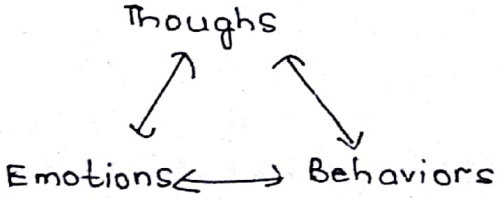
4-Apr-2019

Abnormal Psychology

→ Schizophrenia — 20
→ Anxiety Disorders — 20
→ Personality " — 20
→ Mood " — 20
→ Delusional " — 10
→ Substance Abuse — 10
(in chapter of rehabilitation)
→ Health — 10
→ +ve Health — 10
→ Quality of Life — 10
→ well being — 10

*i) Definition of Disorder
*ii) Etiology (causes)
iii) Clinical Picture
iv) Treatment

i) Definition → a) Disordered thoughts accompanied by affective disturbances
→ Schizophrenia
→ Delusional Disorders
→ b) Disordered emotions accompanied by thought disturbances
→ Mood Disorders
→ Personality "



⇒ Diagnostic and Systematic Measurement

* DSM ⟶ a) Neurotic

b) Psychotic

↳ Disorgo Disorientation w.r.t. to time place & person

↳ serious nature of mental illness

↳ patient does not understand that he has a problem

↳ Bio-chemical (drug based rather than therapy based)

↳ In patient (person has to stay in mental hospital)

a) Neurotic

↳ mild

↳ Psychotherapy

↳ Patient has some idea about the problem

↳ Out patient (hospitalization not needed)

In any disorder:

* Predispository factors

↳ something that orients towards the disorder

* Precipitatory → event in life that triggers the disorder

* Reinforcing → reinforce & hence continue the disorder

* Etiology ⟶ a) Biological → Genetic b) Neurophysiological c) Bio-chemical

b) Psychological & Interpersonal → Family

c) Socio Cultural → Community

↳ some cultures → more precipatory factors than others

↓

those who are on the margin will also have the disorder.

Psychosocial Factors

* Treatment

↳ (i) Biological ⟶ a) Tranquilizers ⟶ major & minor

↓

Issues

→ Side Effects

→ Short term Effect
(Till you take medicine, you are fine)

→ Dependence
(You become addicted)
↳ Physical
↳ Psychological

(ii) Psychological Intervention ⟶ Psychotherapy

↓

Group Psychotherapy
(better than individual Therapy)

→ Cognitive Beh. Therapy
(most common)
& supporting it is Beh. Therapy

(iii) Sociocultural

↳ involvement of community ⟶ social support

⟶ stressors that operate in the society can be reduced

* Rehabilitation → Primary Prevention
→ Secondary "
→ Tertiary "

- Primary → intervention before the disease (person gives
- Secondary → Early detection & prompt Intervention
  ↳ Hospitalization not required
- Tertiary → After disease has set in → Hospitalization required
  → Done in state mental Hospital
  → Problems
    ↓
    Stigma associated with mental hospitals.

* Schizophrenia
  ↳ It is primarily a thought disorder accompanied with emotional blunting.
  ↳ first time identified by ~~Kraeler~~ Bleuler
    ↳ He defined it as splitting of personality (not multiple personality disorder, here, personality disintegrates
    ↳ group of disorders characterised by social withdrawal
    ↳ Gross distortion of reality
    ↳ Disorganisation of thought & affect
    ↳ Huge problem in thought coherence
    ↳ suspicious

⇒ Two types → a) Chronic Type
b) ~~Type~~ Acute "

a) Chronic Type
  ↳ process Schizophrenia
  ↳ gradual onset → symptoms build up slowly, often they go unnoticed unless one has full blown attack.

b) Acute Type

↳ Reactive Type Schizophrenia
↳ Sudden onset of symptoms → clearly visible to all
↳ nightmarish confusion
↳ emotional turmoil
↳ symptoms may vanish on their own in a matter of weeks.

* Clinical Picture
(Symptoms)

- +ve Symptoms → active manifestation of abnormal beh. (not in normal people)
- -ve " → absent in a patient but are present in normal people

+ve

a) Disturbances in thought → Hallucination (perception without sensation)
→ Delusion (absurb illogical thoughts)

b) Breakdown of perceptual filtering → person is in state of emotional turmoil

Filter of RAS not present → Info. overload → They retreat to inner world as there is lot of info. already

-ve

a) Avolition → Lack of will
↳ do not initiate any activity

b) Alogia → No conversation, relative absence of speech

c) Anhedonia → do not involve in pleasure

d) Flat affect or affective flattening → talk in a single tone, monotonous

3rd category (though rare)
* Disorganised Symptoms → Disorganised beh.
" speech

DSM 3 classification

(i) Undifferentiated
(ii) Paranoid
(iii) Catatonic
(iv) Disorganised
(v) Residual

(i) Undifferentiated

↳ symptoms of schizophrenia
eg. There is emotional turmoil, nightmarish sense of confusion, hallucination, presence of panic, delusion
⇓
But on the basis of these, a person can not be classified into the other 4 categories

