual program, A.A. is not a religious program. Thus, A.A. is not affiliated or allied with any sect, denomination, or specific religious belief.

Various behavioural addictions

In alcohol addiction, drinking alcohol sets up a craving for itself. In benzodiazepine drug dependence, taking benzodiazepine drugs such as oxazepam, diazepam, temazepam etc sets up a craving for more benzodiazepine drugs.

In sexual addiction, orgasm (a mood changing experience) sets up a craving for more. In domestic violence and school bullying, gaining power over someone through humiliating and hurting that person, can set up a continuing desire for that powerful feeling, leading towards continuing and escalating the violence.

Narcotic dependence versus sedative dependence

The actual physiological process through which dependence develops with alcohol and sedative drugs is different from the process through which people become dependent on stimulants such as cocaine and amphetamines, and narcotics such as heroin, codeine and oxycodone.

Narcotic addiction, usually to cheap heroin obtained illegally as a street drug, is often associated with criminal activity and prostitution, aimed at providing a high income to support the drug habit. The treatment of

narcotic and cocaine addicts may be complicated by requests to respond to patients involved in criminal charges, court appearances and imprisonment.

However, regardless of the actual neurophysiological changes occurring in different types of drug addictions, the three characteristics of dependence apply equally with these different drugs and behaviours.

1. The development of tolerance. The addict has to take more and more of the drug or do more of the addicting behaviour to get the same desired effect.

2. The addict becomes primarily preoccupied with getting increasing access to the addicting agent or behaviour, at the expense of lifestyle, morals, and occupational, social and family responsibilities.

3..There is a withdrawal syndrome, where withdrawal of the drug or the addicting behaviour causes personal discomfort that is immediately relieved by restoring the drug or behaviour.

The treatment of addictions

There are two phases in the treatment of addictions. The first stage involves the withdrawal of the addicting drug or behaviour. In the case of drug dependence, it is usually necessary to wean the patient off the drug slowly.

In alcohol withdrawal, we usually find that by the time the alcoholic is ready to ask for help, alcohol has caused a gastritis, and giving smaller and smaller doses of alcohol is not appropriate.

In alcohol withdrawal, we usually substitute a benzodiazepine drug such as diazepam for the alcohol and then withdraw the diazepam slowly.

After the addicting agent is withdrawn, the patient has to learn how to live without the addicting agent. And this is the difficult part of the treatment of addictions.

Encouraging self-control has only a temporary effect

Therapists whose treatment involves encouraging the development of greater self-control may attempt to improve the patient's self-esteem through praise and reassurance.

In my experience this simply increases the patient's expectations of himself and can trigger anxiety about achieving unrealistic goals.

L**ow self esteem versus no self esteem**.

Everyone is cursed with an ego, a self-centering concept that puts the self in centre stage. When you're sitting in a train at a station, your ego tells you the platform is moving as the train begins to move. Soon trees are shooting past but you're staying perfectly still. Then you say, "Hang on! Trees can't move!" and

instantly you perceive the trees as staying still and the train as moving.

Your ego tells you the sun is moving across the sky all day. In fact, the sun is still and we're rolling towards the sun all day. Someone walks into the office and for no particular reason says something nasty to you.

Your first thought is "What did I do to make that person say such a nasty thing?" The real question to ask is "Why is that person so bad-mannered today?"

The ego may even prefer that you take the blame for some accidental happening. "I should have seen that coming!" So long as the ego is centre-stage, it will accept blame. In a cock-eyed sort of way, if I am to blame, then I must have been powerful enough to have caused that accident.

The ego hates the thought that your existence is irrelevant to lots of people. You're walking across the street and your ego is expecting everyone will notice you're wearing brown shoes and black pants.

Of course, in reality, people are mostly interested in what they are doing. Some people can get run over crossing the street because they wrongly think the motorists are looking at them.

When an inexperienced therapist tries to increase self-control through praising and encouraging a person who

expresses low self esteem, the result may simply be the expansion of a troublesome ego.

Fearfulness and a need to control

Sometimes we want to know if a person is just a social drinker who drinks a lot or if that person is an alcoholic.

An alcoholic is someone who cannot guarantee his/her behaviour when he/she begins to drink. Some social drinkers may regularly consume more than the community average intake of alcohol without unduly upsetting their relatives. Is this person an alcoholic in the making?

One way of finding out is to suggest the drinker should go to an AA meeting. Real alcoholics are afraid to go to a meeting where they might be asked to admit they have a drinking problem. Real alcoholics are afraid someone will find out their secret, that they drink too much.

Of course, all their relatives and friends already know the alcoholic's secret. The only person who doesn't know he's an alcoholic is the alcoholic himself.

While real alcoholics are afraid of self disclosure, once they attend an AA meeting and find out they are in the company of sensitive people like themselves and identify with the stories of the other people who can't control their drinking, they are no longer afraid. They know that in AA meetings they meet people like

themselves. It is a common experience for an alcoholic person to listen in wonderment as someone else totally unknown to them is telling their story - the same lying about drinking, the same manipulation of their spouse, the same excuses, the same fears.

CHAPTER FOURTEEN

Obsessions and Compulsions

Many of us have obsessive personality traits, like worrying unnecessarily about lists, procedures, punctuality and order.

Many of us have little rituals we perform the same way every day, just to reassure ourselves that all is well, like checking the back door twice and washing our hands when we think about something unpleasant.

However, some unfortunate people's lives are dominated by compulsive rituals and obsessive thoughts. Unwanted thoughts go around and around in their heads, in spite of strenuous efforts not to think them.

For example, a man is driving his car on the freeway. Suddenly he realizes that with one sharp turn of the steering wheel he could put his car directly in the path of an oncoming truck and his life would be all over. Just one turn of the wheel. No more worrying about when his life would end, it would end now. No more uncertainty.

"Am I suicidal?" he thinks to himself, "I must be, otherwise I wouldn't be contemplating suicide. I must put this thought out of my mind. It won't go away, I must be suicidal even though I don't want to kill myself. What if I was thinking about it, and my mind suddenly

turned the wheel even though I didn't really want to kill myself?"

The more he tries to forget the thought the more it plagues his consciousness.

The characteristics of an obsessive thought process:

- **The thought is an unwanted, unacceptable thought**
- **There is no emotion attached to the thought. A thought of suicide is not associated with feeling depressed, a murderous thought is not associated with hate, a thought of rape is not associated with sexual arousal.**
- **The thought is resisted.**
- **The thought continues to intrude against the person's conscious will.**

Obsessive people sometimes use compulsive rituals to reduce the anxiety associated with the obsessive thought.

Compulsive rituals

Common compulsive acts include cleaning, counting, tidying, checking and washing. These compulsive acts are fragments of activities that we usually use to reassure ourselves.

A common mistake is to assume that the compulsive behaviour pattern is a clue to what made the person anxious. But compulsive hand washing, for example may not mean the person is anxious about contamination. It may have originated in some concern about dirt and contamination, but once the pattern is established, hand washing will be used in a vain attempt to reduce anxiety caused by some entirely different matter.

Although someone carrying out compulsive rituals will insist otherwise, the ritual does not in fact help to reduce the anxiety. "I have to do it to set my mind at rest!" But within a minute or two he is repeating the behaviour because it did not set his mind at rest. In fact, the anguish experienced when the compulsive person is prevented from carrying out the ritual is no greater than the anguish that returns soon after the ritual is completed.

Origins of obsessive thought patterns

Obsessive thought patterns begin with an unacceptable, unwanted thought arising in opposition to an acceptable thought. The person then tries to abolish the unwanted thought but it won't go away. The more the person consciously tries to oppose the thought, it continues to plague his conscious awareness. What causes all this?

If I said, "All psychiatrists are crazy", someone would probably say "Not all of them." But if I said, "The way

some psychiatrists behave at odd times, you could be forgiven for thinking that perhaps one or two of them might be a little unusual", the response might be, "Hmmm."

A strong statement (thesis) begets an opposing statement (antithesis). When people make strong statements opposing each other, we usually assume there is some common ground (synthesis) in between. The adversary system in our law courts and parliamentary democracy is based on this assumption.

Obsessive thoughts begin with a thought that begets an opposing thought. For example "I don't know what I would do if I lost my mother" immediately begets the opposing thought "I'll never be free of that woman's influence until she's dead."

If the person decided to let both thoughts co-exist, a synthesis might be reached like "I love my mother but she has a tendency to want to run my life, and I'll have to stand up to her a bit more."

However, someone quick to make judgments and who over-values personal control may be perturbed by the opposing thought "I'll never be free of that woman's influence until she's dead" and try to suppress that thought as unwanted and unacceptable.

If that person's nervous system were running short of inhibitory neurotransmitter chemicals at the time, the

stage is set for a recurring unacceptable thought that the person is unable to suppress.

Three basic characteristics of obsessive thought processes are:

- A tendency to make judgements
- A desire for control
- An inability to forget

The tendency to make judgements and a desire for control arise from the personality itself and from previous emotional trauma. Some people are by nature black and white thinkers. Others are by nature middle of the road, moderate thinkers.

The gift of the black and white thinkers is clarity, the weakness is prejudice. The gift of the middle of the road thinkers is tolerance, the weakness is uncertainty. Many people plagued with obsessive thoughts are by nature people who make strong judgements about things.

The need for control usually arises from emotional trauma, usually in childhood. The nightly chaos when a drunken man comes home and throws the family into turmoil can teach a growing child always to be in control of every situation, never to let anything get out of hand.

Likewise, financial and relationship disasters involving the parents can teach a child that catastrophes are always possible.

The inability to forget unwanted thoughts is caused by a loss of balance in the brain's chemical neurotransmitters.

This is very likely to be a shortage of the brain transmitter serotonin. The SSRI drugs (specific serotonin reuptake inhibitors) are the most effective drugs for obsessive-compulsive symptoms that we have so far, as well as the tricyclic drug clomipramine (Anafranil).

Obsessive-Compulsive Disorder

There is a serious condition called obsessive-compulsive disorder OCD where a person's life is dominated by obsessive thoughts and compulsive actions and disabling anxiety.

OCD tends to be chronic and disabling. Patients are fully aware of how foolish they seem to others, repeatedly performing silly rituals that they know full well are irrational.

OCD is often wrongly regarded as one of the less serious psychiatric disorders because patients suffering from this affliction are not psychotic and many of the patients with OCD can still hold down important jobs.

However, OCD is a serious condition and recent research suggests that OCD can be caused by subtle damage to the nerve cell networks in the brain's basal ganglia.

The role of the brain's basal ganglia

When you decide to do something, the brain's motor nerves fire off instructions to the motor nerve cells in the spinal cord that then activate the individual muscle fibres. These signals go via the collection of specialised nerve cells in the lower centres of the brain that we call the basal ganglia.

The basal ganglia automatically provide the background muscular activity that we don't even think about. While I'm typing these words into my computer, I'm thinking of the words and paying attention to hitting the correct keys on the keyboard.

