Cognitive Components of Anxiety: A Comparison of Panic Disorder and Generalized Anxiety Disorder

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ABSTRACT

Comparative assessment of cognitive components of anxiety in patients with panic disorder and generalized anxiety disorder encountered in an Arab culture was attempted with the aim of detecting possible differentiating characteristics. A sample of patients diagnosed as panic disorder (N = 20) and generalized anxiety disorder (N = 13) were subjected to a standardized interview eliciting information as regards the content of thoughts associated with anxiety, the intensity of anxiety associated with each content, the most prominent of these contents and the types of situations or contexts provoking or accentuating the anxiety. Findings indicate that though cognitive contents of anxiety in both disorders revolve basically around the theme of personal danger, differentiation can be made as regards the nature of the perceived danger. In patients with panic disorder cognitions were largely centered around physical harm or concrete threats to physical existence and integrity while in patients with generalized anxiety disorder cognitions tended to focus on threats to concepts and values related to the "self" and its esteem, image, or integrity in the social or interpersonal realm. Interpretation of findings from an evolutionary perspective supports the differentiation between the two disorders as it suggests that panic disorder represents a more primitive or regressive pattern of psychopathology.

INTRODUCTION

Over the last decade or so a fresh interest has been directed to research concerned with anxiety. This has particularly been stimulated by the suggested nosological differentiation of the acute

state characterized by panic attacks as an entity that is distinct from the less dramatic generalized anxiety state *(American Psychiatric Association, 1980, Tyrer, 1984)*. A considerable amount of research has been conducted along different lines including descriptive, genetic, pharmacotherapeutic and neurobiological lines, all attempting to test the validity of this differentiation and explore the nature of the suggested panic disorder *(Breier et al., 1985)*. Lately, however, most of the research has focused on neurobiological aspects *(Ballenger, 1985)*. In contrast, it can be noticed that, if sufficient attention is paid to the psychological substrates of such anxiety disorders in order to explore and understand possible differential psychopathological factors. Of the few psychologically oriented studies, however, research into cognitive aspects of these disorders probably promises illuminating results, whose value extends beyond understanding to a more effective therapy *(Gelder, 1985)*.

The cognitive approach is generally concerned with cognitive mechanisms involved in the development of different disorders, but it does not address the issue of causality *(Beck, 1985)*. Methodologically speaking it generally belongs to the level of structural psychopathology, i.e., the level concerned with the structure and mechanisms of different psychological phenomena in their normal development and psychopathological transformation *(Arieti, 1974 and 1976)*.

In relation to cognitive aspects of anxiety it is generally agreed that thought contents of patients with clinical anxiety revolve around the notion of threat or danger that is perceived excessively or incorrectly. This perceived threat may be physical or it may be a threat to self-concept following discrepancies between the subject's self image and other perceptions of himself which cannot be ignored *(Lader, 1972; Beck, 1985)*. As far back as 1895, Freud had stressed the anxious patient's preoccupation with fears of dying, a stroke or loss of sanity *(Gelder, 1986)*. In a study by *Beck et al. (1974)*, patients with anxiety disorder could identify cognitions related to personal danger which were associated with periods of anxiety. The content of their thoughts revolved around themes of death, disease and social rejection or failure. In discussing cognitive mechanisms operating in such states, Beck et al. propose that schemata of personal danger activated by stress lead to a pattern of cognitive activity with certain characteristics including: 1) Systematic misconstruing of

experiences along lines such a arbitrary inferences, over-generalization, misinterpretation etc., 2) thoughts and images mostly related to past experiences, 3) cognitions generally preceding the onset or exacerbation of experienced anxiety, and 4) an amount of anxiety proportional to patients appraisal of the plausibility, severity, and likelihood of occurrence of the feared danger.

In a more recent study by *Hibbert (1984)*, patients with panic disorder and generalized anxiety disorder were assessed through a standardized interview. The results confirmed the presence of characteristic ideational components with cognition centering around the notion of personal danger.

Disturbed cognitive mechanisms have also been observed in other studies on patients experiencing panic attacks. In the management of such patients cognitive restructuring methods have led to a substantial improvement *(Gelder, 1985)*.

