

Mood States of Tension Headaches Patients and Normal Respondents

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Tension headache is the most common in headaches experienced by general population. It may leads serious mood related issues. The present study, was constructed to investigate tension headache patients and normal respondents on mood states. For this study shall consists 60 participants (30 tension headache patients and 30 normal respondents) belonging to 20- 45 years of age group will be selected on the recommendation of medical practitioner. They were sampled by following purposive sampling procedure..Eight State Questionnaire (8SQ) (M. Kapoor and M. Bhargwa, 1990) were used to collect the data. Appropriate statistical methods were used to analyzing raw data. Results shows significant difference between Tension headache patients and control group on anxiety and arousal but not found significant difference on other mood states like depression, regression, fatigue or guilt feeling in both the group. Results are discussed below.

Key Words- Tension headaches, mood states.

Tension-type headache (TTH) is most common types of primary headaches (Khil L, Pfaffenrath V, Straube A, Evers S, Berger K., 2012). TTH, previously called muscle contraction headache and stress headache, is characterized by generalized pressure or tightness in the head. There is usually mild to moderate pain which is unaffected by activity. In general, TTH is not associated with nausea, vomiting, photophobia, and phono-phobia (Farooq K, Williams P., 2008) but it may affect one's mood in daily lives. Mood is defined as a consumer's affective state that is relatively global in nature, as opposed to emotions, which tend to have a specific cause (Gardner, 1985; Luomala & Laaksonen, 2000; Rusting, 1998). Within the field of mood research, a variety of moods are available for study. For example, in the context of negative moods, researchers have called attention to sad moods (Rusting & DeHart, 2000),

anxious moods (Thayer, Newman, & McClain, 1994), and angry moods (Rusting, 1998; Sedikides, 1995). Recently, consumer research scholars have compared positive and neutral moods (e.g., Barone et al., 2000; Lee & Sternthal, 1999; Meloy, 2000). However, the present study examines positive and negative moods, specifically, happy versus sad moods.

Recent research suggests that the role of negative moods is unclear in terms of when and why mood-congruent or mood-incongruent effects will occur (e.g., Rusting, 1998; Rusting & DeHart, 2000). Consequently, the study of happy and sad moods remains a topic of key concern to researchers (e.g., Larsen, McGraw, & Cacioppo, 2001; Park & Banaji, 2000; Wood, Michela, & Giordano, 2000). Thus, studying these mood states offers scope to contribute to the understanding of mood regulation, regarding the improvement of a sad mood to a happier mood

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state. Positive mood can be caused by many different aspects of life as well as have certain effects on people as a whole. Good mood is usually considered a state without an identified cause; people cannot pinpoint exactly why they are in a good mood. People seem to experience a positive mood when they have a clean slate, have had a good night sleep, and feel no sense of stress in their life. Positive mood has also been proven to show negative effects on cognition as well. According to the article "Positive mood is associated with implicit use of distraction", "There is also evidence that individual in positive moods show disrupted performance, at least when distracting information is present (Biss, Hasher & Thomas, 2010). Mood studies shows that tension is major cause of mood related problems. Tension headaches are the most common headaches in the general population; other names for them include muscle contraction headache, ordinary headache, Psychomyogenic headache, and stress headache. The International Headache Society (IHS) classifies tension headaches as either episodic or chronic; episodic tension headaches occur 15 or fewer times per month, whereas chronic tension headaches occur on 15 or more days per month over a period of six months or longer.