But my arms are being held high enough to do this, my shoulders are firm and my back is straight, the muscle tone in my shoulders is made adequate to keep my hands still, and all this happens automatically.

There appear to be various complicated feedback loops between the motor nerve cells in the brain surface and the basal ganglia that enable or deny the motor messages from the brain surface.

Included in these feedback loops is a message that reports that a motor instruction given by the motor nerve cells in the brain surface, has been carried out.

When these brain structures are damaged, people experience repetitive involuntary movements and inappropriate disturbances of muscle tone, resulting in conditions such as Parkinson's Disease, involuntary nervous tics and Tourette's Syndrome, Sydenham's Chorea and associated obsessive-compulsive disorder.

Damage to the cells in the basal ganglia will disrupt the normal feedback loops, causing a nagging doubt whether an action was carried out. Did I lock the door or did I just think about locking the door?

The sudden onset of obsessive-compulsive disorder, particularly in a child or adolescent, should be immediately investigated to rule out a diagnosis of Sydenham's Chorea.

This condition is caused by an auto-immune assault on the basal ganglia by antibodies produced in response to a streptococcal throat or skin infection.

Apparently there are molecules in the capsule of streptococcus bacteria that resemble proteins in the basal ganglia, the synovial membranes in the larger joints, the basement membrane in the kidney and the heart valves.

At the current state of our understanding of auto-immune disorders, we usually consider that antibodies produced by the immune system to attack and kill streptococcus bacteria may also inadvertently attack these other tissues, causing diseases such as Rheumatic Fever, Acute Glomerulonephritis, Endocarditis and Sydenham's Chorea. The attack on the basal ganglia either causes or is associated with the sudden onset of obsessive-compulsive disorder.

MRI Assessment of Children With Obsessive-Compulsive Disorder or Tics Associated With Streptococcal Infection
Jay N. Giedd, M.D.; Judith L. Rapoport, M.D.; Marjorie A. Garvey, M.D.; Susan Perlmutter, M.D.; Susan E. Swedo, M.D.
Am J Psychiatry 2000;157:281-283. 10.1176/appi.ajp.157.2.281 "These results support the hypothesis that there is a distinct subgroup of subjects with OCD and/or tics who have enlarged basal ganglia. These findings are consistent with the hypothesis of an autoimmune response to streptococcal infection."

Kirvan CA, Swedo SE, Snider LA, Cunningham MW. **Antibody-mediated neuronal cell signaling in behavior and movement disorders.** J Neuroimmunol. 2006 Jul 26; …"research suggests that an antibody against strep throat bacteria sometimes mistakenly acts on a brain enzyme, disrupting communications between neurons and causing a form of obsessive compulsive and related tic disorder in children."

If blood tests reveal a high level of anti-streptococcal antibodies, the treatment of the obsessive-compulsive disorder will also include long term treatment with oral penicillin to destroy any lurking streptococcus organisms and prevent a recurrence of infection.

Treatment of obsessive thought patterns

The first step in treating obsessive thought patterns is to recognize them for what they are. Obsessive thoughts are recognized as irrational and unwanted, and they are consciously resisted. For example, a person experiencing obsessive suicidal thoughts will not want to commit suicide, and is trying to resist the thoughts.

The next step is medication with either clomipramine or one of the SSRI drugs.

Thirdly, thought stopping techniques may be useful. Some people put a rubber band on the wrist, and snap the rubber to cause a slight sting every time they are bothered by the thoughts. Some people find it is better to let the irrational thoughts run on and allow them to play out like a movie.

Simple feedback information

It is useful for the person locking a door or a window to enhance the sound of the key turning in the lock by actually saying “That’s done!” or any other suitable words.

The actual sound of the words will reverberate in the temporary memory circuit for a minute or two, providing the necessary feedback that the task was in fact completed. This diminishes the desire to go back and check.

Response prevention

When someone who uses compulsive rituals to settle his mind becomes anxious about anything, he will use a compulsive ritual in an attempt to reduce the anxiety. An alcoholic might have a drink. A gambler might think about going to the casino. A compulsive checker of the stairwell outside his apartment begins nervously checking the stairs over and over because he is worried about an unintelligibly garbled telephone message left overnight on his answering machine.

Nervously checking the stairwell does nothing to relieve his uncertainty, and therefore his concerns about who left the message persist. Because the anxiety persists, he keeps on checking the stairwell. Fairly soon he is worrying about the fact that he feels compelled to check the stairwell, even though he knows full well it is a completely silly thing to do. His increasing anxiety makes him check the stairwell even more and more.

We all need to understand that the compulsive action does not in fact relieve the anxiety of the situation, but actually makes it worse by shifting attention to the repetitive behaviour which the person himself knows is totally irrational.

The anxiety which started the compulsive checking is still there, and will not be altered whether he compulsively checks or not. Therefore, the compulsive action must be stopped.

Preventing the person from repeating the compulsive response may appear to increase the anguish for a little while, but then it diminishes. Anguish experienced by the person prevented from repeating a compulsive action is no greater than the anguish generated by repeatedly doing it and looking foolish.

Relatives of people with obsessive compulsive disorder who seek repeated answers to the same silly questions should refuse to answer. An obsessive request from a loved one who begs you to check the letter box just once more even though you have checked it twice, should be ignored.

And patients with obsessive compulsive disorder must be told clearly they have no right to involve anybody else in their silly repetitive actions.

Treatment for compulsive rituals

The treatment process involves:

1. Identifying the behaviour as compulsive.
2. Beginning medication with either clomipramine or one of the SSRI drugs.
3. Convincing everyone in the family it is in the patient's best interests if they refuse to cooperate with the patient's obsessive compulsive behaviour.
4. Encouraging the patient to resist the compulsion to perform the rituals.
5. Self-help groups using a 12-step methodology can be very helpful in reducing anxiety.

The four rules of worrying

Some people are chronic worriers. In times of uncertainty they will sit around wringing their hands and thinking the worst. Try to talk them out of worrying, and they will resist being reassured. Why? Because worrying seems to work.

There are four rules to worrying:

1. Someone has to do it.
2. Picture the worst thing that could possibly happen to the person you are worrying about.
3. Experience the emotions now that you would feel if that worst case scenario were actually taking place.
4. You are suffering so that no harm will come to the person you are worrying about.

It would appear that worrying is a form of prayer action. It is as though the worrier is saying vaguely to an unnamed deity, “I will exchange my suffering for protection for this person.”

Worriers can be encouraged to exchange their worrying for a more specific, and possibly more effective prayer action.

CHAPTER FIFTEEN

Healing the Family Tree

In 1984 I met Dr Kenneth McAll, an English doctor who had worked in China as a Christian missionary surgeon in the years before World War 2. When the Japanese invaded China, Ken and his wife Frances were incarcerated with a large number of other European people in a former tobacco warehouse.

After Ken returned to England after the War, he found himself working mainly in psychiatry, where he applied the spiritual principles he had seen in action in China. Later he wrote a best selling book Healing the Family Tree (published by Sheldon Press).

I had been a specialist psychiatrist for 9 years when I met Ken McAll, and saw how Ken took a detailed family tree history for every patient. In 1984 I began recording detailed family tree histories on every patient, paying attention to information that psychiatrists didn't usually focus on, for example:

- How many pregnancies have you had, and how many children do you have?
- Was your stillborn child ever given a name?
- Did you go to your father's funeral?
- Was there a funeral service for your uncle who was lost at sea?
- Tell me what your suffering feels like - as if what?

I was initially suspicious of Ken McAll's claims in his book Healing the Family Tree. He was saying that previously incurable conditions were being healed quickly and effectively where the hitherto unexplained suffering of a patient could be traced to an unresolved issue involving someone in the patient's family tree history. When a Christian Communion Service was celebrated by a clergyman and appropriate prayers said for that person, the patient was healed.

I was concerned that Ken McAll's interventions might be venturing into New Age rituals at best and into the occult at worst. Then I discovered that the Christian Church since its beginning, had been praying for the dead, and when I began taking detailed family tree histories I soon discovered the same sorts of cases that Ken McAll was dealing with.

Since 1984, I have treated a large number of allegedly incurable patients through the method known as Healing the Family Tree.

I saw a man named Gordon, who was suffering from stress breakdown symptoms, and one of the minor stressors in his life was the behaviour of his two sons aged 11 and 13. These boys were rowdy and unruly, and the patient's wife and family all wanted Gordon to use corporal punishment on them, but Gordon refused to hit them.

Gordon told me his own father had bashed him, and Gordon's father had been bashed by his father, and so

on for several generations of men whose children hated them and who had learned to bash their own children by being bashed themselves. "I vowed and declared I would never lay a hand on my kids," he told me.

Later, Gordon levelled with me, "I'd better tell you the truth, Doc. The fact is, deep down, I know I am capable of being just as violent as my father, and probably even more so, and I am truly ashamed of this.

I'll never lay a hand on my kids because I'm scared if I started bashing them my violent nature would come out and maybe I wouldn't be able to stop."

Gordon was a peaceful and gentle man, but he felt inside himself, he was like a violent threat to peace and order in the family.

He was never violent at all, but he felt bad because of the violence within him that had come down the family tree.

Gordon was suffering for his father's and grandfather's violence for which these men had never apologized. Gordon was innocent of violence. but he felt like the most violent criminal.

Gordon's two sons just thought their father was a softie, who did not believe in violence. Those boys when they grew up and had children of their own, would not physically punish their own children because they had no experience of such violence themselves.

The long term effects of abortion on the family

Terminating pregnancies has serious and long-lasting ill effects on individuals, families and the community.

Anna is a teenage girl and the eldest child in a family. She is not really the eldest child, although she herself does not know this. The first pregnancy in this family was terminated by the parents because a child at that time would have been inconvenient.

Anna develops anorexia nervosa, where she begins to starve herself to skin and bone, insisting all the time that she's too fat. At the same time, she claims that if she is not perfect, she doesn't deserve to live. Where did these ideas come from? The parents have never expressed such views to this child, whom they dearly love.

Anorexic patients are usually difficult to treat. But if attention is paid to the spiritual reality, treatment is much more effective.

When it is revealed that Anna's older sibling was sacrificed for the good of the family, an understanding of the meaning of this girl's deadly perfectionism becomes clear. There is a secret ethos in this family reality. This ethos is - if by your presence you are going to present some inconvenience to your family, you do not deserve to live.

Anna is cured of her anorexia nervosa and her deadly perfectionism when her aborted sibling is named and lovingly handed over to God by her parents in a Communion Service.

In the majority of such cases, the anorexic daughter has no knowledge of her aborted brother or sister. So her deadly perfectionism is not the result of identifying psychologically with the aborted sibling. Instead the perfectionism comes from deep within her, through the unconscious mind.

The termination of a pregnancy is a very sad event. In most cases, the pregnant woman does not want to terminate the pregnancy, but she acts out of self-defence, usually sincerely believing that her reputation, her lifestyle and her future will be irreparably damaged by the unplanned and unexpected birth of a child.

