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The Phenomenon of Emotional Blunting: A Wholistic Quantitative-Qualitative Approach

by O. Shaheen and S. Ibrahim

ABSTRACT

Blunting of emotions is a unique type of emotional abnormality. It is described in the literature as a 'quantitative' reduction (the extreme of which is apathy) without detailed mentioning of the 'qualities' of emotional reactions in the state. The authors had noticed that the phenomenon is not a general decline of all emotions even in its severe degrees. They also noticed that none of the references came across the details that guide to evaluate intermediate degrees.

The authors had introduced a 'qualitative' parameter which was considered to offer a frame of reference with theoretical formulation that might be of value in discriminating mild and moderate states of blunting which are ot gross enough to be apparent clinically. Through such a wholistic quantitative-qualitative approach they suggested a policy for rating the phenomenon as 'clinical grades'. (The suggested grades are six).

In this work the authors discussed the probable usefulness of the policy of grading for both clinical evaluations in every day practice as well as for scientific research.

40 schizophrenics of different severities of the illness, expected to present with different degrees of blunting, were considered suitable to test the suggested discriminative ability for such a policy of rating the degree of blunting as a Grade.

The results obtained were considered preliminary criteria to the side of the validity and thus the suggested value of the introduced wholistic approach to the phenomenon of emotional blunting.

INTRODUCTION

The 'effective' abnormalities, that might be met with clinically, are many. When anxiety, depression... etc., are referred to as 'abnormal', it is usually meant to say that each does manifest in an abnormally

'hightened' degree and/or that each extends over a longer duration than what is expected to be within 'normal'. A very different abnormality, regarding manifest affects, is when they are 'lessened' or 'reduced' in contrast with the state of being 'stirred up' just mentioned.

The clinical states of lessened emotional reactions are referred to in the literature by the terms: indifference, shallowness of affect, blunting of emotion, dullness of emotion and apathy. Shaheen **et al.** (1975) reviewed such terms and their definitions. The trends within the group show that: a) what is referred to is a reduction of 'emotional reactivity', i.e. the capability of emotional experience and/or manifest expression with proper depth; b) both terms 'indifference' and 'dullness' refer to reduction when it is more in expression than in experience; c) the term 'apathy' refers more to reduction in experience, and more to severe degrees; and that d) severe degrees of blunting are states of general decline of all emotions with complete absence of affects including subjective sensations and feelings.

In actual practice, when a 'blunted' schizophrenic expresses a bout of anger (and usually it is clinically evident that he experiences its painful subjective feelings), it is not perceived by clinicians to be a paradox or a contradiction to his blunted emotions. Schizophrenic excitements are well known to be severe with manifest heightened emotional feelings, expressions and acting out of emotional behaviour. Still, the patient could be described as 'blunted'. The authors (Shaheen **et al.,** 1975) concluded that: the phenomenon of blunting implies specific differential 'qualities' regarding which emotion or group of emotions declines before others and thus, it is not a general decline of all emotions and feelings even in its severe degrees. It was also noticed that: while the terms used and the definitions presented imply different degrees of emotional blunting, none of the references come across discussion of the details of the emotional status that guide to judge and evaluate such intermediate degrees between 'no blunting' and 'severe blunting'.

The authors raised several questions. What about the variable degrees

of emotional shallowness ? Before the process advances to include **all** subjective sensations and **all** emotions, what might be the 'qualitative' details and nature of the 'emotional reactivity' of a 'person' ? Does it include only some emotions when the degree is less and gradually includes all when the degree progresses ? Can the process start by any emotion or group of emotions ? It was noticed that such an aspect did not attract the clinicians' attention. The signs and symptoms of 'emotional reduction' is kept as a 'quantum'.

If 'emotion' is to be valued significant, both for clinical practice and scientific research, then, both aspects of 'emotional status' change should be equally considered. Either might reflect different states of affairs regarding functions and dysfunctions of emotion.

A 'reduction' of emotional reactivity is an aspect frequently missed to be regularly reported. If states of blunting are really 'differential' in their details, then, such an aspect should be put nearer into focus.