Tension headaches rarely last more than a few hours; 82% resolve in less than a day. The patient will usually describe the pain of a tension headache as mild to moderate in severity. The doctor will not find anything abnormal in the course of a general physical or neurological examination, although sore or tense area (trigger points) in the muscles of the patient's forehead, neck or upper shoulder area may be detected. Headaches are thought to be caused by changes in chemicals, nerves or blood vessels in the area. These changes send pain messages to the brain and bring on a headache. Headache is a pain in the head and neck region that may be either a disorder in its own right or a symptom of an underlying medical condition or disease. The medical term for

headache is cephalalgia. Headaches are one of the common and universal human ailments, described in the Bible as well as in medical writing from ancient Egypt, Babylonia, Greece, Rome, India and China. Severe chronic headaches were once treated by the oldest known surgical procedure, known as trepanning or trephining, in which the surgeon drilled a hole as large as 1-2 in diameter in the patient's skull without benefit of anesthesia. Evidence of trepanning has been found in skulls from Cro-Magnon people that are about 40,000 years old. Contemporary doctors divide headache into two large categories, primary and secondary, according to guidelines established by the IHS in 1988 and revised for republication in 2004. Primary headaches are those that are caused by an underlying medical condition. There are three types of primary headaches: migraine, cluster, and tension headaches. More than 90% of all headaches are primary headaches. Secondary headaches are caused by disease of medical condition; they account for fewer than 10% of all headaches. The American Council for Headache Education (ACHE) estimates that 95% of women and 90% of men in the United States and Canada have considered a type of primary headache, which means they are not caused by another medical condition or disorder. Other names for tension headache include muscle contraction headache, ordinary headache, psychomyogenic headache, and stress headache.

Tension headache are very common, affecting up to 78% of the general population. Unfortunately, they're also among the most neglected and difficult types of headaches to treat. If your headache happen 15 or more days in a month for several months, they are considered chronic tension headache. If they occur less frequently, they are called episodic tension headache. Although tension headaches can be painful, they are rarely a sign of a more serious illness. A combination of life style, changes, relaxation techniques and traditional and complementary therapies can help reduce the number of tension headaches you have.

Studies examined chronic tension type headache (CTTH) in children and adolescents mainly considers TTH in general and focuses on the internalizing aspects of functioning. Some works based on reports of adolescents with headache and of their parents, show an association between TTH, psychological stress, and internalizing problems (Bag et. al. 2005, Just et.al. 2003, Mazzone et.al. 2006) such as withdrawal, inhibition, shame, passiveness, fear of disease, anxiety and depression, but results are often conflicting (Just et.al 2003). Only a few studies (Mazzone et. al. 2006 Santalahti, Aromaa sourander Helenius, & Piha 2005, Virtanen et. al. 2004) focus on the relation between TTH and externalizing behaviours (environmental conflict, impulsiveness, anger, antisocial behaviour).

The rationale for choosing these mood states is as follows. From a theoretical perspective, much of the research in this area draws upon the mood-congruency hypothesis, which is derived from an associative network model of memory (Bower, 1981). This model posits that mood states prime the recall of memories of a similar affective valence. Positive moods prime positive memories; negative moods, negative memories. A substantial amount of research supports this notion that mood states influence judgments in a mood-congruent manner. Positive moods result in more favorable evaluations, whereas negative moods result in more negative evaluations (see Blaney, 1986; Forgas, 1992, 1995; Gardner, 1985; and Luomala & Laaksonen, 2000). However, some studies have also found mood- incongruent results where mood effects in advertising 251 mar wilej right batch short standard Top of text Base of RF negative moods result in favorable evaluations (e.g., Erber & Erber, 1994; Rusting & DeHart, 2000).

OBJECTIVE

The study of migraine and tension headache is one of the great interests because the impacts of such behaviour mood states and coping of

life. Thus in the light of proceeding review the major objective of the study is to assess and compare the mood states of tension headache patients and normal people. Present investigation will try to find that, is there any difference in mood states of normal respondents and tension headache patients?

HYPOTHESIS

The respondents belonging to normal population and tension headache patients would show significantly different on various dimensions of mood states.

PARTICIPANTS

The present study consists of 60 participants (30 tension headache patients and 30 normal respondents) belonging to 20 to 45 years of age group were selected on the recommendation of medical practitioner by following purposive sampling procedure. One inclusive criteria for the sampling is that, participants with at least 6 months of this problem. A number of extraneous variables like residence, education level and family structure as well as the age were recorded to insure relatively homogeneous sample. The consent of the participants was also taken for their cooperation.