Our society accepts that killing in cases of self-defence is not unlawful. Therefore it is not appropriate for other people to make judgments on the rights and wrongs of a frightened woman trying to protect herself, and it is never appropriate for me to offer an opinion when I am trying to help a woman deal with the long-term effects of abortion on her and her family, long after the event.

These long-term effects include:

Hardening the heart – the mother who justifies throwing a child away by claiming she has a right to

determine the use of her own body, may become hardened, unable to see an issue from the point of view of a child, only from her point of view.

Using death threats in disciplining her other children – "I'll strangle you!", "I'll knock your block off!" The mother is often unaware of the impact her threats have on the peace of mind of her children.

Inconsolable grief It is so sad when a woman who has terminated one or more pregnancies is then infertile and unable to have a child when it is now economically or culturally appropriate. And in a number of instances, a woman who has only boys or only girls and is secretly sure she has thrown away her only daughter or only son, suffers long term regret.

Effects on the siblings I have already referred to the deadly perfectionism that often afflicts the sibling next to the aborted child. This perfectionism may also become obvious in other ways, affecting the children generally.

Suicide

Suicide is regarded by the Christian Church as a crime that may prevent the victim from moving through purgatory to his heavenly destination.

Dennis had been hearing "voices like whispers in the wind" for four months. He was afraid he was developing schizophrenia. Twelve months before, his

brother Gary had hanged himself at night in the public park of a country town.

Gary had been making crazy accusations that were obviously delusional, but before the family had been able to get him seen by a psychiatrist, the brother had suicided.

Dennis attended a family gathering in the place where the brother suicided, exactly twelve months after the suicide. Prayers were offered. The voices ceased.

It is my opinion that the tendency for a relative to commit suicide on the anniversary of the suicide of a spouse or relative may be a tragically mistaken response to vague urgings from the soul of the deceased, seeking help to apologize to God on behalf of the deceased.

Incurable illnesses and incurable people

I have seen many cases of people being healed of allegedly incurable illnesses, through a communion service for the healing of their family tree.

Who are these incurable people? In my experience the people who suffer from unresolved problems in their family tree often show these characteristics: they are naturally sensitive, spiritual, family oriented, motivated towards helping others and they tend to take on the burdens of other people.

When we look at the suffering arising from unresolved issues in the family tree, we find it usually falls into three categories:

Suffering caused by not being loved and cared for by parents, who had too many personal problems themselves. We usually find that when we judge our parents and refuse to forgive them we bring suffering on ourselves.

Suffering caused by trying to avoid repeating the wrong behaviour of previous generations. In this case, we find that generational sins will keep repeating down through the generations, until an innocent person suffers for these sins.

Redemptive suffering. In redemptive suffering, the symptom represents the way some member of their family tree died, or an unresolved issue that some family member did not deal with before that person died.

As soon as we identify the connection between the suffering of an innocent person and the lost soul, we celebrate a communion service and draw to the attention of Almighty God, the situation of this lost soul.

We make whatever apologies seem appropriate. We ask God to have mercy on this soul. And sometimes the person suffering from the incurable symptoms is healed of these symptoms.

Sometimes the person doing the suffering has no know-ledge of the person who died. Therefore the symptom cannot be explained by the sufferer psychologically identifying with the lost soul. We can then see that the incurable symptoms were like a signpost pointing to the needs of the lost soul for our help.

Chronic fatigue. "I feel as if my body parts aren't connected. The patient's father deserted the family, was an alcoholic derelict. He was run over by an express train, and his body was collected in several plastic bags. No family member had attended his funeral because he was so despised.

Unexplained severe pain in the neck about C6 level, occurring after the patient had done studies in theology. The patient's uncle was beheaded in Ambon by Japanese soldiers in the Second World War. The patient had been the only practising Christian in his family, the only one likely to be able to say prayers for the soul of the uncle.

Phantom limb pain from an arm blown off in a trench in France in the First World War. Two friends were killed by the same explosion. There was no military funeral for them because there were no body parts to bury. The phantom limb pain stopped abruptly after a memorial funeral service had been arranged for the two friends.

How do we know when symptoms are caused by family tree problems?

- The symptoms are incurable, they do not respond to medical treatment.

- When patients describe the symptoms in their own words, the actual words they use may tell the story. "I feel I'm in a dark place, in a box." "I feel like I'm in a prison and I can't get out."

- When patients describe their symptoms, their eyes usually fill with tears, and yet they cannot explain why.

- The symptoms can be explained when the family tree history is known.

How do we understand the connection between the innocent sufferer and the soul that needs our help?

The scientists who study quantum physics have for years been aware of a phenomenon they call quantum entanglement, that Albert Einstein described in 1935 as "spooky action at a distance". If particles such as photons or electrons have come from the same source, it may be found that these particles, even though separated for very large distances, can behave as though they are connected.

As our scientific understanding of this phenomenon increases, we may find that continuing connectedness is not uncommon, easily observed between identical twins and between close family members.

The idea that a soul that has departed from the body and is now in what the Buddhists call the intermediate state and what the Catholics call purgatory, might still have a connection with members of their family tree, should not be seen as unusual or even "spooky action at a distance".

CHAPTER SIXTEEN

Eating Disorders & Diabetes

In the treatment of eating disorders including obesity, bulimia, anorexia nervosa and food addiction, simple education has very limited success. In order to help someone overcome a major eating disorder, we have to focus on where these abnormal drives come from – from the unconscious mind.

Our appetites, food cravings, the sensation of fullness, thirst, preferences for food textures and tastes are all functions of the autonomic nervous system and are controlled by the unconscious mind, whose job is to keep us properly nourished and hydrated.

The unconscious mind associates these built in drives with certain aspects of human behaviour:

To be fed by someone is to be loved by them.

To be fed by oneself is to love oneself.

To hate oneself is to deprive oneself of food.

If you have to be big and strong you have to eat a lot.

To reject someone, don't eat what they give you.

Rejection is vomiting.

Vomiting is rejection.

Diarrhea is expressing anger.

To defaecate where and when you want to is a right .

Eating together means you're family.

Being family means eating together.

Being able to share means you have enough.

When you're fat you don't have to worry about boyfriends.

Tasting sweetness is remembering the good times.

A bitter taste means regret and bad memories.

Swallowing is believing.

Believing is swallowing.

If you have value, you're worth feeding.

If you are sent from the dinner table, you have no value.

I reject your values, so I won't eat your food.

Food is reward.

Reward is food.

Food restriction is punishment.

Dieting is punishment for getting fat.

A man running his own sales business was doing so well he thought he should find a partner. The money he would get by selling half of his business to the partner would clear his debts and he would have more disposable income and an easier life.

However, the figures were not quite good enough to give a partner an immediate sufficiently high income, so this man had to work harder to improve his income. He began to worry if he would have enough to feed himself and his family if he took in a partner, and whether he would be better off not taking the risk, and just keep going on his own.

However, he was getting tired and interest rates were going up. He wanted to get out of debt. There seemed to be as many reasons not to take a partner as there were for staying as he was. He then developed a stomach ulcer.

His unconscious mind was being given conflicting instructions about the sufficiency of his income, alias in the unconscious mind, his access to sufficient food. Each time he thought about income, his unconscious mind thought he was about to eat, and it triggered the secretion of acid into his stomach.

After a while, the local environment in his stomach was conducive to the flourishing of the organism Helicobacter that attacked a vulnerable patch of stomach lining, causing an ulcer.

The wife of a tradesman encouraged her husband to buy a better truck and some more machines so he could increase the range of work he could do and increase his income. His wife, who looked after the bills and the accounts, started to wonder if they had bitten off more than they could chew.

He went out and did the work, she began to suffer from symptoms of nausea and fullness as if she had put more food in her stomach than her stomach could handle.

Reducing her food intake did nothing to alter the uncomfortable feeling in her stomach, and she lost weight. Her unconscious mind was signalling that she had bitten off more than she could chew, and this over-full feeling in her stomach was unrelated to the amount of food she had eaten at her last meal.

A woman complained that she had a big lump in her throat that made her feel that if she tried to swallow anything it would get stuck. But the food went down normally.

The lump in the throat appeared suddenly during property settlement negotiations with her ex-husband in

their divorce settlement. He knew what financial difficulties she was in.

At the last moment he offered to pay her immediately 50% of what she had claimed or else he would drag out the legal negotiations for months and months.

She said "I'm not going to swallow that rubbish!" and the lump in the throat appeared soon after.

Anorexia nervosa

Anorexia nervosa is one of the worrying diseases of our time. An intelligent and sensitive girl with an obsessive personality begins to starve herself to attain what she claims is an ideal body shape. To other people this ideal body shape looks like a skeleton.

She appears to be following some inner drive or pattern of thinking that is oblivious of the real condition of her body, and she lets her family know she will resist all their attempts to make her eat sensibly.

Trying to have a normal family relationship with this girl inevitably deteriorates into a conflict over control, and the anorexic girl inevitably wins.

Eventually, when her body weight is so low that she is in imminent danger of death, this girl is admitted to a psychiatric hospital under an involuntary treatment

order. Over years of trying different methods, psychiatric units have found a method that works.

The anorexic girl is confined to bed, not allowed to use the bathroom or get out of bed until she has attained a goal weight. As her weight increases, she wins more privileges. Eventually she gains enough weight to be allowed to go home. The psychiatric unit wins the battle of wills. The recovery rate is about 30%

How do we understand this condition? The British doctor and author Dr Kenneth McAll who wrote "Healing the Family Tree" (Sheldon Press) claimed that in a series of anorexia nervosa patients he treated in the Southampton area, he had a success rate of about 86%.

McAll found that most of the patients suffering from anorexia nervosa had a deep seated spiritual problem that he dealt with through ritual mourning, specifically through a Holy Communion service. Unfortunately McAll was never able to have his study published in a medical journal because it was regarded as too controversial.

The spiritual problems in patients with anorexia nervosa are usually very deep and fundamental to survival. The commonest situation is that a couple have become pregnant and the child was aborted because the child would present a threat to woman's career. Later they marry, and when it is convenient, they have children.

The anorexic girl is often the child next to the secretly aborted sibling.

The girl who will later become anorexic after puberty, is often a perfectionist who seems to believe that if she cannot live up to her own high expectations of herself, she has no right to live or no right to be fed. She is following an archetypal story that was written when her pregnant mother aborted her brother or sister – the story says "If you are going to represent an inconvenience, you have to go."

Because the anorexic girl's drive to starve herself is coming from the unconscious mind, she cannot easily express what she is intending to do in starving herself. Consciously she may say she looks too fat when she sees herself in a mirror, in comparison to the gaunt skeletal fashion models parading the catwalks. Sometimes she says there are people in the world starving and she doesn't have the right to use nutrients they should have. When the fact of the secret abortion is made known to the starving girl, the underlying archetypal story becomes conscious and can be dealt with.