The Rationale for Discriminative Evaluation of Emotional Blunting :

To start, what quantum of significance are we going to adhere to the 'emotional' aspect of human functioning and existence ? Within the still 'active' schooling in the field of psychological sciences, the controversy around the topic of 'emotion' acquires a perplexing nature. Each of the different present-day doctrines has different quantum of interest and adheres to different quantum of significance.

Strongman (1975) reviewed the subject and clarified that it is the least defined and the least agreed about. The emotional phenomena range from a 'feeling tone' to 'widespread bodily changes' to an 'impulse to behave'. Its components include the most 'subjective' side by side with the very 'objective'. To observe, to evaluate, to experiment, to interpret and to hypothesize, different theories took different starting points and modify the accompanying 'social action' and 'physiological changes'. The net result is that synthesis becomes impossibe. He concluded that this policy ruined academic studies of 'emotion'.

It is only recently that emotion has been tried to be viewed in much more wholistic policies. Kagan (1975) explained how it is more practical and useful to consider 'emotion' as consisting of three elements: emotional feeling, social action and physiological changes, and that these elements are interelated to each other and are markedly affected by a fourth element: 'intellectual symbolization'. He stated that there is little doubt, in the human at any rate, that intellection may both stimulate and be stimulated by emotional feeling; diminish or enhance emotional feeling; modify the accompanying'social action' and 'physiological changes'. The 'social action', he recognized as those physical and mental acts which accompany 'emotional feeling', and that 'physiological changes' are preparation of the organism of 'social action'.

The recently accumulating neuroanatomical and neurophysiological knowledge about emotion is gradually regaining interest in the subject. As a result, some scientific problems are gradually realized. Levies (1975) viewed the physiological changes, e.g., the changes mediated by the hypophyseal-adrenocortical and sympatho-adrenomedullary systems, to be non-specific; have always been found in emotional situations. Mason (1975) points out that to claim non-specificity it would be necessary to demonstrate these changes in all types of emotional situations and that has yet to be done. He speculated (and demonstrated some evidence) that there is a different pattern of enzyme activity for each of the several emotional situations. He concluded that this would be of great importance if it were true and suggested to include in some studies of emotion a battery test to cover the large number of enzyme changes that might constitute more than one parameter.

Lader (1975) raised the problem of cause and effect. In the face of clear strong association of emotional feeling, social action and physiological changes, he stressed the need to clarify whether emotional feeling causes physiological change or vice versa and whether either can occur independently.

Such an increasing orientation of the necessity and usefulness of a wholistic approach to study 'emotion' increases the burden of responsi-

bility within the domain of clinical fields. A comprehensive theory about 'emotion' cannot be reached without regular correlation between the accumulating laboratory data on one side and clinical states, psychopathological formulations, and clinical emotional changes that parallel psychotherapeutic techniques and psycho-pharmaco-therapeutic courses, on the other. In such correlations, accuracy of clinical evaluations of emotional aspects becomes indespensible for reaching factual data.

Such regular correlations in between laboratory findings and clinical data may prove to be the channel through which scientific problems around 'emotion' can be solved. Instead of being the aspect which underlies a good mass of present-day disagreements, 'emotion' may shift to become the pool in the centre of which extremely 'organic' and extremely 'dynamic' minds can 'grasp' each other.

A 'reduction' of affects may be of no less significance than other abnormal emotional clinical states. It is the clinical change towards shallowness versus the opposite one towards stirr up. Both directions of change might be of value in comprehending 'emotion'. Clinically, some states of bluting are gross enough to be easily diagnosed. But, what about less evident degrees ?

It was suggested by the authors (1975) that scrutinizing the phenomenon of bluting with the aim to search for its 'quantitative' emotional details will be of value in further comprehension of the phenomenon. The authors proposed a policy of grading the clinical states ; of blunting probably of different severity, through a wholistic approach that includes a 'qualitative' parameter. It may facilitate the evaluative task, discriminate milder degrees and may prove to be a working frame of reference that allows for agreement in clinical evaluations by different physicians.