This study aims at a comparative assessment of cognitive components of anxiety in patients with panic disorder and generalized anxiety disorder as encountered in an Arab culture. In a separate study *(Arafa et al., 1987)*, comparative assessment was attempted at a descriptive level, i.e., the level dealing with the clinical characteristics of the two disorders. In the present work the attempt is made to identify possible differentiating characteristics in relation to the cognitive aspects of the structural psychopathological level.

MATERIAL AND METHODS

The sample of this study consists of 33 consecutive referrals to a psychiatric outpatient clinic in Saudi Arabia, who were diagnosed as having panic disorder (N = 20) or generalized anxiety disorder (N = 13) according to DSM-III criteria. The diagnosis was made by an experienced psychiatrist and was substantiated by a second psychiatrist, through the detailed psychobiograms. In a separate study *(Arafa et al., 1987)* this sample of patients received a thorough clinical assessment with the aim of comparing clinical characteristics of the two disorders in Arab patients. Relevant characteristics of the sample are summarized in Table (I).

Table I: Identification data of the sample

	Panic dis. (N = 20)		Gen anx. dis. (N = 13)	
Age: Mean ± S.D.	27.5 ± 5.5		27 ± 6.5	
	N	%	N	%
Sex:				
. Male	6	30	2	15.4
. Female	14	70	11	84.6
Martial status				
. Single	5	25	6	46.2
. Married	14	70	5	38.4
. Divorced	1	5	2	15.4
Education				
. Illiterate	3	15	2	15.4
. Primary school	5	25	-	-
. Middle school	6	30	6	46.2
. Secondary school	3	15	5	38.4
. Higher	3	15	-	-
Occupation				
. Student	2	10	-	-
. Skilled labour	8	40	8	61.5
. Professional	5	25	4	30.8
. Housewife	5	25	2	15.4

For the purposes of the present study these patients were subjected to a standardized interview eliciting information as regards the following:

1. Content of Thoughts Associated with Anxiety

According to a standard form each patient was asked to try to identify "ideas or thoughts that go through his mind when he feels anxious", (whether during a panic attack or otherwise), from a list of

possible thoughts presented to him one by one. This list was previously prepared on the basis of information from the literature (e.g., *Beck et al., 1974; Hibbert, 1984)* as well as observations from a pilot study that preceded this work. The listed categories (Table II) were not intended to be all inclusive, and the patients were also asked to add any further thought contents not included in the list.

Table II: Thought contents associated with anxiety in patients with panic disorder and generalized anxiety disorder compared

Thought Contents	Panic dis. (N = 20)		Gen anx. dis. (N = 13)	
	N	%	N	%
1. Death***	15	75	4	30.8
2. Having a heart attack**	15	75	3	23.1
3. Breathing will be arrested***	15	75	4	30.8
4. Fainting**	12	50	1	7.7
5. Having a serious illness	10	50	4	30.8
6. Going mad or crazy	8	40	5	38.5
7. Loss of self control	13	65	4	30.8
8. Being seen in fear	11	55	5	38.5
9. Inability to cope	7	35	8	61.5
10. Social embarrassment	8	40	8	61.5
11. Social rejection	-	-	2	15.4
12. Harming others	-	-	2	15.4
13. Ill-defined danger	7	35	5	38.5
14. Others				
. Feeling of unreality	1	5	-	-
. Feelings that life is meaningless and fruitless	-	-	1	7.7

* A single patient may report more than one thought content whether associated or alternating.

** $P < 0.01$ (Chi-square analysis)

*** $P < 0.05$ (Chi-square analysis)

2. Intensity of Anxiety Associated with Different Thoughts.

On a 4 points scale (0 = not present, 1 = mild, 2 = moderate, 4 = severe) the patient was asked to evaluate the intensity of anxiety associated with each of the identified ideas.

3. Most Prominent Thought Content

From the identified contents the patient was asked to specify the thought content which he considers most prominent or important as a whole (including frequency, intensity and credibility).

4. Situations or Situational Contexts Provoking or Accentuating Anxiety

Each patient was asked to indicate situations provoking panic attacks or leading to an accentuation of anxiety in general.

Interviews with all patients were conducted by the same psychiatrist. Statistically, chi-square analysis was utilized to test for the significance of differences on frequency data while t-test was used to evaluate differences as regards mean scores on the rating scale.