(ii) Paranoid

↳ less disorganisation of personality
↳ illogical delusions & vivid changable hallucinations and impairment in critical thinking
↳ Delusions can undergo a change over time (changable)
↳ Suspicion
→ They talk a lot about them → speech problems are observed

(iii) Catatonic

↳ 2 phases → catatonic Stupor
" excitement
→ characterised by waxy flexibility

- Stupor → withdrawal
- Excitement → intense energy & action

} alternate bet. the 2

⇒ Waxy Flexibility → stay in the same position for a long time (stay in the same mould)
↳ as wax can take the shape of the mould and can be melted again)

(iii) Disorganised

- Paranoid Personality Disorder → tendency to be over suspicious

- Paranoia → Delusion but no hallucination
- Paranoid Schizophrenia → Delusion + hallucination

(iv) Disorganised

↳ early onset and long persistent
↳ speech incoherence, hallucination & delusion
↳ silly laughter & behavior
↳ extreme disorganisation of personality

(v) Residual

↳ Symptoms that remain after a person has come out of schizophrenia.

* Causation

a) Biological
- Genetic
- Neurophysiological
- Biochemical
- Neuroanatomical

(i) Genetic
- Family studies
- Twin "
- Adoption "

} very strong genetic linkage

For same socio-cultural status of foster homes
Children from schizophrenic mothers → more chance of getting it.

⇒ Chances are higher if one parent has schizophrenia, even more if both of them have it

⇒ Concordance rate → much high in monozygotic twins

(ii) Neurophysiological → Abnormalities in Autonomic Nervous System
↓
panic attacks, high arousal, etc.

(iii) Biochemical → Overactivity of dopamaine
↓
overstimulation
↓
panic

→ All drugs aim to reduce dopamaine activity

(iv) Neuroanatomical → Enlargement of ventricles in the brain
(ventricles are hollow spaces in brain filled with cerebro spinal fluid)

b) Psychological & Interpersonal

(i) Early psychic trauma & increased vulnerability
↓
Individual suffers deep hurts in his env.
↓
withdraws
↓
starts hallucinating

⇒ Early childhood } most vulnerable
⇒ Adolescence }

(ii) Schizophrenogenic Parenting

↳ Mothers: Rejecting, dominating & overprotective & unresponsive

→ Mother-child relationship is cold

→ If predisposition → schizophrenia
otherwise anxiety disorder

} This is applicable to many points [Predisposition → very imp. factor]

(iii) Destructive Family Interaction

Father → Ineffectual

Mother → Engulfing (extreme overindulgence)

- Husband-wife relationship → strained
→ continuation of marriage is threatened

(iv) Pseudomutuality & Role Inflexibility

↳ false mutuality

↳ Typecasted in a single role → not allowed to play other roles
→ not accepting diversity of personality

(v) Faulty Communication

↳ comm. amorphous & fragmented

↳ Bateson → double mind
↳ mutually incompatible personality

(vi) Excessive Life Stress & decompensation

↳ Decompensation → breakdown of integrated functioning

↳ life stress → personal
↳ professional

vii) Faulty Learning

↳ Observation Learning & conditioning.

c) Socio-cultural

↳ Caroth

↳ Disorganised Schizophrenia → widespread among African tribals

↓

they do not have well developed defence mechanisms

* Low SES → more prone
  ↳ due to more stressors, rapid social change, etc.

* Treatment

2 progs. → (i) for Acute patients
(ii) Chronic "

• Chronic patients → whose interpersonal ties have been disrupted and ties with the community have been fractured

• Acute " → whose ties are intact

⇒ With acute patients → symptoms are not well set
  ↳ They can recover → near to normal

⇒ For chronic " → Use drugs to ~~not~~ non make them ~~not~~ threatening

→ complete recovery not possible.

* Tranquilizers
* Group Therapy
* CBT & ~~there~~ with it BT
* Freudian & Humanistic → for mild disorders
  ↳ (Not effective)
* Take care of relapse (the go back to disorder)

⇒ Reduce stressors in the env. → help them to ~~correct~~ rehabilitate.

* Anxiety Disorders

↳ Anxiety is a future oriented state characterised by -ve effect in which a person focuses on the possibility of uncontrollable danger or misfortune.

Fear is a present oriented state characterised by strong escapist tendencies & a surge in Sympathetic branch of ANS in response to current danger.

- Anxiety disorder as a term suggests a group of disorders characterised by unrealistic, irrational, fear or anxiety of disabling intensity as its core & also its principle & most obvious manifestation.

5-Apr-2019

* Generalised Anxiety Disorder

→ excessive worry about no. of events

→ free floating anxiety (not tied to any cause)

→ As per DSM 4 → this worry should atleast for 6 month & patient should find it difficult to control

→ 6 symptoms

↓

If any 3 → Patient has GAD

(i) Sleep Disturbances
(ii) Muscle Tension
(iii) Sense of being easily fatigued
(iv) Irritability
(v) Mind going blank & difficulty in concentrating
(vi) Restlessness & a feeling of being on the edge

• Barlow → Patients of GAD have anxious apprehension

↳ future oriented mood state in which the person attempts to be constantly ready to deal with upcoming -ve events

• GAD frequently occurs with other mood disorders, particularly → Panic disorder with Agoraphobia

(fear of open spaces)

Causes / Explanations

* Biological

→ Highly anxious people have functional deficiency in GABA

* The evidence regarding genetic factors is mixed as there is modest heritability.

