

# The Analytical Study of the Stress Temperament

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## Abstract

After the theory of the four moods which had its full development with Hippocrates at the end of the fifth century and beginning of the fourth century BC and recovery then reinforced centuries later, including Galen, doctor and philosopher of the times that followed. Through the Middle Ages and the Renaissance, these people speculated on the four temperaments that result from these moods and their correspondence with the four ages of man. There was talk of a "sanguine" youth, a "choleric" maturity (up to 40 years), a "melancholy" period (40 to 60 years) and a "phlegmatic" old age.

**Key elements:** Causes of stress, stress and human nature ,initial treatments ,monitoring, stress management .

**Research paper** = Stress therefore immediately has its place as a typical temperament. The major symptoms are fear and sadness. Treatments are studied to restore balance and diets to maintain it. We can correct the excessive coldness of the old men by offering them a little wine, but the excessive heat of young people absolutely forbids them this drink. If the mood cannot be evacuated naturally (by the bleeding nose, urine, defecation, vomit), we can resort to remedies that will cause it (diuretic, cholagogue). *“Therapeutics therefore rely essentially on certain types of diet to restore the humoral balance, associated with certain drugs including a specific, hellebore (root of a pungent and bitter nauseating taste, very violent purgative)”*<sup>1</sup>. Purge is one of the oldest treatments of madness and was abandoned in the nineteenth century. Conversely, when a mood is lacking, it can be remedied by appropriate food or exercises (walking, massage).

Prior to the late 19th century, although detailed systems of classification abounded, the main problem for psychiatric nosology was the establishment of the broad major disorders. Melancholia was recognized as early as the time of Hippocrates, and continued through Galenic medicine and medieval times. The earlier connotation of the term was very wide, and included all forms of quiet insanity. It was linked with the humoral theory of causation, specifically, as the term indicates, with black bile.

Most psychiatric terms have changed meaning over their history, and they are always partly dependent on language. Melancholia later became more clearly associated with the more modern idea of melancholy or despair, for instance, in the classic work of the English Renaissance author, Richard Burton, *The Anatomy of Melancholy*,<sup>1</sup> first published in 1621. The alternation of melancholia and mania in what is now termed bipolar disorder or manic-depressive disorder, although in some respects suggested in the writings of Arateus of Cappadocia, and those of later authors, was not clearly described until 1854, independently by the French psychiatrists, Falret and Baillarger. The term Stress also began to appear in the 19th century, to indicate a state of sadness. Detailed accounts of these aspects and later history can be found in Jackson' and Berrios.

*“When Kraepelin, in the late nineteenth century, built on the work of his predecessors and simplified it to delineate the foundations of the modern classification of psychiatric disorders, one of his major categories was that of manicdepressive insanity.”*<sup>2</sup> Kraepelin's classic textbook went through successive editions, which included some changes in his views. Initially he distinguished a further category, involitional melancholia, but in later editions' he returned it to the manic-depressive category. The latter not only included cases of alternating mania and melancholia, but all cases of mania, and seemed to include all Stresss. Kraepelin regarded psychiatric disorders as disease entities based on a medical, neurological model, with specific, organic etiology and pathology. He believed that manicdepressive insanity was largely independent of psychological stress. While such stress might precede the onset of some attacks, it could not be the true cause, but merely something akin to a trigger mechanism. He did, however, regard some pathological Stresss as psychogenic in origin.

While he did not completely clarify his views on their position in his classification, or how they were to be distinguished from manic-depressive illness with incidental stress, he appeared to regard them as a separate, but relatively small and unimportant, group.

At the same time as Kraepelin and others were establishing a generally accepted classification of the major psychiatric disorders in terms of disease entities based on a medical model and organic etiology, another growing school of European psychiatrists were developing a very different approach. These were the psychoanalysts. Freud and Abraham, in a perceptive group of studies, developed a theory of the origin of Stress in relation to actual or symbolic losses of a love object. Here was a theory regarding the origin of most, if not all, Stress as psychogenic.