RESULTS

From the presented list all patients could identify one or more of the anxiety related ideational or thought contents. These thoughts were highly oriented to expectations of physical and/or psychological harm. In table II it can be noticed that patients with panic disorder show a higher frequency of most thoughts explored. Of these, differences as regards some thoughts of impending physical harm (death, having a heart attack, breathing will stop, fainting) are statistically significant, while the differences are not significant in relation to other thoughts of physical or psychological harm (having a serious illness, loss of self control, being seen in fear and going mad or crazy. On the other hand patients with generalized anxiety disorder show substantially higher frequency of thoughts related to inability to cope, social embarrassment and social rejection though differences are not statistically significant.

Table III: Mean scores on the rating scale evaluating the intensity of anxiety associated with the different thought contents

Thought Contents	Mean scores of associated affect	
	Panic disorder (N = 20)	Gen. anx. dis. (N = 13)
1. Death*	2.15	0.69
2. Having a heart attack*	1.90	0.46
3. Breathing will be arrested*	1.80	0.61
4. Fainting*	1.30	0.15
5. Having a serious illness	1.48	0.62
6. Going crazy	0.80	0.62
7. Loss of self control	1.35	0.62
8. Being seen in fear	1.20	0.92
9. Inability to cope	0.80	1.46
10. Social embarrassment	0.75	1.31
11. Social rejection	0.00	0.30
12. Harming others	0.00	0.31
13. Ill-defined danger	0.60	0.79
14. Others		
. Unreality	0.10	0.00
. Life is meaningless	0.00	0.15

* $P < 0.01$ (t-test)

Table (III) presents mean scores on the rating scale for the intensity of anxiety associated with different thoughts as evaluated by the patients themselves. In patients with panic disorder mean scores of anxiety related to ideas about death, having a heart attack, arrest of breathing and fainting are significantly higher than in patients with generalized anxiety disorder. Mean scores of anxiety related to having a serious illness, loss of self control, being seen in fear and going crazy are also higher but differences are not statistically significant. On the other hand, anxiety related to thoughts of inability to cope and social embarrassment shows higher scores in patients with generalized anxiety disorder though not reaching a statistically significant level.

Table IV: Most prominent thought contents as evaluated by patients arranged according to the number of patients indicating each

Panic Disorder (N = 20)				Generalized Anxiety Disorder (N = 13)			
Rank	Thought Content	N	%	Rank	Thought Content	N	%
1.	Death	10	50	1	Inability to cope and social embarrasment*	7	53.8
2.	Having heart attack	3	15	2	Ill-defined danger	2	15.4
3.	Having serious illness	2	10	3	Death	1	7.7
4.	Going crazy	2	10	4	Having serious illness	1	7.7
5.	Loss of self control	2	10	5	Harming others	1	7.7
6.	Inability to cope	1	5	6	Life is meaningless and fruitless	1	7.7

* Reported in association as the most prominent thought content by all seven cases

Table (IV) shows the most prominent thought contents as indicated by the patients arranged in a decreasing order according to the number of patients indicating each. The highest rank is occupied by ideas of death in patients with panic disorder while it is occupied by an association of the ideas centered around social embarrassment and inability to cope in patients with generalized anxiety disorder.

Table V illustrates the situations or situational contexts which provoke panic attacks (in panic disorder) or significantly accentuate the anxiety (in generalized anxiety disorder).

Table V: Situations provoking panic attacks (in panic disorder) or significantly accentuating anxiety (in generalized anxiety disorder)

Situation	Panic dis. (N = 20)		Gen anx. dis. (N = 13)	
	N	%	N	%
1. Emotionally exciting events	12	60	-	-
2. Excessive physical effort or strain	5	25	1	77.0
3. Driving a car	3	15	-	-
4. Social situations	2	10	9	69.2
5. Night time, specially before sleep	8	40	1	7.7

In patients with panic disorder situations most frequently reported (60% of patients) can be grouped as representing exposure to emotionally exciting events. These events were generally within the average range of every-day life stresses including bad news of misfortune (death, disease, divorce ... etc) affecting persons known to the patients, irritation by children or quarrels with spouse and thoughts of stressful personal problems in work or family life. Two reported panic attacks provoked by watching exciting football matches while one patient reported attacks after feeling happy and laughing excessively. Next in frequency comes the night time and more specially the getting to sleep situation (40% of patients). Three

of these patients reported being awakened in the middle of their sleep by panic attacks. Next come situations at the peak of excessive physical strain, during driving a car and lastly social situations. In patients with generalized anxiety disorder, on the other hand, social situations in which the patients's abilities to cope and affirm his esteem were challenged, were the situations reported by most patients (69.2%) as being responsible for the accentuation or intensification of their anxiety.