Psychosocial

a) Cognitive

↳ presence of **dysfunctional schemas**

↳ because of life events that were uncontrollable

↳ which generated fear response

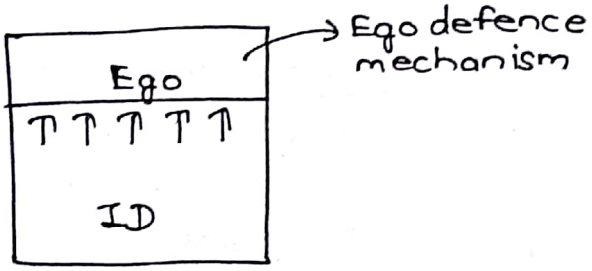
⇓

belief that world is a dangerous place

(persistent fear irrespective of the events)

b) Psychoanalytical

↳ Freudian → All anxiety is neurotic



control is
(If Ego ~~DNorg~~ not sufficient)

~~Phobi~~ Phobia

* Due to ID pressure, ego develops fear for a specific object to control expression of ID Impulses.

↳ If Ego is not able to develop a phobia like channelisation for these Id impulses

↓

GAD

⇒ For Neo- Freudian → GAD is due to insecure attachment

⇒ In GAD this, no intense anxiety → you just feel uneasy

c)

* Behavioristic → conditioning is for one object (little Albert)

→ If many such objects in your env. which you have been conditioned to fear

Fear of many objects → generalisation → GAD

* In neurotic disorders → role of biological factor may be dispository but most imp are precipatatory ~~function~~ factors.
→ Biological factors not as imp. as Schizophrenia

⇒ In individualistic cultures → no support → GAD system

Treatment

(i) Biological

a) Tranquilizers

b) Anti-Depression Drugs

c) Anti-Anxiety Drugs

(ii) Psychological

a) CBT → as it aims as cognitive restructuring & it helps to correct dysfunctioning schema and it also enables the client to focus on what is really threatening

→ Therapies accompanied by relaxation training program to reduce physiological arousal

* Phobic Disorder

• Phobia → Exaggerated irrational fear of something that presents no actual danger to the person or where fear is magnified out of all proportion to actual threat caused by the object.

* Clinical Picture

(i) Somatic complaints

(ii) Indecisiveness

(decidophobia → you can't take a decision)

(iii) Exaggerated irrational fear response to specific object.

* Etiology

(i) Biological

a) More temperamental person → more phobic (they will fear more)

⇒ More evidence is for Psychosocial

(ii) Psychosocial

a) Behavioristic → conditioning & avoidance learning

b) Freudian → you displace neurotic anxiety on specific object to control excessive anxiety.

c) Cognitive → dysfunctional schema
↳ w.r.t. to specific object

* Treatment

Drug Treatment → same as GAD

Psychological → make person realise real & imagined danger
⇓
→ respond selectively to each

* Systematic Desensitization
* Implosion Therapy
* CBT
* Response Shaping (sometimes)
* Aversive Counter Conditioning

SD & IT → Most Imp

* Panic Disorder

↳ unexpected panic attacks that seem to come out of the blue

→ Symptoms

a) Intense Anxiety that leaves the patient with a feeling as if he is going to die.

→ Lasts for few minutes to a few hours

In GAD → mild anxiety which is persistent.

- Acc. to DSM 4, the person is labeled as having panic disorder must have experienced recurrent, unexpected attacks & must have persistent concerns about having another attack or be worried about the consequences of an attack for atleast a month. For a person to have panic attack, he must show 4 out of following 13 symptoms.

(i) Accelerated Heart Rate
(ii) Profuse Sweating
(iii) Trembling or shaking
(iv) Shortness of breath
(v) Choking
(vi) Chest pain or discomfort
(vii) Nausea or abdominal distress
(viii) Feeling dizzy or unsteady
(ix) De-realisation (no real self)
(x) De-personalisation
(xi) fear of losing control
(xii) Chills or hot flushes (eg. reddening of ear lobes)
(xiii) Paresthesia (numbness or tingling sensation) & mild depression

The 2 features of panic disorders are brevity & intensity.

→ The age of onset is bet. adolescence & mid 30s

→ Panic disorders are generally accompanied by Agoraphobia (fear of open spaces)

* Etiology

(a) Biological

→ Panic disorders & agoraphobia tend to run in families

→ Kendler, etal reported greater concordance bet. monozygotic twins than dizygotic twins.

→ Neurobiological researches by Gorman etal have proposed that diff. brain areas are involved in diff. aspects of panic disorders. The panic attacks themselves arise because of the activity in locus coeruleus in the brain stem & involves storms of autonomic nervous activity. For those who have anticipatory anxiety, the limbic system is involved & the phobic avoidance seen in agoraphobia is truly a learned act that is controlled by pre-frontal cortex.