Such a policy of grading the phenomenon, if improved through application, could be of real help for clinical evaluation in every day practice as well as for scientific research.

The Qualitative Parameter, The Suggested Grades:

The concept of the new parameter was formulated (Shaheen et al., 1975) through Cannon's classification of emotions into 'emergency' and 'welfare' groups. The former group is called for in threatening situations. The nature of relatedness to the source of threat will be limited to a few procedures to achieve a sort of 'defence'. The latter group, on the other hand, is experienced in a completely different psycho-social setting; a pleasantly-toned attraction and gratifying interactions. Contrary to the situations of 'emergency', which are waited for eagerly and anxiously to break off, the pleasant feelings in case of the welfare group and their social context tend to broaden or generalize to other objects and situations. The welfare group settings are always constructive, both in present and next-coming relations, and are so, both for the 'subject' and 'object'.

The welfare emotions constitue the baseline for healthy continuous colour and taste for the daily relatedness of human beings towards each other in a constructive way. Such emotions cannot be dispensed with except temporary, when the emergency ones take the fore-front. The latter group, their experiences, expressions and functions, are all 'potentialities' that remain to be called for, whether the person is normal or abnormal in his psychological make-up or reactions. It is the welfare group emotions that the authors considered, when they are shallow, the person is perceived and is considered as abnormal in the breadth and depth of his emotional reactivity.

It is this specific 'qualitative' aspect of the phenomenon which guides to a 'wholistic' evaluation of the state as a 'quantum'; a grade.

The suggested Grades are six. Grade O is supposed to be the 'normal' vivid state of emotional reactivity and relatedness in between 'human' in a 'social context'. The other five Grades start by Grade I; the level just below normal, and graduate to Grade V which is considered to be the severest state of blunting; when 'human' meanings and 'social' settings are lost.

The application of such a policy of grading, is basically a pure 'clinical' judgement; on the part of the physician. The conative and cognitive aspects of psychological functionings, as adherent as they are to affects, are indispensible in the process of grading. The authors stressed the perceptive nature of objects in the setting of experiencing an emotion, the social setting itself, the policy of relating and dealing with the object, the objectives aimed at and the consequences and effects on both subject and object.

Through such scrutiny, mild degrees of blunting are expected to prove to be more frequent among populations than thought to be. The very wide range of individual differences should be properly considered. A 'minimal' state of 'emotional reactivity'; depth of experiencing and expressing different emotions, the congruity of an emotion to a thought content and social setting, and the breadth and depth of a social sphere of human relatedness, all together and as concerns normal human social gatherings, such a 'general' minimal state could be hypothesized and agreed about below which a 'reduction' can be detected clinically; in different individuals.

Grades I and II, viewed as 'mild' and 'moderate' degrees respectively, are considered not to 'crumble' a person in relating socially to others. By the time the degree of blunting amounts to Grade III or more; 'marked' or more, it is expected to parallel a considerable difficulty in the face of relatedness to others with a resulting proportional degree of social withdrawal. So, clinically speaking, Grades III and more are considered the degrees of blunting which are suited to be described as 'apathetic emotional states'.

MATERIAL AND METHOD

The work undertaken could be considered a pilot study testing the potential discriminative usefulness of the suggested policy of grading presenting clinical states of emotional blunting; probably of different degrees. A group of schizophrenics was considered a suitable sample to achieve such an aim. Schizophrenics are known to manifest the phenomenon of blunting which, when severe, is considered pathognomonic. Forty schizophrenics were included in the study.

The classification followed was that of the Egyptian Association of Psychological Medicine (DMP-I) (1975). It was attempted to include most of the subtypes of the schizophrenic clinical pictures and of different durations. This would include in the sample different degrees of severity along the schizophrenic pathological process.

No limitations regarding sex, socio-economic or educational levels were considered. It was only age which was intended to be within the range from 18 to 45 years to avoid inclusion of organic brain syndromes and adolescent turmoil reactions.