DISCUSSION

Findings of this study are broadly in line with previous studies *(Beck et al., 1974; Hibbert, 1974)* in demonstrating the presence of characteristic ideational components in anxiety disorders with cognition centering around the theme of personal danger. In addition, however, the findings point to a possibly significant differentiation of patterns between patients presenting with panic disorder and those presenting with generalized anxiety disorder. Patients with panic disorder show a significantly higher frequency of thoughts related to a perceived physical or materialized danger. This may be general as in fear of death or it may be more specific and clearly related to somatic symptoms experienced during panic attacks. Patients who experience marked palpitation, breathlessness and weakness during the attacks may interpret them as a heart attack or impeding respiratory arrest similarly the experience of apparently uncontrollable parathesiae, sweating, breathlessness and palpitation may be interpreted as a sign of loss of self control. On the other hand, patients with generalized anxiety disorder show substantially higher frequency of thoughts related to a psychological threat involving self-esteem, self-concept or social image (inability to cope, social embarrassment and social rejection). Though differences as regards the frequency of these thoughts are not statistically significant as was the case in thoughts related to death or physical harm (Table II), the other parameters investigated in this study persistently confirm the above trend. In addition to frequency data the following can be noticed:

1. Intensity of anxiety is significantly higher in patients with panic disorder in relation to thoughts of death or physical harm while the intensity is higher in patients with generalized anxiety

disorder in relation to thoughts centered around self-esteem or social image (Table III).

2. Most prominent or important thought contents as specified by the patients were again those of death and to some extent other physical harm in panic disorder while they were clearly those of social embarrassment and inability to cope in generalized anxiety disorder (Table IV).
3. In patients with generalized anxiety disorders, provocation or accentuation of anxiety is mostly (69.2) related to social situations which clearly challenge the patient's abilities to cope and affirm his esteem or self-concept (Table V). In patients with panic disorder, on the hand, panic attacks are provoked by a different and wide variety of situations including various emotionally exciting events, excessive physical strain, driving cars as well as a tendency for night time occurrence. This part of our findings requires further discussion which will be attempted after our current discussion of the main theme revealed in the study. Findings indicate that though the ideational components in patients of the two groups broadly revolve around the theme of personal danger, a differentiation can be made as regards the nature of the perceived danger in patients with panic disorder the feared danger is largely perceived as physical harm while in patients with generalized anxiety disorder the threat is mainly perceived in relation to esteem, self-concept or social image.

In the study of *Hibbert (1984)* patients with panic disorder and generalized anxiety disorder identified cognitive contents similar to those identified in this study. Frequency of thoughts centered around physical harm were significantly higher in patients with panic disorder, while thoughts of inability to cope and social embarrassment were relatively more frequent in patients with generalized anxiety disorder, but not to a significant level. His interpretation of data was restricted to emphasizing the theme of physical or somatic harm in the ideational contents of patients with panic disorder. In his conclusions, these contents can be understood as a reaction to the prominent somatic symptoms in such patients through pathological cognitive processes described before by *Beck et al. (1974)* (e.g. systematic misconstruing of experiences along the lines of misinterpretation, arbitrary inferences, over generalization, ... etc.). In addition, however, he sees that "patients experience panic because of their somatic symptoms" and that "the maintenance of a panic

disorder may result from fear of any uncomfortable bodily sensation, particularly those reminiscent of a previous panic". Ultimately, the basic assumption is that these somatic symptoms originate from some concrete biological dysfunction, an assumption supported by different biologically based hypotheses which he reviewed from the literature. If we have understood the author's inferences properly, this type of interpretation clearly represents the biological conceptual model which attempts to attribute psychological phenomena to some ultimate concrete biological dysfunction or pathology. In contrast, however, a growing awareness seems to be building in this direction recognizing that such a reductionistic attitude is unjustified and grossly ignores the multidimensional nature of psychological or psychiatric phenomena in which a complex interplay of biological, psychological and psycho-social factors is implicated in the aetiology as well as the mechanisms of pathology transformations. At a description level, somatic symptoms have indeed been reported as significantly more prominent in patients with panic disorder *(Hoen-Saric, 1982; Anderson et al., 1984; Arafa et al., 1987)*.