(b) Psychosocial

(i) Freudian → for Agoraphobia
↓
It is due to the reason that the person is afraid that he will act out sexual impulses in open spaces.

Neo-Freudian → Insecure attachment
↓
world is a dangerous place

• Dangerous object (a little danger element) → Panic attack (perception of unmanageable danger)

* It is unlikely to have Agoraphobia without Panic Disorder (not vice versa)

ii) Cognitive
↳ strongest
↳ Catastrophising

Stimulus → Perceived Threat → Anxious Apprehension → Body sensation ↓ Catastrophic Interpretation → Intensifies (back to Perceived Threat)

* Psychological Treatment

(i) Breathing Retraining → It teaches the client to reduce their breathing rates & thus promotes relaxation

(ii) Interoceptive → Exposure to somatic cues that trigger an attack. This exposure is intended to reduce anxiety about physical sensations.

(iii) Cognitive Restructuring → geared to correct client's misinterpretation about bodily sensations

A therapy known by the name 'Panic Control Treatment' which involves cognitive-behavior behavioral intervention has been found to be effective.

* OCD (Obsessive Compulsive Disorder)

→ Obsession → Repetive thoughts

→ Compulsive → " actions

⇒ If actions are present, thoughts will be there always (not vice versa)

→ person is forced to think about something that he doesn't want to think & performs some actions against her will.

* Etiology
* Biological

(i) Genetic → Concordance rate is higher in Monozygotic twins in comparison to dizygotic twins

→ But since the diff. is not significant, we can say that genetic factors play a moderate role

(ii) Biochemical → Increased ceratonin activity & increased sensitivity of the brain to ceratonin may be involved in OCD.

Studies of OCD patients have revealed abnormally active metabolic levels in orbital fre frontal cortex.

(*) Psychosocial

(i) Freudian

a) Displacement of anxiety
b) Defence against threatening impulses

a) Displacement of anxiety → Developing a particular thought/practice or an action
↓
keep yourself (mind) occupied & prevent anxiety from causing a problem.
eg. Lady Macbeth washing hands after murdering King Duncan

→ Keep yourself busy

b) Guilt is causing you problem

Management of Anxiety not efficient [Immature ego] → compulsive behaviors (to keep yourself busy) → Anxiety is reduced [This is repeated]

(ii) Behavioristic

↳ In phobia → Little Albert developed fear of white rat
↓
He could reduce fear by running away

Running Away [to reduce fear] → If done again & again → OCD (conditioning)

(iii) Cognitive → Dysfunctional schema.

Treatment

(i) Biological → anti anxiety & anti-depressants
→ side effects

(ii) Psychological

a) Helping the patient differentiate bet. real & imagined dangers & respond selectively to each.

b) Helping the patient discriminate bet. his thought & action & accept his forbidden desires as common to most people & integrate into his self structure.

c) Blocking the obsessive compulsive ritual by consistently rewarding the patient as & when he abandons the beh.

CBT → Most effective

SD
IT
Relaxation Training } useful.

*PTSD (Post Traumatic Stress Disorder)

→ trauma is present

→ you have to be present on the field experiencing it

→ War neurosis

→ Insomnia is common reaction

→ Nightmares

⇒ In DSM 4 ⇒ Acute Stress Disorder

⇒ In PTSD, and ASD, the stressor ~~the~~ is unusually severe, involving intense fear & is psychologically traumatic. PTSD occurs weeks after individual has experienced Traumatic episode and the symptoms include intense fear related actions that continue for several months.

→ In DSM 4, PTSD & ASD find mention under the category of anxiety disorders but the diff. bet. them is of duration.

→ The diagnosis of PTSD is not given until the Symptoms last for at least one month.

(i) frequent re-experiencing of the event through intrusive thoughts, flashbacks, nightmares & dreams.

(ii) Persistent avoidance of stimuli associated with trauma & a general numbing and deadening of emotional feeling.

(iii) Increased physiological arousal resulting from exaggerated startle responses or difficulty is sleeping.

(iv) Impaired concentration & disturbances in memory.

(v) Feeling of depression
(No hallucination or delusions)

* Causes

→ PTSD is the only anxiety disorder in which specific causal agent i.e. trauma serves as the diagnostic criterian. Although trauma is the necessary cause of PTSD, its occurence does not tell the whole story. Among the other factors are the characteristics of the trauma itself, what happens to the victim after the trauma & the coping style of the trauma victim.

- Resnick etal. in their study found that individuals whose trauma was crime related are more likely to develop PTSD ~~that~~ than those who are non-criminal trauma victims. The extent of injury during the trauma & victim's perception of trauma can also increase the chances of PTSD. The absence of social support can also increase PTSD chances in trauma victims.

Researches have shown that people who are more likely to develop PTSD are the ones who are highly suspicious, overly concerned about bodily functions & are socially maladjusted.

* Biological factors

↳ There are some studies that have associated PTSD with excessive surges in neuro-transmitte such as nor-epinephrine & hyper sensitivity in certain brain structures such as locus coeruleus There is some evidence for genetic linkage in PTSD as the concordance rate in M2 is higher than D2.