In other cases, some anorexic girls appear to be mourning a lost soul who has not had a funeral. In one case, the lost soul was a pilot who crashed into the sea and was never accorded a funeral as his body was not recovered. In some cases, the lost soul was a twin who was dead at birth and was never named.

In another case, the story begins in south-east Asia during the Second World War. A ship's captain Peter was not at home when the Japanese invaded, and his wife and four children were put into a prison camp. There was very little food, and the woman gave her food to her four children. She began to starve, became ill with dysentery and died. She was buried and the children were moved to other camps. The eldest child was Alex, a 12 year old boy who was very resourceful and he kept himself and his three younger siblings alive.

At the end of the war, Peter was waiting in to meet a Red Cross ship in Australia. He thought that his wife and children were on the boat, but they were not.

He had to return to south-east Asia to search for them. Eventually Peter found his four children alive, but nobody knew where his wife was buried.

He returned to Australia, where he re married. Alex grew up, became an engineer and got married. He and his wife Carol had four children, the eldest being a girl Rebecca who was 13 years old when the baby was born.

One Saturday, Alex and Carol were attending a work function and the woman next door was baby-sitting the children. Rebecca suddenly wanted to check on the baby, but the baby-sitter told her not to disturb the baby as he had just gone to sleep.

About 10 minutes later, Rebecca could not suppress her feeling of rising alarm, and she went in to find the baby was dead, a cot death.

Some time later, Rebecca began giving her lunch away to other students at school.

She ate less and less and had to be hospitalized on three occasions. She was not responding to treatment. When eventually she saw another psychiatrist who took a detailed family tree and personal history, the contrast between failing in her role as the eldest child to keep the baby safe, compared with her father's success in looking after his younger siblings, and the similarities between Rebecca's giving away her food and her grandmother's action in giving her food to her children in the prison camp, drew attention to the soul of the grandmother who had never had a family funeral service.

The family organized a memorial communion service for the grandmother, and Rebecca recovered from her anorexia nervosa. Rebecca had not known the story of her grandmother's death before the psychiatrist took the detailed family history.

Obesity

Some overweight people are genetically destined to accumulate excess body fat throughout their lives. They lack a gene necessary for the release of a substance called leptin from their body's fat cells.

Usually when a globule of fat is taken up by the cell it releases an amount of leptin.

Leptin has two effects – it decreases the appetite and increases the body's metabolic rate. If leptin is not released, the body has no signal that it is accumulating excess fat.

These people destined to be overweight usually have small, graceful hands and feet.

The Polynesian people who inhabit the islands of the Pacific and who arrived in New Zealand about 1500 AD (Maori people) have a tendency towards being fat because during the long sea voyages in ocean-going canoes when they first explored the Pacific Ocean, the naturally lean people tended to die on the journey because of dehydration, starvation and exposure, while the fat people who had less surface area in relation to their fat stores tended to survive the long months at sea. The survivors tended to be the people who were naturally fat.

Psychological factors in obesity

It is a common observation that when people are given positions of responsibility where it is up to them to support everyone else, they have a tendency to put on weight. The unconscious mind says "If you have to be big and strong for them, you need to eat a lot." This is an example of "thinking thick".

These people usually don't lose weight unless the sole responsibility for the safety and support of others is lifted from them. When these people can assume the role of being an observer, rather than a "mover and shaker", the archetypal story shifts to "You can relax and eat when you're hungry."

The obesity epidemic and type two diabetes

Diabetes mellitus is a chronic disease that occurs when the pancreas does not produce enough insulin, or alternatively, when the body cannot effectively use the insulin it produces. Insulin is a hormone that regulates blood glucose.

Type 2 diabetes (formerly known as maturity-onset diabetes) accounts for 90% of the people with diabetes around the world. While type 1 diabetes is caused by a lack of insulin being produced by the Islets of Langerhans cells in the pancreas gland, type 2 diabetes is caused by the body's ineffective use of the insulin it produces. This is called insulin resistance or glucose intolerance, and is considered to be the condition that leads to type 2 diabetes. The World Health Organization claims that type 2 diabetes is largely the result of overeating and a sedentary lifestyle.

However, the statistics do not appear to fit in with the idea that there should be more cases of type 2 diabetes in affluent countries where people drive rather than walk and have plenty to eat. Instead the diabetes epidemic appears to be worse in developing countries.

The World Diabetes Foundation based in Denmark, in their Media Backgrounder Diabetes in the Developing World, predicts that "by 2025, 70% of all people with diabetes will be living in the developing world.

"The prevalence of diabetes has reached epidemic proportions. The WHO predicts that developing countries will bear the brunt of this epidemic in the 21st century, with more than 70% of all new cases expected to appear in developing nations."

The China People's Daily reported on October 13th, 2005: "China is ranked second in the world in the incidence of diabetes, with the number of diabetes patients expected to grow from 80 million to 100 million in 2010. According to a China Youth Daily report, China has 35 million diabetes patients at present, or one fifth of the world total. And the number is increasing at a speed of 3,000 per day."

The International Diabetes Federation's e-Atlas of diabetes prevalence rates in 2003 shows the United States, Canada, Russia, Pakistan, Afghanistan, Egypt and Germany equal at 8-11%. Australia, Brazil, Argentina and India shared a similar diabetes prevalence rate at 5-8%

Some of the countries with similar diabetes prevalence rates, such as the United States, Afghanistan and Pakistan cannot be said to be similar in regards to lifestyle. The simple concept of diabetes caused by eating too much and not doing enough exercise does

not appear to fit. There has to be some other explanation.

The Canadian Breakthrough

In December 2006, Canadian scientists published a paper in the journal Cell that could change current scientific thinking on diabetes.

The Canada.com website quoted Tom Blackwell of the National Post:

"In a discovery that has stunned even those behind it, scientists at a Toronto hospital say they have proof the body's nervous system helps trigger diabetes.... Diabetic mice became healthy virtually overnight after researchers injected a substance to counteract the effect of malfunctioning pain neurons in the pancreas."

See CELL Volume 127, Issue 6 , 15 December 2006, Pages 1123-113

The mystery of impaired glucose tolerance

Many people suffering from Type 2 (maturity onset) diabetes have a condition known as insulin resistance. In Type 2 diabetes, the islets cells of the pancreas are capable of producing insulin, but either the insulin is produced in insufficient quantities, or something is interfering with the ability of insulin to regulate the blood glucose. This impaired glucose tolerance is usually called insulin resistance.

Community starvation and insulin resistance

It has been reliably and consistently shown that starvation causes insulin resistance in human beings, presumably by an effect on the thyroid gland's production of thyroid hormone.

The revenge of the hungry ghosts

Every year Singapore celebrates the Hungry Ghost Festival (Zhong Yuan Jie). Here are some excerpts from an account of this festival written by Bonny Tan for the Singapore National Library Board in 1999:

The Hungry Ghost Festival ..is held on the 7th month of the lunar calendar. On the 15th day.. families pay respect to their deceased relatives and visit their graves often with much feasting as if their dead relations are still were with them.

It is believed that during this time, the souls of the unborn and that of departed ancestors and friends are released from Purgatory to wander the earth for 30 days. The souls of the dead ignored by relatives may do acts of mischief, so steps must be taken to appease the spirits before they go on a rampage.. food is offered so that the souls do not go hungry and thus less likely to wreck havoc.

The story of Mu Lian, who tried to save his mother from Hell, is connected to this festival. Mu Lian was reputedly a favourite disciple of Buddha. However his mother had broken her vow of abstention from meat-eating and was cursed to suffer the afflictions of hungry ghosts in purgatory.

Although Mu Lian offered rice to his dead mother, hungry ghosts would consume it before she could eat it. In anguish,

Mu Lian appealed to Buddha for help. Buddha pointed out that only the monks of the Ten Directions could save her. They had to prepare all kinds of food and items and offer it to the ancestors of the past 7 generations on the 15th day of the 7th month. Thereafter, Mu Lian's mother was delivered from her torments.

Dr Kenneth McAll, author of the best-selling book *Healing the Family Tree*, told me of significant numbers of diabetic patients who had ancestors who died of starvation.

Influence on the unconscious mind of starving millions

The psychoanalyst Carl Jung believed there was abundant evidence for the existence of a Group Unconscious, an unconscious mind that is shared by and contributed to, by a group or community. Each individual in that group is influenced by the Group Unconscious, through the connection between the individual's unconscious mind and the spiritual reality.

And through the unconscious mind, the autonomic nervous system that controls the body's blood sugar levels, is influenced by the Group Unconscious.

Imagine the influence of millions and millions of hungry ghosts, of souls who starved to death, on the autonomic nervous system of a person who is spiritually sensitive, and receptive to, the cries of those starving souls.

If the unconscious mind believes the body is starving

If the unconscious mind of a spiritually sensitive individual begins receiving false messages from the Group Unconscious that everyone in the outside world is starving, and therefore although the person has food in his stomach, he will inevitably starve, what is likely to happen?

The unconscious mind triggers the running of a story from its library called "There is no food available." This story immediately triggers off a number of body responses:

The thyroid gland is shut down by the pituitary gland to lower the body's metabolic rate so the person will slow down, sleep more and use less energy. The person would feel lethargic and tired.

The skin, hair and fingernails are denied blood stream nutrients because they are regarded as not essential to survival. Hair would fall out, skin would lose its sheen and the fingernails would become thin and brittle and break easily.

The reproductive organs are shut down by the pituitary gland. Reproduction is wasteful of body resources in times of famine. Menstrual periods might stop or become irregular.

The pancreatic islet cells that produce insulin are told to shut down production of insulin because the lowered

blood glucose levels as a result of starvation will not require the same amount of insulin as before.

Insulin receptors on body cells generally retract into the interior of the cell, leaving only a small fraction of the receptors protruding from the cells able to be activated by insulin.

The various parts of the gastrointestinal system that have local signal systems that will tell the parts lower down the line when food has arrived, are told to stand down because there won't be any food coming in anyway.
So what happens the next time the person whose autonomic nervous system is expecting no food to be entering his stomach, has his next hearty meal?

The food in the stomach and duodenum are unexpected, and the liver is surprised by the sudden need for bile to be squirted from the gall bladder into the duodenum.

Usually the pancreas gland is told long before the food arrives to get ready to produce the enzymes to break down the large proteins and the fats in the food coming down from the stomach. The sudden presence of food in the duodenum that catches the gall bladder off guard also has the pancreas unprepared.

This uncoordinated release of bile and pancreatic juice will cause abdominal discomfort and bloating as the small intestine receives food that it cannot easily digest.

However, some of the food is absorbed as usual by the small intestine and transferred into the bloodstream going to the liver, which is also surprised to find amino acids, sugars, fats and starches arriving. Because the metabolic rate has been lowered, and the liver furnace is only working at half-pace, the nutrients are stacked in the corridors until the liver cells can get them into the furnace.
(This is the cause of a fatty liver, where more nutrients arrive than the liver can process, and fats and starches get stacked in the corridors and passageways)

Because the pancreatic islet cells that release insulin have been told not to release insulin, these cells are unprepared when a bolus of glucose arrives in the bloodstream, and the islet cells begin releasing insulin into the bloodstream an hour too late.