Also, evidence from pharmacotherapeutic, genetic and neuro-biologic research points to definable biological bases or correlates of phenomena observed in such patients *(Breier et al., 1985; Ballenger, 1986)*. However, it is not sufficient to account for such disorders unless integrated with psychological aspects involved both in the aetiology as well as the mechanisms of pathological transformation or symptom production. In our opinion, particularly in the light of the findings of this study, a more cogent and meaningful interpretation is possible from an evolutionary perspective.

In ontogenetic as well as phylogenetic development, emotions, including anxiety, undergo an evolution from primitive undifferentiated feeling states largely experienced as somatic changes and involving primitive cognitive processes, into more differentiated affective states which are less somatized and involve higher cognitive processes *(Arieti, 1976)*. Thus, with development, anxiety becomes increasingly differentiated, attenuated, more affective and less somatic in character *(Nemiah, 1985)*. The perceived danger or threat in its cognitive content becomes not merely to physical survival but also to meanings and values related to survival *(Arieti, 1976)*, and to the integrity of self in the interpersonal world *(Sulivan, 1973)*. Several types or qualities of anxiety may further be differentiated along a hierarchy according to the degree of awareness and level of

personal growth *(Rakhawy, 1981).* In pathological conditions a process of de-differentiation and resomatization of affects including anxiety tends to take place. In other words, anxiety tends to re-emerge in its earlier somatic and undifferentiated form *(Nemiah, 1985).* Disturbed cognitive processes including misconstruing of experiences is part of the regressive phenomenon and represents corresponding regression to earlier and more primitive cognitive stages *(Beck, 1985).* In the light of these conceptions, the findings of this study probably indicate that the pattern of anxiety in panic disorder represents a more regressive phenomenon than the pattern noticed in generalized anxiety disorder. The anxiety in panic disorder is intense and retains its ge ıetically earlier tendency to be expressed in the form of massive somatic discharge while its cognitive components are largely centered around concrete threats to physical existence, and integrity. On the other hand, anxiety in generalized anxiety disorder is less intense, less somatized and its cognitive components are mainly centered around threats to concepts and values related to esteem or integrity of the self in the interpersonal world. In panic disorder the activated fear is more primitive, massive and conceives a sort of total annihilation whether physical (actual death) or psychic (going crazy or disorganization of the self) while in generalized anxiety disorder the activated fear is more differentiated, less intense and conceives threats to concepts of the self in relation to others.

From this perspective the prominent somatic symptoms cannot be considered the origin of panic but can be understood as a integral part of the aspect of a whole phenomenon, i.e., a part of the pathologically activated primitive pattern. Through feedback mechanisms these symptoms probably play a role in accentuating anxiety and perpetuating a sort of a vicious circle but they cannot be considered as the "origin" of panic attacks. Similarly, the suggested biological origin of such symptoms whether a central or peripheral noradrenergic overactivity or otherwise *(Hibbert, 19884),* cannot be considered as the "sufficient cause" of the disorder, but should be integrated with psychological dynamics involved in the genesis of the disorder.

Finally, the findings as regards the situations or situational contexts provoking or related to the onset of panic attacks (Table V) probably represent a significant related issue that deserves some illuminating discussion.

The tendency for nocturnal occurrence of panic attacks as a situational context reported by a significant proportion of patients (40%), is probably one of the important findings of this study. It confirms a similar observation documented by *Taylor et al. (1986)*. In the opinion of these authors this probably links panic attacks to the circadian rhythm since most circadian hormone cycles reach their apex around this timing. This probably opens an important new line of investigations as regards the biological substrate of this disorder.

The above findings, i.e., the unusual psychophysiological reactivity or vulnerability to environmental stimuli and the possible relation to biological rhythm, generally support the notion of a close or intimate link between panic disorder and biological variables. In view of our previous discussion this in turn supports the assumed more primitive and somatized nature of this psychopathological pattern compared to that of the generalized anxiety disorder.