Treatment

a) Biological
(i) Anti depressants drugs, tranquilizers,
→ Anti anxiety "

b) Cognitive Beh. therapy has been found to be useful. The general approach of all Cognitive therapies is to:

(i) Activate fear memory network

(ii) Provide experiences that are incompatible with the info. stored in it.

Direct exposure treatment & CT have provided good results.

6-Apr-2019

* Personality Disorder → Person is not aware that he has disorder.

* Delusional " → Delusions but no hallucinations, thought based

* Mood " → Emotion based

• Thought disorder $\xrightarrow{\text{with time}}$ Emotion disorder (vice versa)

* Personality Disorder

Paranoid Personality Disorder → Paranoia → Paranoid Schizophrenia

⇒ More because of socialization

⇒ DSM4 describes PD as enduring pattern of inner expectations and behavior that deviates significantly from the expectations of individual's culture, is pervasive and inflexible, has an onset in adolescence or early childhood, is stable over time & leads to distress and impairment.

American Psychology Association

↳ PD are generalised & long standing and people with PD might not see their condition as a problem that needs some treatment. They are basically very unhappy though in some cases, they may give less pain to themselves than to those who deal with them.

Q) Why it is difficult to diagnose patients with PD?

Ans=(i) Co-morbidity → having symptoms of 3-4 disorders
Anti social PD + Narcissistic PD + Borderline PD

→ No exclusive categories

(ii) Dimensional nature → Symptoms range from normal suggestion to pathological exaggeration

(iii) Definition Problem → not very clearly defined

* Clusters of PD

* Cluster A → a) Paranoid
b) Schizotypal
c) Schizoid

a) Paranoid

(i) Tendency to see oneself as blameless

(ii) Person is always on guard for perceived attack by others.

(iii) Mistrust & suspiciousness

(iv) Person bears grudges & is unwilling to forgive others for perceived insults.

b) Schizoid

(i) Reduced social interaction

(ii) Impaired social relationships

(iii) Inability to form attachment with others.

c) Schizotypal

(i) Peculiar thought patterns

(ii) Impaired social relationships

(iii) Oddities of perception & speech that interferes with normal communication.

* Cluster B

a) Histrionic

b) Antisocial

c) Narcissistic

d) Borderline

a) Histrionic

(i) Self dramatization
↓
Lively & dramatic
↓
Can charm others but can't sustain relationships

(ii) Excessively attention seeking & feel frustrated if not attended to

(iii) Irritable beh. & anger outbursts if neglected

(iv) Over concern with attractiveness

b) Anti-social

(i) They are guiltless, remorseless & Conscienceless

(ii) Ability to put up a good front to impress & exploit others.
(iii) Unconventional & unrestrained sex life
(iv) Inability to follow approved models of beh.
(v) Inability to learn from their mistakes

c) Narcissistic

(i) Grandiosity
(ii) Impulsive behavior if not attended to
(iii) Pre-occupied with receiving attention
(iv) Lack of empathy for others
(v) Excessive concern for self

d) Borderline

(i) Drastic mood shifts
(ii) Chronic feeling of boredom
(iii) Impulsiveness & inappropriate anger
(iv) Attempts at self mutilation & suicide
(eg: suicide bombers)
Some terrorists are narcissistic borderline
(v) Disturbances in basic identity.

* Cluster C → a) Avoidant

(i) Excessive shyness
(ii) Insecurity in social interaction
(iii) Hypersensitiveness to rejection

b) Dependant

(i) Feeling of difficulty in separating in relationships.

(ii) Subordination of one's needs to keep others in relationship.
(iii) Feeling of discomfort when alone.

c) Obsessive Compulsive (OCPD)
(i) Inability to relax & have fun
(ii) Person is a perfectionist
(iii) Lacks expressiveness & warmth
(iv) Excessive concern with orders & rules

* Provisional → a) Depressive PD
(i) Persistent unhappiness or dejection
(ii) Feeling of inadequacy
(iii) Passive depressive cognition

b) Passive Aggresive PD
(i) -ve attitude
(ii) Complaining nature
(iii) Envious beh. towards those who are more fortunate

* Etiology
* ~~Biological~~
↳ Since most of the personality traits are moderately heritable → It is not surprising to find that there is increasing evidence for certain PD

→ Research suggests the genetic factors may be imp. for PD like Borderline PD, Antisocial PD & Paranoid PD

* For many PD → malfunctioning of inhibitory mechanisms in CNS
↓
mistakes are repeated

Esp. in anti-social → ANS is such that they experience less anxiety.

Experiment

Delinquents

(i) Psychopathic

(ii) Due to social adjustment

As the clock will strike 12, they will be given painfull shock

(i) → No anxiety

(ii) → massive surge in anxiety

- Without anxiety, social ~~earki~~ conditioning will not be proper.

* Psychosocial

Trauma produced as a result of

(i) Early parental loss

(ii) Ambivalent beh. of the parents which produces extreme anxiety & insecurity in the children.