The case material of Kraepelin, and others like him, consisted of severely ill patients in institutions. The first depressed patients studied psychoanalytically were also severely ill. Subsequently, increasing attention began to be paid to milder forms of disorders, at first particularly by the psychoanalysts. *“Psychological theories of causation became more widely accepted for these disorders. A challenge now arose as to how to reconcile these theories with older ones of organic causation.”*<sup>3</sup> Adolf .Meyer, a Swiss psychiatrist who became the highly influential head of the Henry Phipps Psychiatric Clinic at Johns Hopkins University, moved away from the idea of clearcut disease entities, and viewed all psychiatric disorders as reaction types, or psychobiological reactions of the organism to stress.<sup>5</sup> Both psychological and organic factors had to be taken into account. Others preferred to retain a view which kept separate the two types of psychiatric disorders. On one hand were the psychoses, severe illnesses requiring admission to an asylum, and presumed to have organic causes. On the other hand were the neuroses, milder and not requiring admission to an institution, regarded as more related to psychological stress, and amenable to psychological treatment. Hie stage was now set for two competing theories as to the classification of Stress, which were to figure strongly in debates about subtypes in later years, and will be reviewed in due course.

### **Stress and Human Nature –**

Recently, I’ve found myself somewhat annoyed at the Pinterest mental health community. I know some may consider it taboo to disagree with other mental health professionals or, worse, to challenge the beliefs of people who live with mental health conditions, but I feel strongly that many in my profession do a great disservice to the people we serve and our culture by perpetuating the belief mental health issues are mostly biological and always require treatment. What irks me even more is that in a well-intentioned effort to reduce stigma, we may suggest there is relatively little individual choice or personal power in creating an emotionally healthful life for oneself.





take longer to achieve in older patients. Elderly patients usually start antidepressants at lower doses than their younger counterparts.

Most primary care physician can successfully treat uncomplicated mild or moderate forms of major Stress in their settings with careful psychiatric management (e.g., close monitoring of symptoms, side effects, etc.); maintaining a therapeutic alliance with their patient; pharmacotherapy (acute, continuation, and maintenance phases); and / or referral for psychotherapy. The following situations require referral to psychiatrist: suicide risk, bipolar disorder or a manic episode, psychotic symptoms, severe decrease in level of functioning, recurrent Stress and chronic Stress, Stress that is refractory to treatment, cardiac disease that requires tricyclic antidepressants treatment, need for electroconvulsive therapy (ECT), lack of available support system, and any diagnostic or treatment questions.

Antidepressant medications' effectiveness is generally comparable across classes and within classes of medications. The medications differ in side effect profiles, drug-drug interactions, and cost. The history of a positive response to a particular drug for an individual or a family member, as well as patient preferences, should also be taken into account. Most psychiatrists agree that an SSRI should be the first line choice. The dual action reuptake inhibitors venlafaxine and bupropion are generally regarded as second line agents. Tricyclics and other mixed or dual action inhibitors are third line, and MAOI's (monoamine oxidase inhibitors) are usually medications of last resort for patients who have not responded to other medications, due to their low tolerability, dietary restrictions, and drug-drug interactions. Most primary care physicians would prefer that a psychiatrist manage patients requiring MAOI's.

Psychotherapy may be a first line therapy choice for mild Stress particularly when associated with psychosocial stress, interpersonal problems, or with concurrent developmental or personality disorders. Psychotherapy in mild to moderate Stress is most effective in the acute phase, and in preventing relapse during continuation phase treatment. Psychotherapy is not appropriate alone for severe Stress, psychosis, and bipolar disorders. For more severe Stress, psychotherapy may be appropriate in combination with the use of medications. The most effective forms of psychotherapy are those with structured and brief approaches such as cognitive behavioral therapy, interpersonal therapy, and certain problem solving therapies. Regardless of the psychotherapy initiated, "psychiatric management" must be integrated at the same time.

Patients, who live with Stress, and their family and friends, have enormous challenges to overcome. Primary care physicians can provide compassionate care, important education, psychiatric monitoring, social support, reassurance, and advocacy for these patients and their loved ones.

## References

1. Awasthi R.K. Stress. Psychology Alka Prakashan Delhi, 2001 p. 19
2. Ibid, p 79
3. Ibid, p 88
4. Ibid, p 48
5. Ibid, p 51