CONCLUSION

Through a cognitive approach, this study provides evidence supporting the differentiation between the anxiety states labeled as panic disorder and generalized anxiety disorder *(American Psychiatric Association, 1980)*. Though cognitive contents of anxiety in both disorders revolve basically around the theme of personal danger they seem to differ as regards the nature of the perceived danger. In panic disorder the feared danger is perceived as physical harm and cognition is largely centered around concrete threats to physical existence and integrity. In generalized anxiety disorder cognitive components tend more to center around threats to concepts and values related to the "self" and its esteem, image or integrity in the social or interpersonal realm. From an evolution perspective these findings, when integrated with other descriptive and biological features, probably indicate that the pattern of psychopathology in panic disorder represents a more primitive or regressive phenomenon in which there is more de-differentiation and somatization of affect associated with a corresponding relatively primitive cognitive operations. However, the distinction in this sense is not sharp or exclusive, but rather represents a differentiation on a continuum with panic disorder occupying a more primitive position. Further work is recommended to explore the validity of this differentiation in terms of the dynamics responsible for the genesis of such psychopathological patterns.

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LES COMPOSANTES COGNITIVES DE L'ANGOISSE: UNE COMPARAISON ENTRE LE DÉSORDRE DE PANIQUE ET CELUI D'ANGOISSE GÉNÉRALISÉ

ABSTRAIT

Une évaluation des composantes cognitives de l'angoisse chez les patients souffrant de désordre de panique comparativement avec ceux souffrant de désordre d'angoisse généralisé, dans le context d'une culture arabe, a été tentée dans le but de détecter des charactéristiques distinguant les deux groupes.

Un groupe de patient diagnostiqué comme souffrant de désordre de panique (N = 20) et un autre souffrant de désordre d'angoisse généralisé (N = 13) ont été assujeti à un interview étalonné pouvant déduire des informations ayant garde au contenu de la pensé associé avec l'angoisse, l'intensité de l'angoisse associé avec chacune de ces pensés, la pensé la plus saillante, ainsi que le genre de situation ou le context provoquant ou aggravant l'angoisse.

Les résultats indiquent que le danger personnel est le thème principal du contenu cognitive associé avec l'angoisse dans les deux désorders. Malgrès cela une distinction peut être faite en ce qui concerne la nature du danger percu. Chez les malades souffrant de désordre de panique, la pensé était centrée autour du théme de nuisance physique ou de menace concrète à l'éxistence physique. Chez les malades souffrant de désordre d'angoisse généralisé, la pensé se concentrait plutôt sur une menace à la representation du moi, aux valeurs qui lui sont liées, à son image, éstime, ou intégrité dans le domaine social et interpersonnel.

L'interprétation de ces résultats d'une perspective évolutionnelle donne appui à la considération de ces deux désordres comme distinct l'un de l'autre, et suggère que le désordre de panique représente un modèle de psychopathology plus primitive.

الموجـــــز

المكونات المعرفية للقلق:
مقارنة بين إضطراب الفزع العام وإضطراب القلق العام

تقدم هذه الدراسة تقييما مقارناً للمكونات المعرفيه للقلق لدى المرضى الذين يعانون من إضطراب الفزع وإضطراب القلق العام فى إحدى الثقافات العربية وقد أجريت هذه المحاولة بهدف الكشف عن الخواص المختلفة التى تميز بينهما وقد تكونت العينه من عشرين مريضاً يعانون من إضطراب الفزع وثلاث عشر مريضاً يعانون من إضطراب القلق العام وأجريت لهم مقابله مقننه بهدف إظهار معلومات متعلقة بمحتوى الأفكار المرتبطة بالقلق ونوعيه المواقف أو السباق الذى يستثير أو يزيد من القلق وتشير النتائج إلى أنه بالرغم من دوران المكونات المعرفيه للقلق فى كل من الاضطرابين حول يتم أساسيه وهى الخطر الشخصى الا أن هناك أختلافات متعلقة بطبيعة الخطر المدرك ويتركز الجانب المعرفى للمرضى الذين يعانون من اضطراب القلق فقد وجد ميل الأفكار الى التركيز على تهديد المجه للمفاهيم والقيم المتعلقة بالذات وقيمتها وصورتها وتكاملها فى المجال الاجتماعى والبين شخصى.

وبتفسير النتائج من منظور تطورى تدعم الغرض القائل بالتمييز بين الاضطرابين حيث أن اضطراب الفزع يمثل نمطاً أشد بدائية أو نكوص من السيكوباثولوجى.