Parenting → Inconsistent, unresponsive & erratic

(iii) Domestic violence/physical & emotional abuse particularly during early childhood

(iv) Arbitrary administration of reward & punishment

(v) Exposure to undesirable role models

(vi) Impoverished living conditions; rapid social change

* Treatment

(i) Secure co-operation from the patients

→ (difficult as patients are convinced that they don't need treatment)

→ They are clever (They can befool the therapist)

(iii) Comorbidity & Dimensional nature of the problem make the treatment difficult.

CBT ⟶ as dysfunctional schemas need restructuring.

BT
Response shaping, aversive counter cond. → Also useful

Biological → Anti anxiety, anti-depressants
⇓
To those who are unstable

* Mood Disorders

(i) Unipolar
(ii) Bipolar

(i) Unipolar ⟶ a) Major Depressive Disorder
b) Dysthymia
c) Adjustment Disorder with depressed mood

(ii) Bipolar ⟶ a) Bipolar Disorder I
b) " " II
c) Cyclothymia

In Unipolar → theme is depression
↳ In general, psychomotor retardation

• In Bipolar → theme is Depression + Mania (alternately)
→ Theme of mania is psychomotor overactivity

* Characteristics of Depression

(i) Loss of initiative
(ii) Anhedonia
(iii) Pessimistic Outlook
(iv) Feeling of sin & guilt
(v) Insomnia & Hypersomnia
(vi) Loss of appetite & overeating
(vii) Social withdrawal
(viii) Low self esteem & -ve self concept

* Unipolar

a) Major Depressive Disorder

↳ Person is not able to involve himself in pleasure giving activity & is in a severe depressed mood. Symptoms last for a few months & a person is depressed every day.

b) Dysthymia

→ Depression is chronic but less severe & person is not depressed everyday. Symptoms are long lasting. They have to persist for atleast 1 yr in children & 2 years in adults for them to be labelled as having Dysthymia.

* Bipolar

a) Bipolar Disorder I

↳ characterised by a full blown manic episode & one or more episodes of major depressive disorder.

b) Bipolar Disorder II

↳ characterised by hypomania & major depressive episode

c) ~~Psycho~~ Cyclothymia

Moods fluctuate over a period of 2 yrs or more but neither the manic or depressive phase is as severe as seen in above 2 cases.

* Symptoms of Mania

(i) Reduced need for sleep
(ii) Impulsive beh.
(iii) Tendency to pace rapidly, speak rapidly, eat rapidly, etc.
(iv) Thought processes are speeded up
(v) Delusion of grandeur
(vi) Feeling of extreme elation

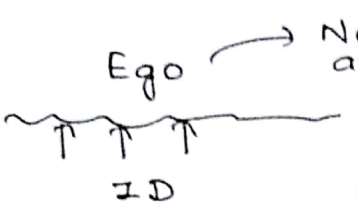
* Etiology

For depression, plenty of evidence, not for mania.
unipolar → Psychological & Psychosocial evidence available
Bipolar → Biological (mania)
~~Unipolar~~ Depression → (i) Psychoanalytical
→ Freudian
→ Neo-Freudian

(ii) Behavioristic
(iii) Cognitivistic

(Not much available for mania)

(i) Freudian



→ To use EDM
↓
when EDM inadequate
↓
Ego uses depression to thwart Id Impulses from taking over.

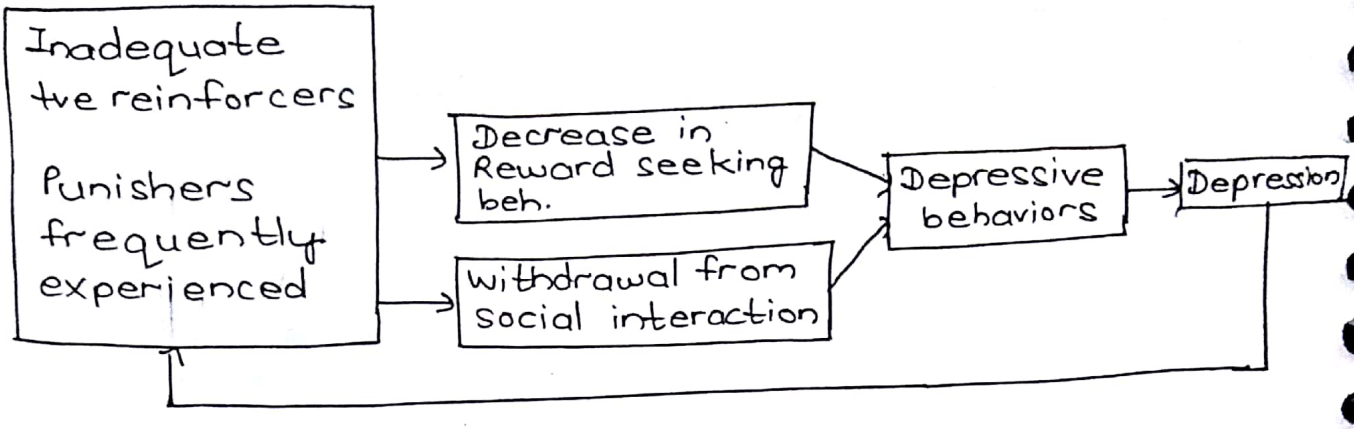
Another explanation → Ego does a mistake (inadequate to handle Id impulses)
↓
Superego punishes
↓ guilt
Depression

eg.
⇒ Loss of treasured object due to a mistake will lead to depression

• Neo-Freudian → Insecure attachment
↓
world is a danger place belief
↓
child will not be comfortable with parents
↓
Comfort is sought with some other person (dependence)
↓
If that person is no longer available
↓
Depression