The blood glucose level is suddenly too high, and it is filtered out into the urine, dragging along more water than usual by osmosis. Extra urine suddenly keeps filtering into the bladder, the blood becomes dehydrated, the person becomes thirsty and begins to drink more water.

However, an hour later, the situation is reversed. The bolus of glucose in the blood stream has passed, and the pancreas has released its insulin an hour too late.

The effect is to drop the blood glucose below the normal fasting level, and this makes the person instantly

very hungry, and so eats again earlier than normal, favouring the sweet, rapidly absorbed sugars and starches that will quickly bring the blood glucose back to normal.

Thus begins a chronic pattern of eating followed by panicky overeating, and a strange mixture of symptoms of diabetes (glucose in the urine, thirst and frequency of passing urine) and hypoglycemia (feeling faint and hungry with the feeling "if I don't eat, I'll die")

Add to this the lowered metabolic rate, and the person is well on the way to obesity, chronic fatigue, hormonal abnormalities, bad skin, falling hair, breaking fingernails and a feeling of hopeless despair.

And this is all due to one single cause – the unconscious mind has wrongly believed that the person is starving to death.

What to do about it?

Firstly, it should be abundantly obvious that putting a fat person on a calorie restriction diet is exactly the wrong thing to do.

The unconscious mind has only a rudimentary awareness of the outside world, and if the conscious mind begins thinking that certain foods are bad, that this person is no longer allowed to eat what they like,

the impression gained by the unconscious mind that there is a famine out there is well and truly confirmed.

The most important thing to do is to convince the unconscious mind that there is no famine, and that the body has been doing a really good job preparing for a famine, saving up lots of fat for the lean times ahead.

How do we convince the unconscious mind that there is no famine, when from its depths it continues to hear the moanings of the hungry ghosts who starved to death in the genocidal cruelty of the 20th century?

My view is that we all share this problem. The hungry ghosts moan and groan, but only the spiritually sensitive people are hearing their pain.

When as a community we begin to address practically the causes of famine, and begin to realize that we will all eventually pay a price wherever we live, for those people starving half a world away, we will see changes in the incidence and prevalence of obesity and type 2 diabetes.

CHAPTER SEVENTEEN

Criminal behaviour is feral behaviour

Some people, beginning in childhood, choose to do illegal things throughout their lives. Given a chance of rehabilitation and "going straight", versus getting into trouble and serving time in prison, some people will still choose a criminal lifestyle.

Many police and prison officers see these people as belonging to a distinct sub-group, with its own rules and values.

In my view, criminal behaviour is actually feral or wild behaviour. It results from a failure of the taming or civilizing process.

Consider how we would normally proceed in taming a wild animal. We will be careful not to alarm the animal; we will provide for its every need; we will often hold it and touch and stroke it affectionately; when it bites or scratches because it wrongly thought we were about to harm it, we don't punish or admonish.

We reward any response the animal makes which resembles the responses we want to teach it. We ignore inappropriate responses. Eventually, we win the animal's confidence, it learns to trust us, it likes being near us, and it begins to imitate human behaviour.

Child taming

This animal taming process is exactly the same method we use in bringing up our children, although we don't usually refer to child rearing as "taming". Several characteristics of human beings make the taming or civilizing process possible. The first is the powerful commitment of human mothers to the safety, survival and happiness of their children. The second is the basic drive for human fathers to protect and feed their families. The third is the very long childhood of human beings in comparison with the same juvenile period in other animals.

It is surprising how many mothers are unaware of how much teaching they do, while caring for their young children. To some mothers it seems that their children learned to speak all by themselves, unaware of the countless times in feeding, bathing and dressing their children when they have patiently corrected and shaped their toddlers' attempts at words. Likewise, to many parents, their greedy, selfish little offspring just seemed to become considerate and caring human beings all by themselves.

The taming process is not automatic at all. There are countless occasions when feral behaviour in children is patiently and lovingly discouraged in normal families. Through patiently extricating baby's hair from toddlers' fingers, adjudicating grabbing and pinching disputes, discouraging aggression and encouraging acts of kindness, loving parents tame their young.

However, under certain conditions the taming process does not happen at all.

It is not difficult to find offspring of domestic animals reverting to a feral state when they are not exposed to a human civilizing influence. The same applies to human beings. When human mothers are not able to guarantee the safety and happiness of their children, and when human fathers abuse and abandon their families instead of protecting and supporting them, the children do not learn to trust human beings, and may revert to a feral state.

If we compare criminal gangs with groups of wild dogs or wolves, we find many similarities. Firstly, criminal gangs behave like predators, regarding the community as a hunting ground. The rule is, anything you can get or catch, is yours. Vulnerable people are considered easy game, in just the same way as predators will concentrate on attacking the young, the old, and the weak.

Secondly, wild dogs show a tendency to take more risks while in company with their peers than when they are alone. Mob or crowd behaviour in wild dogs is similar to that of criminal gangs.

Thirdly, leadership is determined by strength and the ability to cause the others to feel fear. While predators such as wolves usually respect kinship ties and territorial boundaries, the leader is always the strongest and nastiest. Similar rules apply to criminal gangs.

They usually respect the territory of other gangs, and discipline within the criminal group is maintained through violence and fear.

In wild animals, there is a difference in what determines male and female dominance. Male dominance of other males is based simply on who is strongest and most dangerous. Female dominance is based on who has access to resources which others need. The dominant female is the one whose kinship ties control access to feeding grounds or food supplies.

Similar principles operate in prison populations. In men's prison populations, power hierarchies are based on the ability to bash and intimidate others.

In women's prisons, the dominant female prisoner may be the one who is able to control the supply of contraband such as cigarettes and drugs, or the distribution of sexual favours.

The role of human touch

Touching, holding, stroking, caressing and grooming are essential in building up relationships of mutual trust. In wildlife documentaries, we often see examples of mutual grooming in animals that rely on group cooperation for hunting and survival. It is assumed that grooming in baboons for example, is more important for group cohesion than for simply getting rid of irritating burrs and parasites.

Touch is essential for bonding of human mothers and babies. Where babies are born premature and are too fragile to be carried and nursed normally, it has been found necessary for the mother to hold and touch her tiny baby within the first six weeks of life , even though she may have to wear sterile clothing to avoid introducing infection.

If bonding (called imprinting in birds) does not take place in the first six weeks of a baby's life, the mother does not develop that special feeling for her child that we recognize as mother love, an unconditional commitment to care for that child for life. In the first six weeks, the mother falls in love with the child and the child falls in love with the mother.

From the child's perspective, if bonding to the mother or a substitute mother is interfered with in the first six weeks of life, the child may grow up with a deep unfulfilled longing for unconditional love.

This feeling of aching incompleteness can cause two different reactions. The child may spend years searching for a deep satisfying relationship only to find that everyone fails the test.

In my experience girls who have been neglected in infancy are more likely to respond in this way. Or the child may turn away from intimacy altogether, becoming feral. In my experience, neglected boys are a little more inclined to react in this way.

Touch in therapy

Feral children who come to our notice through various forms of criminal behaviour are usually fearful of human touch, just like wild animals. And we usually find that as infants, these children rarely experienced a mother's touch.

It is quite common to find that sexual intercourse without foreplay or body caressing is the only concession to touch that feral human beings will allow.

Therapy for feral people who continually re-offend is therefore most likely to be effective if it includes human touch as well as re-education.
However, it is impossible for psychiatrists, psychologists, prison officers, teachers and social workers to provide physical touch because of the certainty that such activity would be regarded as inappropriate.

CHAPTER EIGHTEEN

Delirium, Confusion

Most of us have had some experience of someone who was delirious and for some time did not seem to know who they were, where they were and what day it was. A delirium or confused state arises from a major malfunction of the brain's processing capacity.

We diagnose a confused or delirious state by assessing the patient's orientation in time, place and person. "Mr Jones, can you please answer these simple questions? What day is it today? What month is it, and what year? Can you tell me where we are right now? What is this place called? Could you give me your date of birth? What is your wife's name? What is the name of your daughter? Where were you born?"

Recording the patient's orientation in time, place and person is a useful first step in differentiating between delirium, dementia, and Korsakoff psychosis. In delirium or confusional state the patient is disoriented in time place and person.

In early dementia, the patient may not know what day or year it is, may not know where he is at the moment, but may have quite a good grasp of his own personal information. So the patient with early dementia may be confused in time and place, but not in person.

In Korsakoff psychosis the patient has a memory problem that began at a particular time in his life. The patient will have full memory of personal information up to that point and from that point onwards he has been unable to retain any memories.

He will be like someone frozen in time. Providing that his personal information has not changed much since his memory was damaged, the patient may be oriented in person, but not time. If where the patient currently is, was familiar to the patient before he developed his memory disturbance, he may appear oriented in place, but he will be unable to remember how he got there.

Korsakoff psychosis is usually caused by a combination of alcohol abuse and vitamin B group deficiency, but can also be caused by a deceleration head injury where the tips of the temporal lobes have been damaged.

We must always remember that delirium always means a person is seriously ill, and therefore delirium represents a medical emergency.

For example in the case of a person who has a chronic lung condition and now appears confused, the most likely cause is hypoxia. The brain is not getting enough oxygen.

And this means the person will die unless the hypoxia is reversed.

Likewise a person who has suffered a heart attack and who is now confused, is suffering from a lack of oxygen getting to the brain, caused by cardiogenic shock. This person is very likely to die unless he receives urgent medical treatment.

We should also remember that if a patient has sustained a head injury and was knocked unconscious, the patient will not actually remember being knocked unconscious. In cases where a person is found wandering the streets confused, an examination of the patient's scalp may show bruising, indicating an underlying head injury.

It is usually not difficult to discover the causes of the delivery or confusion. This question will help you remember some common causes:

DAD, IS POT SAFE?

D Drugs and drug withdrawal. Look for evidence the person has been taking legal or illegal drugs. People using illegal drugs may also try toxic agents like toxic mushrooms and toxic plants. Remember the danger of children getting access to grandma's sleeping pills.

A Alcohol and alcohol withdrawal. The smell of alcohol on the breath will diagnose simple drunkenness. Empty bottles and observations by neighbours can indicate this person might have been on an alcoholic bender, and this condition might be delirium tremens from alcohol or drug withdrawal. Remember that people can die from drinking too much whisky or vodka too quickly.

And also remember that combinations of drugs and alcohol can produce an unpredictable and dangerous synergy.

D Deficiency states. People with inadequate diets can develop vitamin B group deficiency states which can cause mental confusion. Other deficiency states include deficiencies of thyroid hormone in hypothyroidism and cortisol deficiency in Addison's Disease. You may find the confused person has not been taking their medication.