BEHAVIOURAL MEASURE

The present study aims to investigate and compare tension headache patients and normal respondents on mood states. Following behavioral measure was used to obtain relevant data in the present study: ?

Eight State Questionnaire (8SQ):

This scale was constructed and standardized by M. Kapoor and M. Bhargwa, 1990. (Hindi adaptation of Curran and Cattell, Eight state questionnaire). It consists of 96 statements. This is a 4-point scale categorized into eight dimensions namely, Anxiety, Stress, Depression, Regression, Fatigue, Guilt, Extraversion and Arousal. Reliability co-efficient of the Eight State Questionnaire was calculated by Test- Retest Reliability method was established 0.91 and obtain concurrent validity co-efficient of the 8SQ scale is 0.71.

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RESULTS AND DISCUSSION

The aim of the study was to assess and compare the migraine and Tension headache on the

mood states. After scoring the obtained data were analyzed by using mean, SD and t- test. Outcomes of the analysis is presented below-

Table

Mean, SD and t - Values Scores on Dimension of Mood States for Tension Headache and Control Group.

Mood States	Category	N	Mean	SD	t-Value	Significance
Anxiety	Tension headache patients	30	20.03	3.82	3.75	.01
	Control	30	16.17	4.15		
Stress	Tension headache patients	30	16.87	4.08	.465	NS
	Control	30	17.33	3.68		
Depression	Tension headache patients	30	19.00	2.87	.512	NS
	Control	30	18.57	3.63		
Regression	Tension headache patients	30	18.10	3.45	.181	NS
	Control	30	18.27	3.66		
Fatigue	Tension headache patients	30	18.27	4.06	1.64	NS
	Control	30	16.53	4.10		
Guilt	Tension headache patients	30	16.00	2.75	.088	NS
	Control	30	16.07	3.12		
Extroversion	Tension headache patients	30	16.80	3.87	1.40	NS
	Control	30	15.50	3.28		
Arousal	Tension headache patients	30	19.50	4.24	4.41	.01
	Control	30	14.67	4.22		

Table shows that mean, SD and t - Values Scores on dimension of Mood States for Tension headache patient sand Control Group. Table shows that there is significant difference between Tension headache patient sand control group on anxiety ($t = 3.75, p < 0.01$) and arousal ($t = 4.41, p < 0.01$). Table also shows that mean and SD of Tension headache patient son anxiety ($M = 20.03, \pm 3.82$) and arousal ($M = 19.95, \pm 4.47$) is higher than control group. Further result shows that there is no significant difference between Tension headache patientsand control group on stress ($t = 0.465, > 0.05$), depression ($t = 0.512, > 0.05$), regression ($t = 0.181, > 0.05$), fatigue ($t = 1.64, > 0.05$), guilt ($t = 0.88, > 0.05$), and extraversion ($t = 1.41, > 0.05$). Mean score of Tension headache patientson Regression ($M = 18.10, \pm 03.45$) and Guilt ($M = 16.00, \pm 02.75$) appears equal than control group.

Results show that patients of tension headache are sensitive towards anxiety and arousal related mood problems. While it was not found associated with other mood states like depres-

sion, regression, fatigue or guilt feeling. On the bases of findings, it may be argued that tension headache and different kind of anxiety disorder are often found with each other and arousal in mood is biologically natural reaction of any type of tension based headache. Doctors don't have a separate name for a stress or anxiety headache. But the most common types of headaches all have a link to anxiety. Laura Stiles (2016) from Seoul, Korea also found that patients with tension-type headaches (TTH) had a significantly higher prevalence of anxiety and depression compared with those without TTH. TTH symptoms were also worse in those who had anxiety or depression. Researchers noted that, the prevalence of anxiety in the patients of TTH is higher than the normal population (Song et al. 2016; Puca et al. 1999; Holroyd et al. 2000). The present researcher wants to suggest that the proper diagnosis and treatment of anxiety needed for the improved management of tension-type headaches.

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