(ii) Behavioristic

↳ Inadequate reinforcers



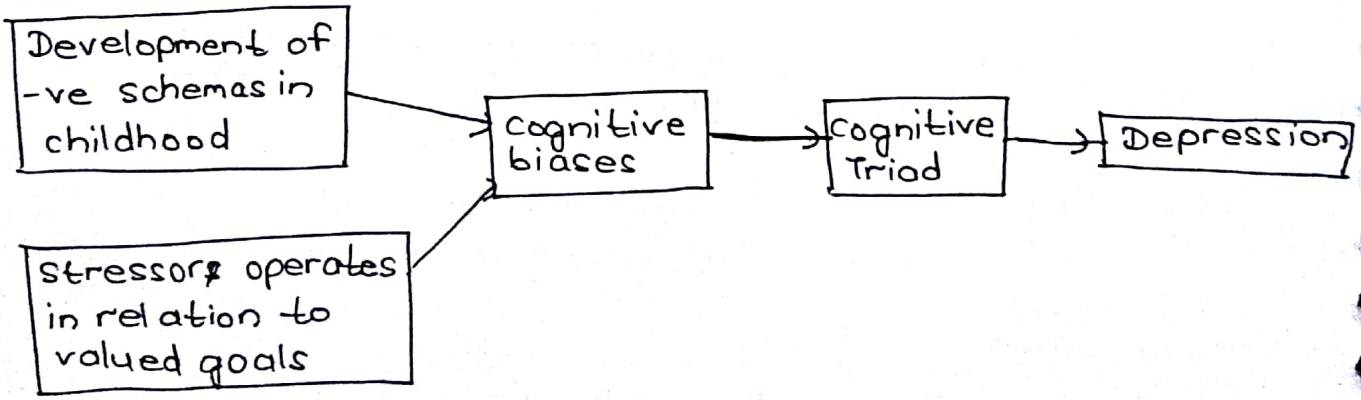
Lewinsohn's Model

(iii) Cognitivistic

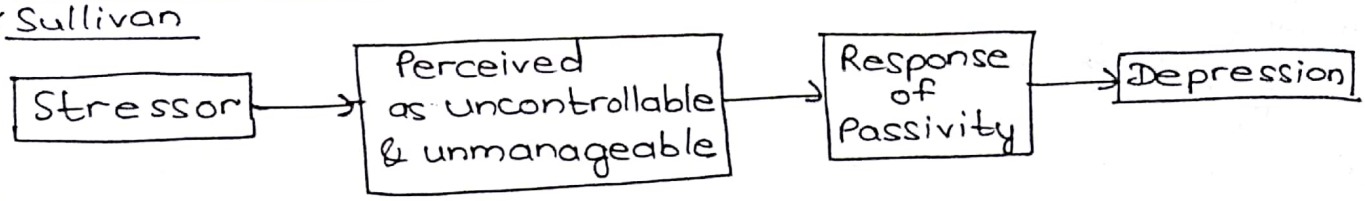
↳ Beck → faulty appraisal & attribution
↓
cognitive triad (-ve about oneself, env. & future)
↓
Depression

↳ Stressor perceived as unmanagable
↓
Learned Helplessness
↓
Depression

*Beck's view



* Sullivan



* Biological

↳ For Bipolar

↳ Mania is biological

(i) Genetic

↳ concordance rate in MZ twins is higher than DZ

↳ Genetic evidence is more powerful for Bipolar disorders in comparison to Unipolar

(ii) ↳ Irregularities in the way neurons fire their msgs.

(iii) Abnormalities in endocrine system esp. HPAC Axis (Hypothalamic, Pituitary & Adrenaline Cortex)

(iv) Disturbances in the functioning of following neurotransmitters

a) seratonin
b) Dopamine
c) Nor-epinephrine

In collectivistic culture → Bipolar (Mania orientation)
individualistic " → Unipolar
} more chances

* Treatment

(i) Biological

↳ Antidepressants

↳ Anti anxiety

↳ Lithium Therapy → very successful for bipolar

(ii) Psychological

(a) BCT
(Beck's Cog.)

(b) Short Term Dynamic Therapy

(c) Interpersonal Therapy

(d) Logo Therapy → to provide meaning

(e) Relaxation Exercises → meditation, Jacobson's Rel. Technique.