I Infection. Meningitis and encephalitis caused by infection of the brain and its coverings. As well as confusion, the patient usually complains of a severe headache and may have a painful stiff neck. The patient will have a raised body temperature.

S Sugar. Untreated diabetes mellitus may cause confusion because the blood glucose has been too high and the body has been burning body fats for energy, causing the blood to become too acid. You might smell acetone on the breath.

However, low blood glucose from inadequate control of diabetes is a much more likely possibility when a person you know to be diabetic is disoriented and confused. The patient needs to be given some glucose by mouth, or an injection of glucagon.

P Poisons. What was the person doing in the previous four hours before becoming confused? Spraying

garden pests? Using glues, paints and thinners with inadequate ventilation? Many modern solvents and acrylic glues are quite toxic.

O Oxygen. When the blood cannot carry enough oxygen to the brain, the patient becomes confused. If the patient has a cough or a known chest condition, or has chest pain or a known heart condition, mental confusion may be a sign that death is not far away.

T Trauma. People who have sustained a head injury serious enough to cause them to be confused and disoriented, were probably knocked unconscious at the time.

This means the person may have no memory of the injury itself, and could be wandering around confused, complaining of a sore head. The skull fracture may be discovered by someone examining the scalp, looking for cuts or for bruising behind an ear.

S Steroid drugs. Anti-inflammatory corticosteroid drugs can have unusual effects. As mentioned before, some people need to take cortisone regularly to replace a deficiency. If they stop taking their pills, confusion could result.

A Arterial hypertension or hypotension. We're talking about excessively high or excessively low blood pressure. If a confused person has lost blood, or looks pale and feels cold, make sure they are lying down.

F Fever. A fever caused by infection anywhere in the body, not just the brain, can caused delirium, particularly in children. Simply feeling the forehead of a confused person might suggest the diagnosis.

E Epilepsy. People recovering from epileptic seizures can be confused and disoriented for some time. This is easy to recognize if you see the person in a seizure, but sometimes the person has had the seizure before you come on the scene. In this case, the confusion usually lifts within half an hour.

How to manage a confused client

Having made an initial assessment that the patient is confused and disoriented, called for medical help and/ or arranged for his admission to hospital, you should be considering the possible causes for delirium and looking for clues to the correct diagnosis. Look for medication containers, empty alcohol bottles, unusual hobbies where the patient has been using toxic products, household poisons etc.

Meanwhile, you need to be able to manage this person until he can be safely given into the care of the hospital staff.

It is important for you to realize that the main emotion being experienced by the confused patient is fear. People react to being afraid in different ways. Some people believe in attack as a useful form of defence,

and may become quite aggressive if not handled gently and sympathetically.

With confused people, it is a good idea to respond to any aggressive display with reassurance and explanation. Remember that confused people have diminished capacity for recognition, so it is important to act the part clearly.

I have found that wearing a stethoscope and asking the patient to open their mouth and say "aah", makes me more easily recognized as a doctor.

Taking the patient's pulse and blood pressure helps affirm they are ill and also provides useful information. Nurses and ambulance officers in uniform are easier to recognize.

Relatives should repeat their names and position in the family: "I'm your son, John. Remember Dad we're all going on holidays together next week."

Never attempt to lighten the atmosphere by joking with a confused patient. To see the funny side of a joke requires a fully functioning brain. Confused people may respond to jokes as if they are threats or insults.

When the patient is taken to hospital, make sure that all his medication goes with him.

A close family member should stay with the patient during the admission process to answer questions and reassure him.

CHAPTER NINETEEN

Alzheimer's Disease

Alzheimer's Disease is a progressive loss of all brain functions that looks like some disease process is inexorably causing the brain to wither away.

The person who develops Alzheimer's Disease is locked into his own world, progressively losing the ability to make sense of his surroundings or relationships, and progressively losing control of their own body functions.

Eventually, having withered away physically, Alzheimer's patients die as a result of being unable to cough efficiently to protect the lungs, to feed themselves or keep the body adequately hydrated. Usually they die of pneumonia as bacteria normally resident in the respiratory tract overwhelm the body's impaired defences.

Alzheimer's Disease is one of the forms of dementia. The dementia of multiple strokes, or multi-infarct dementia appears to be closely related to Alzheimer's Disease.

The dementia of multiple strokes is the result of a number of episodes where the cerebral arteries supplying the brain with blood, block up, and the brain tissue supplied by that artery is irreversibly damaged and ceases to function.

Alzheimer's Disease appears to be caused by frequent blockages of small arteries by blood clots so that the condition appears to be smoothly progressive, compared with the dementia of multiple strokes where definite discrete episodes of loss of function can be identified.

"You know she's always been a bit like this"

Over many years of clinical practice in psychiatry, I have frequently heard comments from relatives of patients suffering from Alzheimer's Disease "You know she's always been a bit like this." When asked for clarification, the explanation is usually something like: "Well she always preferred her own reality. She would rather read romance stories than the daily newspaper. And she never wanted to hear about the outside world."

It is as though the people who will develop Alzheimer's Disease prefer to live in a smaller, more personal world where scary things don't happen.

Brain plasticity and re-wiring

I saw a program on the National Geographic Channel where actor Alan Alda was playing a role in various experiments. In one of these, a laboratory technician in an American hospital agreed to wear occlusive goggles for three weeks, agreeing therefore to become virtually blind.

Before the blindfold was applied, some studies were made on the sensitivity of the fingertips of both hands, measuring touch, pressure and two-point discrimination, and then the EEG (brain wave) results of repeatedly electrically stimulating the fingertip pad of her right index finger. The subject was right handed.

The EEG stored all the wave formations. Because the waves seen on an EEG are mostly random, if these wave forms are stored, they will cancel each other out, and all that is seen is usually a thick line. The electrical stimulus applied to the right index finger tip was not random, and the repeated stimuli produced a spike on the EEG at the expected point, on the left side of the head about halfway down, in the sensory area that represents the right index fingertip.

Then the occlusive goggles were fitted. After a week of blindness, the subject began to learn Braille for two weeks or so. Braille is the touch language used by blind people, who are taught to read words made up of patterns of raised bumps on paper.

At the end of this Braille learning period, the sensitivity tests were repeated. The results were the same as the initial ones, with the exception that now the right index finger was now relatively insensitive to touch, pressure and two-point discrimination.

And when the electrical stimulus EEG brain wave test was repeated, the spike was no longer in the expected position on the left side of the head, halfway down, but

over the occipital area, right at the back of the brain. The occipital pole of the brain is the “seeing” or visual cortex.

The seeing part of the brain was using the right index fingertip to “see” the outside world.

Watching blind people read Braille has always fascinated me- the way their fingers move across a line of raised paper dots at the same speed our eyes traverse a line of written words.

The experiment involving Alan Alda revealed why blind people can decipher the Braille dots at the same speed as a sighted person moves his eyes across a page. The occipital cortex that interprets the information coming in through the eyes has taken over, and moves the observing mechanism (now the right index finger) at its usual speed for scanning newsprint.

This experiment reported by Alan Alda demonstrates the plasticity of the nervous system.

The mind that wants to see can rewire the brain to receive the input from a fingertip and tell the brain not to seek information on touch and pressure from that same fingertip.

Lose it when you don’t want to use it

Consider the situation where we lose some function of the brain that we don’t need. We know this can happen

over long periods of time. Just look up the number of species of animals living in underground caves that have lost their eyes. But can this happen over a few years?

Over many years of clinical practice I have heard of people who claim they are going deaf who often say, "I don't want to hear that. Don't tell me that!" These are people who want to say what they think and they don't want to listen to anyone who might disagree. Over time these people may in fact become deaf. It's as though the unconscious mind says "He doesn't want to hear anything. Shut down the input from his ears. It's just wasting energy."

Likewise there are people who complain of poor eyesight but don't want to bother getting spectacles. These people often say "Don't show me that. I don't want to look at that!" These are the people whose relatives might say "I am sure she can see if she really wants to."

Consider the possibility that someone doesn't want to know anything about the outside world. They feel more at home with their memories and their daydreams than they do talking to their neighbours and doing the shopping.

They don't mind watching TV so long as they're watching a movie or a soap opera and they don't have to watch a news broadcast.

As they grow older they actively seek to focus on their immediate surroundings and relationships with their immediate family. They forget names and numbers because these are of no use to them. They are wasting away mentally.

As the disease progresses, the Alzheimer's Disease patient is only interested in the confines of their home, then their room, then in the nursing home, only the area around their bed.

Progressively, they lose interest in feeding themselves and keeping themselves clean.

Eventually their immune system loses interest in protecting the body from being overwhelmed by bacteria.

Is Alzheimer's Disease a reaction pattern?

I don't expect many people to agree with me, but I regard Alzheimer's Disease as a mystery disease that has defied our attempts to understand it.

In my experience, in some cases of Alzheimer's Disease, the afflicted person's decline in mental efficiency began with an active turning away from involvement in the external world, and a preference for avoidance rather than understanding the changes in their personal environment.

It is almost as though a person who suffered some reduction in their ability to cope with their world that followed a small stroke from blockage of a small blood vessel, decided to give up rather than seek active rehabilitation.

It is as though Alzheimer's Disease might represent a reaction pattern rather than a disease.

I realize that tomorrow someone may find the cause of Alzheimer's Disease, and this theory of mine will be subjected to well-deserved ridicule.

I certainly hope so. However, in my experience, anxiety about coping in the real world is an integral part of the picture of Alzheimer's Disease, and attention to this anxiety might limit the deterioration in some cases.

CHAPTER TWENTY

The soul or spirit

As counsellors, how are we to regard the various claims of bodily healing through the words of Jesus of Nazareth in the New Testament and by Christian healers today?

There are so many claims of divine healing of deformities and body illnesses that we cannot simply ignore them as most Australian psychiatrists do.

I find that those who deny the existence of God usually deny the existence of souls or spirits.

The beliefs of Australian Aboriginal people that most people have two souls or spirits have been confirmed by the research of American hypnotist Michael Newton (see his book "Journey of Souls").

In June 2011, I attended the eighth International Conference of the World Christian Doctors Network in Brisbane, Australia.

A number of fully documented cases were presented where people had been healed of serious medical conditions as a result of heartfelt prayer.

In each case it appeared that prayer had accelerated the rate of the body processes of inflammation and repair far beyond what would have been expected.

In the case of Dr Sean George from Western Australia, the rate of destruction of his body tissues as a result of complete cardiac arrest appeared to have been stopped as the result of a simple, desperate prayer by his wife.

Dr Brian Yeo, a surgeon from Korea, in presenting the case of his own son's total recovery from multiple fractures and intracranial haemmorhage, suggested that prayer was responsible for creating a "Spirit Space" in which the normal restorative processes proceeded at an accelerated rate because the Holy Spirit was directing the body's repair mechanisms.

Body souls and incarnating souls

There appear to be human souls or spirits in the spirit world who are permitted to reincarnate into an unborn human being.