The patients were examined, diagnosed and categorized by three psychiatrists. A third one, other than the authors, was always participating. Specific scrutiny was made regarding the affective status of individual patients. Many of the details of the psychobiograms were made use of in the process of evaluation of the nature of the expressed emotions: their genuinity, depth, appropriateness and social setting which might provocate each. The three psychiatrists put their Grade for individual patients, at first, separately. This was considered the first impression. In cases of discrepancy in between the three raters, a detailed discussion of the case was always fruitful in achieving a final agreement.

The patients were put on one of the phenothiazine group of drugs. Only 7 patients needed additional E.C.T. When the degree of 'general' improvement was 'marked', or, when the period of follow up completed three months, the 'general clinical condition was re-evaluated and the Grade of blunting was re-judged.

RESULTS

The 40 schizophrenics proved to be within 7 clinical schizophrenic subtypes (Table 1).

The durations of the illness are presented in Table 2.

The different Grades of emotional blunting manifested by the patients are included in Table 3. None of the schizophrenics under study

TABLE I

Schizophrenia Clinical Subtypes

Clinical Subtype	Number of Patients
1. Incipient	11
2. Schizoaffective	2
3. Paranoid	10
4. Hebephrenic	3
5. Simple	3
6. Acute Undifferentiated	3
7. Chronic Undifferentiated	8
Total	40

TABLE II

Distribution of Duration of Illness

	Months					Years										
	-1	-2	-3	-6	-9	-1	-2	-3	-4	-5	-6	-7	-8	-9	-10	+10
Incip.					1	3	1	5	1							
Sch-aff.				1			1									
Para.				1	3	3	2			1						
Hebeph.							1					1	1			
Simp.											1	1	1			
Ac. Undif.	1	2														
									3			1			2	2
Total	1	2	-	2	4	6	5	5	4	1	1	3	2		2	2

TABLE III

Different Grades of Emotional Blunting

	Grades of Emotional Blunting					
	0	I	II	III	IV	V
Incip.	—	3	8	—	—	—
Sch.aff.	—	1	1	—	—	—
Para	—	2	7	1	—	—
Hebeph.	—	—	—	2	1	—
Simp.	—	—	—	3	—	—
Ac. Undiff.	—	—	1	2	—	—
Chr. Undiff.	—	—	1	6	1	—
Total	—	6	18	14	2	—

manifested Grade O; the supposed 'normal' state of emotional reactivity. 6 patients (15%) manifested Grade 1; 3 incipients, one sch-aff. and 2 paranoids. 18 patients (45%) manifested Grade II; one acute undiff., 8 incipients, one sch-aff., 7 paranoids and one chronic undiff. 14 patients (35%) manifested Grade III; 2 acute undiff., one paranoid, 2 hebephrenics, the 3 simple patients and 6 chronic undiff. 2 patients (5%) manifested Grade IV; one hebephrenic and one chronic undiff. None of the patients manifested the emotional deterioration of Grade V.

29 patients out of the 40 schizophrenics (72.5%) completed the enough period of follow-up. Applying the Scale detected positive shifts; to the side of improvement, in 10 patients out of the 29 (34%) : 5 patients shifted from Grade II to Grade I, 4 from Grade II to Grade II and one patient from Grade IV to Grade III. This 'emotional' improvement paralleled some degree in 'general' clinical condition which was : Marked in 3, Moderate in 6 and Mild in one patient.

The remaining 19 patients did not manifest any improvement in their state of blunting. This was not the case in 'general' improvement. 13 patients (45%) manifested different degrees of improvement : Moderate in 7 and Mild in the remaining 6 patients. Only 6 patients (21%) were not generally improved.

DISCUSSION

Through the suggested 'wholistic qualitative-quantitative' approach for grading clinical emotional blunting, the group of schizophrenics under study recorded a wide range of different Grades; from Grade I to Grade IV. The results obtained are discussed in view of the generally known and reported data regarding the phenomenon of blunting in schizophrenics.