(f) Lewinsohn's coping with depression course
(based on behavioristic principles & provides the patient Relaxation & Assertiveness Training)

* Delusional Disorder

↳ illogical absurd thought

↳ just a thought disorder

↳ Former name → Paranoia

↳ no personality fragmentation (as in Schizophrenia) (disorganisation)

↳ No impaired contact with reality

↳ 2 types → (i) persecution
(ii) Grandeur

* Etiology

↳ principally Psychosocial

↳ CRPs are imp.

↳ mostly in victims of authoritarian CRP
↓
focus is on proving oneself as superior

More chances if children are
→ seclusive
→ adamant
→ normal socialisation with peers not present

To prove yourself as superior → selective perception → misread social cues

↓

even light banter seems an insult to you

↓

Delusion

⇒ Many times such people have

History of failures → You have to prove that failure was due to the plotting by others

* Treatment

⇒ (i) CBT will be used

↳ dysfunctional schemas would be changed.

(ii) Aversive Counter Conditioning

⇒ These people are impervious → if intervention is done early then it will be useful, otherwise very difficult.

Health Psychology

Sushrut described health as a state of delight or a feeling of physical, spiritual & mental well being.

There are diff. views regarding the understanding of the concept of health. The biomedical view describes it as an absence of disease. The ecological view describes it as dynamic equilibrium bet. man & his env. & the Psychosocial view considers health ~~on~~ not only as a biological phenomena but also as psychosocial phenomena.

There is merit in each view & therefore health is a wholistic concept.

WHO

↳ Health is a state of complete physical, social & mental well being not merely an absence of disease or ~~infermity~~ infirmity.

The limitation of this def. is that:

a) It is too broad for practical purposes

b) Health is not a state but in fact a continuous process in the light of changing env.

WHO recognises 2 concepts of health today:

(i) Broad concept

↳ It defines health as the quality of human organism expressing adequate functioning of the organism in the given conditions genetic or environmental.

(ii) Narrow Concept

a) No obvious evidence of disease
b) Several body organs are functioning adequately in themselves and in relation to one another.

* Modern view

(i) It is fundamental human right
(ii) Integral part of development
(iii) Essential for better quality of life
(iv) Essence of productive life
(v) Responsibility of not only an individual but also a national & international responsibility.
(vi) World wide goal
(vii) Multi-dimensional concept

Imp. Dimensions

a) Physical
b) Social
c) Mental
d) Spiritual
e) Vocational
f) Emotional
g) Political

(viii) It is a major social responsibility

8-Apr-2019

+ve Health

* Happiness

↳ state of subjective well being

↳ Hedonic satisfaction

↳ Eudaimonic → sense of self fulfillment
(experience Psychological growth)

Happiness → when you have sense of
a) Acceptance
b) Adjustment
c) Achievement

Quality of life → social, physical, spiritual, economic well being

+ve Health → when you optimise your well being

For well being → a) Psychological Aspects
b) Physical "

a) Psychological Aspect

i) Autonomy
ii) Personal growth
iii) Mastery experiences
iv) +ve relatedness
v) Life purpose
vi) Self acceptance

⇒ These for well being, +ve health & QoL.

(i) fulfilling life
(ii) Enriched "
(iii) Meaningful "

+ve Health → Realise our true self

-ve " → Removing disease

In well being, imp. features → (i) Life satisfaction
(ii) Presence of +ve emotion
(iii) Relative absence of -ve emotions.

WHO

+ve Health refers to perfect functioning of body & mind. It conceptualises health biologically as a state in which every cell & every organ is functioning in optimum capacity in harmony with the rest of the body. Psychologically it is a state in which individual feels a sense of perfect well being & a mastery over his env. and socially it is a state in which individual's capacity for participation in social system is optimal.

• Dubos is of the opinion that the concept of +ve health cannot become reality because man will never be able to so perfectly adapt to his env. so that he will have no struggle or conflict

WHO considers a person to be +vely healthy when he can express his genetic heritage completely. However, this goal is not easy because it requires a very healthy relationship with one's env. and also the knowledge of one's

potential so that he can transform it to phenotypic reality.

* Characteristics of +vely healthy individual

(i) Optimistic mindset
(ii) Awareness about one's potentialities.
(iii) Proactive rather than reactive nature
(iv) Relativistic Thinking
(v) Flexible use of coping mechanisms & hardiness
(vi) Adaptability
(vii) High self efficacy & +ve self concept.

WHO's definition of health introduces the concept of well being, though there has been no satisfactory effort to define well being, psychologists realise that there are 2 components of well being

(i) Objective Component
(ii) Subjective "

The objective comp. relates to the standard of living or level of living whereas subjective Component is associated with quality of life.

* Standard of living refers to the usual scale of expenditure, the goods we consume and the services we enjoy. It includes the level of education, employment status, the accomodation we have, recreational facilities & the other comforts of modern living.

* Quality of life implies something that increases the sense of satisfaction & well being. WHO defines QoL as a condition of life resulting from

combination of effects of complete range of factors such as those determining health, happiness, education, social & intellectual attainment, freedom of action, justice & freedom of expression.

Most contemporary Psychologists define QoL as a composite measure of physical, mental & social well being as perceived by each individual or a group of individuals.

From psychological standpoint, to define QoL, we ask people about their well being, satisfaction & happiness.