The purpose of this is to give this soul a chance to live out another human life to learn the lessons the spirit failed to learn the last time it occupied a human body. This applies only to some celestial human souls, only those experiencing the mercy of God, allowing them to return as part of the education necessary to be able to stay in Heaven and perform a useful function there.

When an incarnating spirit enters a human unborn baby, there is already a body soul present, created at conception, that controls basic body functions and manages the templates for the different phases of body growth and development.

The incarnating spirit has to come to some working agreement with the body soul. It would appear from Michael Newton's research that character traits like irritability and violence and various addictions are genetic, inborn and the province of the body soul. And the incarnating soul will need to learn to cooperate with the body soul and control this person's life to earn divine approval.

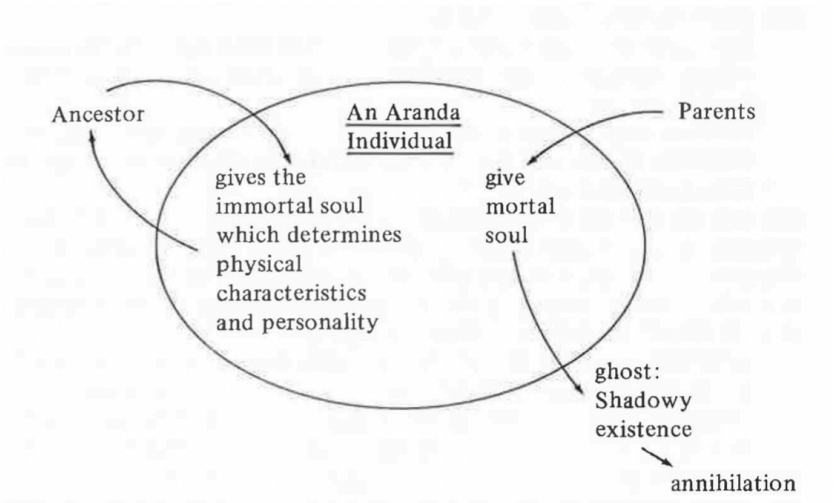
If you would like to learn more about Australian Aboriginal beliefs about the soul, here are two excerpts and references:

At death, the two types of soul have different trajectories and fates. The egoic soul initially becomes a dangerous ghost that remains near the deceased's body and property. It eventually passes into nonexistence, either by dissolution or by travel to a distant place of no consequence for the living. Its absence is often marked by destruction or abandonment of the deceased's property and a long-term ban on the use of the deceased person's name by the living. Ancestral souls, however, are eternal. They return to the environment and to the sites and ritual paraphernalia associated with specific totemic beings and/or with God.

Read more: http://www.deathreference.com/A-Bi/Australian-Aboriginal-Religion.html#ixzz7PtoHtdHW

From Encyclopaedia.com

Afterlife: Australian Indigenous Concepts



As a therapist, I am not interested in enquiring into my patients' past lives. This would be like a driving instructor having to learn all the technical specifications of his car's engine, transmission and electrical system, before he could teach his pupil how to drive properly.

I am interested in my patient's life at present, knowing of course, that this person has an immortal soul. or spirit. Sometimes, knowing that my patient's soul has a pre-decided narrow choice of destinies, I may be able to help in career choice, given from this person's

personal and family history, their obvious gifts and weakness.

And if this patient has a highly sensitive nervous system and is intrinsically spiritual, I need to know about how to deal with evil spirits and help the patient interpret helpful angelic voices.

CHAPTER TWENTY-ONE

The problem of evil

When we try to understand why people do wrong things, it is not difficult up to a point. For example, we can understand someone becoming disobedient and nasty as part of trying to establish their autonomy or independence. After all, nations sometimes go to war to assert their independence.

We can also understand that feral people who see the community as a hunting ground will prey on the young and the old and the weak, just as predatory animals do. They simply choose easy targets.

People whose work involves frequent contact with criminals, sometimes have a certain fondness for the thieves and con-men who can't seem to stay out of trouble.

When you know that a repeat offender did not have a normal upbringing, did not experience love or acceptance from parents, and learned how to live by his wits on the street, theft and fraud can be seen as equivalent to a predator simply living off the land.

On the other hand, the rapists, the bullies, those who plan violence or murder to facilitate a robbery, represent something more sinister.

Their behaviour may well have begun with growing up wild because of a failure of the taming or civilizing process. But their further decline into evil usually follows a decision to put their trust in violence and assign to themselves certain rights.

Evil behaviour

Some people seem to enjoy inflicting pain and suffering on others to gain satisfaction in a weird way that we cannot understand by putting ourselves in their position.

There are some characteristics of such behaviour that makes it easier to identify the behaviour as evil.

- Evil seeks to harm, deform, deface or destroy the human body and to turn the human body into something to be ridiculed.

- Evil seeks to destroy and ridicule trust, goodness and innocence.

- Evil may have a religious focus, aiming to twist traditional religious beliefs into negatives.

Religious teachers claim that such behaviour does not originate within the human mind, but originates in “principalities” or “powers”.

A more modern description might be that evil behaviour begins outside the individual person and resides in

"isms" or "paradigms" such as Fascism, Sadism, Nazism, Satanism and anti-Semitism.

Forensic psychiatrist Robert Simon in his book "Bad Men Do What Good Men Dream" says that everyone has a dark side, and explains "Perhaps our dark side comes from our evolutionary heritage, in which aggression ensured our survival. Maybe it is the result of faulty wiring in our brains. (p 3)

The Christian writer Francis MacNutt in his book **Deliverance From Evil Spirits- A Practical Manual** sets out four basic concepts (page 46):

Evil is something we cannot overcome by simple human good will and teaching. Evil is, at its root, demonic and too great for us to overcome.

It is for this purpose that Jesus came: to overcome evil.

Evil cannot be overcome just through teaching ethical values, but by the power of God, which is given to us by the Holy Spirit.

Through prayer- prayer for healing and prayer for deliverance- we become channels for Jesus to heal and to free people (as well as institutions and societies) from the evil that weighs them down.

Demons

All human beings are subject to temptation. Temptation is referred to by exorcist Fr Amorth as the "ordinary activity" of demons. None of us is exempt. The

Gospels describe how Jesus himself was tempted by Satan.

Sometimes temptation becomes so severe that the patient's life is seriously disrupted by obsessive thoughts, and the term demonic obsession may be used. It may be difficult initially to differentiate demonic obsession from obsessive-compulsive disorder.

In demonic obsession, the usual medications which help diminish obsessive-compulsive behaviour (such as Clomipramine and the SSRI drugs) will be ineffective.

Furthermore, there is a characteristic twistedness in demonic obsession. The obsessions will be seen to be aimed at tempting the patient into activities which would cause ruin to his reputation, health, or life itself, such as obsessive thoughts of homicide, suicide, abnormal sexual acts, and there may be an increased appetite for illicit drugs and alcohol.

In his foreword to the Italian edition of Gabriele Amorth's book, **An Exorcist Tells His Story**, Father Candido Amantini, an exorcist for 36 years, writes: "An illness that is associated with even the lowest levels of demonic activity is peculiarly resistant to every known prescription drug. In contrast, even illnesses that are considered mortal are mysteriously healed by religious interventions."

More serious than demonic obsession is demonic oppression. Here the afflicted person is aware of a presence with him, weighing him down, but not in him.

The demonized person is often attacked in dreams. Sometimes he might claim he wasn't asleep at the time, but was pummelled and pushed by some unseen entity while lying in bed. In demonic oppression the patient looks as though he is carrying a heavy load, and has a characteristic defeated appearance.

The person oppressed by evil spirits may be often angry or deeply depressed, with inner urgings towards revenge or suicide. He may feel afraid of what he might do if he gave in to temptation to commit some violent act.

In demonic possession, the evil spirit actually takes over the person's body from time to time. During these periods of possession, the afflicted person will demonstrate causeless spite, anger and hatred, arrogance and disdain, all consistent with the behaviour of an entity that hates human beings.

However, there will also be periods when the person is able to go about his business, with an appearance of normality. In these periods of seeming normality, however, the patient is rarely at peace. When the evil spirit takes over, the patient will not be able to remember later what has taken place in that time.

People with experience in the deliverance ministry often remark on a characteristic appearance associated with a darkness in the eyes of a possessed person.

Treatment of demonic possession

The principles involved in getting rid of an unwanted demonic entity are the same as those involved in getting rid of an unwanted intruder (for example, in Brisbane, a possum in the ceiling). Firstly, we have to find out what the intruder is, and how it gained entry.

Then, after closing off the entry points, we need to get control over the unwanted intruder, and remove it.

We will then re-locate the intruder to a place far away so that it cannot return.

Discovering the point of entry

In some cases, the patient has been involved in the occult, and has deliberately invited an evil spirit into his life, in the hope of gaining some extra knowledge or power. The demonised person will need to renounce this former invitation.

In some cases, the point of entry of an evil spirit is through a gaping emotional wound in a vulnerable person. A traumatized person may have made a vow to exact revenge or some form of compensation and has become vulnerable to evil.

Healing up the point of entry

Healing up the emotional wounds that have allowed entry of evil spirits may require the skill of a competent counsellor. Medication might be useful, and it is better to proceed slowly and carefully.

Eventually the patient may be able to renounce his previous claim that he has a right to exact vengeance or demand compensation. Evil is legalistic. The patient may need to put in writing that fact that he has changed his mind and is no longer claiming the right to harm others.

The Lord's Prayer contains an exorcism

The ***Our Father or Lord's Prayer*** is a prayer that can be said by people of any religious affiliation. It has no mention of Jesus Christ because it is a prayer that Jesus himself used. This prayer is very useful in that it contains the exorcism at the end- "and deliver us from evil."

Sexually abused people who cut themselves

There is abundant evidence in the psychiatric literature showing a relationship between sexual abuse in childhood and adolescence and self-harming behaviour later as adults.

Childhood sexual and physical abuse and adult self-harm and suicidal behaviour: a literature review. Can J Psychiatry 1998 Oct;43(8):793-800 (ISSN: 0706-7437)

Santa Mina EE; Gallop RM Inpatient Mental Health Services, St Michael's Hospital, Toronto, Ontario *"..empirical studies have generally demonstrated more reports of self-harm, suicidal ideation, and suicidal behaviour in clinical and community populations of adults who report sexual and/or physical abuse in childhood than in comparison groups who do not report abuse."*

Childhood trauma, dissociation and self-harming behaviour: a pilot study.
Br J Med Psychol 2000 Jun;73 (Pt 2):269-78 (ISSN: 0007-1129) Low G; Jones D; MacLeod A; Power M; Duggan C Rampton Hospital, Retford, UK.
"Childhood trauma is known to be an important antecedent in those who engage in deliberate self-harm (DSH). We aimed to explore the mediating mechanisms between childhood trauma and subsequent DSH in a sample of women detained in a high secure setting… "two paths emerged: one major path which linked childhood sexual abuse to DSH via increased dissociation and another, more minor association, linking childhood sexual abuse via reduced self-esteem."