None of the schizophrenics under study manifested the normal state of emotional reactivity; Grade O. This could be considered consistent with schizophrenia however early the patient is along the course of the illness.

Three patients out of the eleven incipients were of Grade I blunting and the remaining eight manifested Grade II. The incipient stage of the illness, or the so-called pre-schizophrenic states, are reported to be the stage during which the reduction of emotional response starts. (Kolb, 1968; Meares, 1963). That our incipients were within the 'mild' and 'moderate' degrees of blunting could be seen to agree with such reported statements.

One of our schizo-affective patients manifested Grade I blunting while the other patient was of Grade II. Our 10 paranoid schizophrenics manifested Grade I by two patients. Grade II by seven and Grade III by one single patient. These two schizophrenic subtypes are reported to retain, though well-formed schizophrenia, relative emotional reactivity (Kolb, 1968; Lehmann, 1976; Modonesi, 1953), Our results parallel these reports.

The dulling of feelings is reported to progress insidiously to become evident as poverty of emotion in the manifest schizophrenic psychosis (Arieti, 1969); Kolb, 1968; Lehmann, 1976; Sakel, 1958). This could be seen to parallel our results of the remaining seventeen patients: three hebephrenics, three simple, three acute undiff. and eight chronic undiff. Out of these group, only two were of Grade II, while most of them; thirteen patients were of Grade III and the remaining two were of Grade IV. Thus, most of the group manifested 'marked' or 'severe' degrees of blunting.

The discriminative ability of the approach was further confirmed in the group under study who completed the follow-up period. The 'positive shift' (to a lower Grade) within the re-grading records was reported in ten patients. All members of this group were improved 'generally'. The improvement was mild in one patient while the remaining nine patients manifested either moderate or marked improvement. These results reflect the intimacy between emotional reactivity in schizophrenics both in states of gross progression and gross remission directions.

Though the remaining nineteen patients did not record any improve-

ment in their emotional reactivity, most of the group (13 patients) manifested some degree of 'general' clinical improvement which was only of a mild degree in nearly half of the group (6 paients) and none of them improved to a marked degree. These results reflect the generally known 'lagging' of improvement of the emotional aspect though active schizophrenic symptomatology might turn to be quiscent, and in which case, the degree of improvement usually cannot be judged more than being mild.

The other seven patients who manifested 'general' clinical improvement that amounted to be moderate though without improvement in their blunted states, could be viewed to reflect a quiescent state of active schizophrenic symptomatology probably to predict a schizophrenic deficit which is usually most manifest in the affective aspect.

About the remaining group of patients of 'no general improvement', it is considered clearly consistent to manifest no improvement regarding their blunted state.

That the suggested approach can record degrees of emotional blunting that predominently parallel the already known and reported changes in emotional reactivity of schizophrenics, in both directions of progress and remission of the pathological process, could be viewed to be preliminary criteria to the side of probable clinical value of the introduced qualitative-quantitative approach to the phenomenon of blunting of emotions.

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الموجـــز

ظاهرة التبلد والانفعال

(مدخل كمى ونوعى متكامل)

ان حالات اللامبالاة المرضية (تبلد الشعور) تستلفت النظر بطابعها الخاص · وقد لوحظ أن الاشارة اليها فى المراجع المختلفة يقتصر على تقييمها « كميا » دون التعرض للتفاصيل « النوعية » للحـــالات الانفعالية التى قد تتضمنها بينما الملاحظة الاكلينيكية تبين أن عملية التبلد لا تشمل العواطف جميعها بل من الممكن أن يظهر على المريض حتى فى الحالات الشديدة من اللامبالاه انفعال واضح يستشعره داخليا ولكن بأسلوب خاص ولنـــوع محدد من الانفعالات ·

سبق فى بحث سابق لنا أن نوقش هذا الجانب « النوعى » من ظاهرة اللامبالاه ، وتم اقتراح وضعها فى الاعتبار فى التقييم الاكلينيكى الشـــامل للظاهرة ، كما تم شرح أسلوب مقترح لتقييم حالة اللامبالاه فى « درجة » على مدرج يشتمل على ٦ درجات ·

فى هذا البحث تمت مناقشة الفائدة التى يحتمل أن تعود على الممارسة الاكلينيكية اليومية وعلى البحث العلمى بصفة عامة ·

وقد تم تطبيق هذا الأسلوب فى التقييم على عينة تتكون من ٤٠ فصامى لتوقع أن يبدى أفرادها درجات مختلفة من اللامبالاة تظهر مدى صحة وصدق الأسلوب المقترح فى اكتشاف وتقييم الدرجات البينية فى حالات اللامبالاة ·

ونتائج البحث تدعم صحة أسلوب التقييم الشامل « الكمى ـ النوعى » المقترح وقدرته على تمييز الدرجات المختلفة اكلينيكيا خصوصا الخفيف منها ·

ABSTRAIT

Le phénomène de l'épointement** émotionnel (Une approche quantitative-qualitative entière)

L'épointement des émotions est une genre unique des anomatités émotionnelles. Il est décrit dans la litérature, sans mentioner les détails sur les qualités des réactions êmotionnelles, comme une rêduction quantitative (l'extrême duquel est l'apathie). Les auteurs ont remarqué que le phénomène n'est pas un déclin général de toutes les émotions, même dans ses plus sévères intensités. Ils ont aussi notifié qu'aucune des références n'a traité les dêtails qui aident à évaluer les degrés intermédiats.

Les auteurs ont introduit une mesure qualitative qui a été considérée pour offrir une forme de référence, dépourvue de formulation théorique, et qui peut être de valeur dans la distinction des états mineurs et modérés de l'épointement êmotional, ceux-ci ne sont pas assez gros pour être aperçu par le coup d'oeil clinique. A travers une telle entière quantitative-qualitative approche, ils ont suggéré une méthode pour classer le phénomène dans des grades cliniques.

Dans ce travail, les auteurs ont discuté l'utilité probable de la politique du classement pour l'évaluation clinique dans la pratique de chaque jour; aussi bien que pour la recherche scientifique.

Quarante schizophréniques, de différentes sévérités, expectant de présenter par de degrés différents d'épointement, furent considêres convenables pour étudier la capacité distinctive d'une telle politique classant les dégrés d'épointement dans des grades.

Les résultats obtenus ont été considérés comme des critériums préliminaires qui sont avec la validité de ce système, et ainsi suggèrent la valeur de cette approche entière au phénomène de l'épointement des émotions.

** Le mot "épointement" est employé ici au sens figuré pour désigner l'apparence dévitalisé des émotions.

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The Impact of Parental Loss in Childhood on Adult Anxiety States

By A. Okasha, A. Sadek, F. Lotaif and A. M. Ashour

ABSRACT

Information was obtained from 200 patients on their feelings of anxiety and on their history of loss of parents. They were evaluated both by clinical examination and by Hamilton Anxiety Scale.

The data revealed that the loss of father before the age of 10 years was more highly correlated with signs of anxiety than loss of mother.

INTRODUCTION

Separation anxiety can be defined as the subjective accompaniment of awareness of the danger of loss. The way in which it is handled by children, has been regarded as a major determinant in character formation and, as an important variable determining proneness to mental illness in adult life. The relationship between separation in childhood and mental health in adult life has been examined by a number of workers. Bowlby (1960) has linked grief and mourning to the reaction of children to separation from their mothers. Brown (1961) found that 41 per cent of 216 depressed patients compared with 19.6 per cent of a control group have suffered parent death before age. 15. Birtchnell, (1970) found that the loss of a parent is equally common in depressed patients as in other types of psychiatric patients. In a recent study by Brown **et al.,** (1977), only loss of the mother before the age of eleven is associated with greater risk of depression. Birtchnell (1978) found that early bereaved depressed patients scored higher on certain MMPI clinical scales than non-bereaved depressed controls, the most affected scales were hypochondriasis and paranoia. Hypochondriasis was shown to be more strongly associated with early father death. Little is written about other mental illnesses which might be related to parental loss in childhood.