Sexual molestation of males: associations with psychological disturbance.
Br J Psychiatry 2002 Aug;181:153-7 (ISSN: 0007-1250) King M; Coxell A; Mezey G Department of Psychiatry and Behavioural Sciences, Royal Free and University College Medical School, London, UK. m.king@rfc.ucl.ac.uk.

…"Men reporting 'consenting' sexual experiences when aged under 16 years also were more likely to report acts of self-harm (odds ratio=1.7, range=0-2.8). CONCLUSIONS: Sexual abuse as a child or adult is associated with later psychological problems. All forms of sexual molestation were predictive of deliberate self-harming behaviour in men."

What is the connection between cutting oneself to draw blood and having been sexually abused as a child? The study by Sansone, Gaither and Songer (above) indicates that the connection is not simply that sexual abuse in

childhood leads to borderline personality disorder which is expressed in self-harming behaviours.

Similarly, the study by Low et al reported in the British Journal of Medical Psychology found the main relationship between sexual abuse and later self-harm was via “increased dissociation”.

I think it would be reasonable to assume that increased dissociation refers to an altered state of consciousness at the time the self-harm was taking place.

In my practice, I have noticed that cutting oneself is more likely when the sexual activity went on for a period of time, and the paedophile was able to convince the child that the child was to blame for the sexual activity.

Patients who believe that they were bad, sexy little girls are the ones more likely to cut themselves as adults. I note that the study reported in the British Journal of Psychiatry in August 2002, showed that this trend was certainly true for boys.

I have asked patients why they cut themselves. Answers include:

- It feels good.
- It relieves the tension that is welling up inside them.
- It causes a visible wound so that people can see how much they are suffering inside.
- They feel numb, and the pain brings them back to reality.
- It brings the suffering to the surface.

I find these explanations inadequate. I have never heard butchers or cooks who cut themselves accidentally ever say it felt good or relieved tension.

Instead I have another explanation that connects self blame for sexual abuse and cutting oneself to draw blood.

In the Old Testament Book of Kings, chapter 18, there is an account of a confrontation between the prophet Elijah and the priests belonging to the Canaanite gods Baal and Asherah.

The worship of the particular Baal by these people involved penis worship, and the worship of Asherah involved sexual intercourse with the holy prostitutes representing Asherah. Baal and Asherah could be described as gods of sexual misuse.

By verse 27 of 1 Kings 18, the priests of Baal and Asherah were having difficulty calling down fire from their god Baal on their altar:

27. At noon Elijah started making fun of them: "Pray Louder! He is a god! Maybe he is day-dreaming or relieving himself, or maybe he's gone on a journey! Or maybe he's sleeping, and you've got to wake him up!" So the prophets prayed louder and cut themselves with knives and daggers, according to their ritual, until blood flowed. (Good News Bible- Today's English Version)

People who belong to the gods of sexual misuse cut themselves to draw blood.

In my view, people who blame themselves for the sexual abuse done to them by devious paedophiles have unwittingly given permission for demons of sexual abuse to affect their lives.

They have unknowingly allowed themselves to be demonized.

This is important, because it means that adults who cut themselves after being sexually abused as children are probably going to need deliverance in some form.

I have found the most important aspect in healing these people is to get them to acknowledge that they were in fact innocent children and they now have to stop blaming themselves.

When they no longer blame themselves, the demonic entities no longer have any legal right to have access to their minds. This may be all it requires for them to get rid of the demon that has been urging them to cut themselves or commit suicide.

Some Psychiatric Definitions

Addiction An addictive substance or behaviour pattern is one that creates a craving for itself. The signs of addiction are:

- the development of tolerance, where more of the substance or behaviour is required, to produce the same effect.
- an increasing psychological dependence on the substance or behaviour, and a preoccupation with maintaining the addiction.
- a withdrawal syndrome, where stopping the behaviour or substance causes some undesirable effect which in turn ceases on re-starting the substance or behaviour

Affect is another word for *mood*.. An *affective* disorder is a disorder of *mood*.

An ***alcoholic*** is a person who, when he/she begins to drink, take sedative drugs or marijuana, cannot guarantee his/her behaviour.

Bipolar Disorder is an affective disorder in which the mood is either elevated beyond normal or depressed below normal. Bipolar disorder is due to abnormal brain chemistry, runs in families, and does not respond to psychotherapy.

Bullying is the deliberate and repeated infliction of physical or emotional stress by someone with superior strength or numbers upon a more vulnerable person. It is always unequal, it always causes harm, and it is never justified.

When someone is being bullied, they should

- Tell as many people as they can,
- Change their response, and
- Harden the target. Don't be where the bullies are.

Co-dependency You know when you are in a co-dependent relationship with an addicted person, when you find you are at the same time, the saviour and the victim of that addicted person.

A ***compulsion*** is an action which the person knows to be irrational, but which he/she feels compelled to do against his/her will, in order to diminish feelings of anguish or guilt.

Delirium is an abnormal state arising from an acute interference with brain function, and always represents a medical emergency. It is characterized by disorientation in time, place and person.

Dissociation is an altered state in which the person's behaviour or language appears unrelated to events taking place.

A *delusion* is a false belief (in relation to a person's culture) which is held despite proof to the contrary, and which cannot be altered by reasonable argument.

Dementia is a progressive disease process characterized by a deterioration in all mental and emotional functions.

Depression is an abnormal state characterized by lowered mood, decreased physical energy and slowed-down thought processes.

Flattening of affect is a symptom of schizophrenia where the mood is neither elevated nor lowered, and does not alter.

Flight of ideas is a symptom of mania, where the person moves rapidly from one train of thought to the next.

Grief is a process through which a person recovers from the loss of an important loved one, object, role, or fond belief. The three stages in grief are:

- A stage of numbness or disbelief
- A stage of protest or anger
- Acceptance which initially resembles depression.

“Non-grief” is an attempt to recover from the loss of an important object by devaluing that object. It invariably results in the person devaluing themselves and is associated with the development of depression.

When a counselling client weeps when recalling a lost person or object more than five years after that loss, this is a sign that the client's problems include unresolved grief.

An ***hallucination*** is an abnormal perception which arises in the absence of any external stimulus.

Hypomania The periods of elevated mood in bipolar disorder are called mania when severe, or hypomania, when less severe. Psychiatrists use the term hypomania (hypo = less than) for manic mood swings in which the overactivity that characterizes mania is mostly confined to the patient's thought processes.

An ***illusion*** is an abnormal or distorted perception of an existing stimulus.

Incongruity or inappropriateness is a symptom of schizophrenia, where the emotions being displayed do not match the patient's words or behaviour.

Major Depression The depression which occurs in bipolar disorder has been called endogenous depression, biological depression, or major depression. This condition feels like an illness, runs a course like an illness, and responds to medical treatment as if it were an illness. It does not respond to psychotherapy. The three main symptoms of major depression are:

- A feeling of sadness or hopelessness that the person cannot be talked out of

- Difficulty staying asleep. Usually having no difficulty falling asleep, the person wakes through the night or early in the morning, experiencing troubled unhappy dreams.
- Diurnal variation in mood. There is one period in the day when the person feels more hopeless and depressed, usually in the mornings.

Mania is an abnormal state characterized by an elevated mood, increased physical energy and accelerated thought processes.

Neurosis refers to an emotional state characterized by anxiety.

Neurotic behaviour is maladaptive behaviour which primarily aims to reduce anxiety, fear or guilt.

An ***obsession*** is a silly, meaningless or unacceptable thought which repeatedly intrudes into consciousness in spite of an effort to resist it.

In ***obsessive-compulsive disorder***, the patient is in touch with reality, but suffers from obsessions and compulsions.

Orientation in time, place and person Recording the client's orientation of the client in time, place and person is a simple but useful way of classifying organic disorders.

- In dementia, the client retains memories about person and family identity for a long time, while

being unable to give an account of the current time or place.
- In Korsakoff Disorder, the person retains appropriate orientation in time place and person only up to the point of the illness.
- In delirium, the person is disoriented equally in time, place and person

In ***Paranoia***, people hold delusional beliefs and construct their own reality to justify these beliefs.

Post traumatic stress disorder occurs in response to a traumatic event in which the person experienced, witnessed, or was confronted with actual or threatened death or serious injury, and the person's initial response involved intense fear, helplessness, or horror. Behavioural patterns in post traumatic stress disorder include:

- Avoidance of thinking about, talking about, or revisiting the traumatic situation.
- Re-experiencing the traumatic events repeatedly in dreams and “flashbacks”.
- Emotional numbing, and a reduced involvement with the external world.
- General anxiety symptoms and fears for the future
-

Projection is the mental process through which normal human beings identify unwanted features in others which they reject in themselves.

Psychosis is a severe mental illness where reality perception is lost.

Psychotic Depression When a person suffering from endogenous depression becomes psychotic, the condition is then known as psychotic depression. Delusions are usually of sin, poverty and disease. There is a significant risk of suicide and homicide if the patient is not treated medically. Psychotic depression requires hospital treatment with drugs and often electroconvulsive therapy. It does not respond to psychotherapy.

Rationalisation is the process by which a person explains intellectually some pattern of behaviour which is in fact motivated by emotion.

Reactive Depression Reactive depression is a state of self-protective withdrawal from the possibility of being hurt by involvement in the world. It occurs as a reaction to an overwhelming disappointment. It is neurotic behaviour, and the symptoms of reactive depression include the symptoms of anxiety. Antidepressant drugs are not required in the treatment of this condition. Treatment is with psychotherapy.

Schizophrenia is a mental illness characterized by a splitting off (schizo) of three aspects of brain function, those of thinking, emotion, and activity. Whereas in conditions like mania and depression, these three aspects of brain function run parallel with each other, in schizophrenia they lose this parallel relationship. Thus in schizophrenia, the thoughts may be elevated as in

mania, the mood may be flat, and activity reduced as in depression.

Diagnosis of schizophrenia is made from a history of delusions, hallucinations, thought blocking, emotional inappropriateness and deterioration in employment history and mental efficiency.

Schizophrenia is caused by abnormal brain physiology and requires medical treatment with drugs, and sometimes ECT in the case of catatonia. Psychotherapy is possible while the patient is taking medication.

The Twelve Steps Program of Alcoholics Anonymous, which is now the basis of many self-help programmes, is useful when the person's problems include addiction to some substance or behavioural pattern.

The Twelve Steps programme aims at lifestyle change for someone who over-values something which is actually causing harm, like marijuana, alcohol, violence, control, sexual promiscuity etc.

The Twelve Steps programme encourages addicted people to admit they have come to the end of their own resources, and are powerless to change themselves. It encourages them to accept the reality of a power greater than themselves, to turn over their will and their lives to the care of God as they understand Him. It suggests a means for dealing with past mistakes, living day by day in an ethical responsible manner, leaving the future up to their "higher power".

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