MENTAL HEALTH & PSYCHIATRY

TAILORED FOR MEDICAL STUDENTS, USMLE, PLAB, PA & NURSING

4th EDITION

MedicalNote.in

PDF

120 PAGES

COMMON PSYCHIATRIC CONDITIONS

COMMON PSYCHIATRIC CONDITIONS

Overview of General Classes of Psychiatric Disorders:

Anxiety Disorders (Respond to certain objects or situations with fear and dread, as well as with physical signs of anxiety or nervousness, such as a rapid heartbeat and sweating - diagnosed if the person's response is not appropriate for the situation, if the person cannot control the response, or if the anxiety interferes with normal functioning)	Generalised Anxiety Disorder PTSD (Post Traumatic Stress Disorder) OCD (Obsessive-Compulsive Disorder) Panic Disorder Social Anxiety Disorder Specific Phobias (
Mood Disorders (Affective Disorders) (Persistent feelings of sadness or periods of feeling overly happy, or fluctuations from extreme to extreme)	Depression Mania Bipolar (Manic Depressive)
Psychotic Disorders distorted awareness and thinking. Two of the most common symptoms of psychotic disorders are hallucinations -- the experience of images or sounds that are not real, such as hearing voices -- and delusions, which are false beliefs that the ill person accepts as true, despite evidence to the contrary.	Schizophrenia (+ Related) Brief Psychotic Disorder Delusional Disorder Substance-Induced Psychosis Paraphrenia
Eating Disorders	Anorexia Nervosa Bulimia Nervosa
Impulse Control & Addiction Disorders (unable to resist urges, or impulses, to perform acts that could be harmful to themselves or others, and cause them to ignore responsibilities & relationships.)	Pyromania (Starting Fires) Kleptomania (Stealing) Compulsive Gambling/ Alcohol/Drugs
Personality Disorders (extreme and inflexible personality traits that are distressing to the person and/or cause problems in work, school, or social relationships. In addition, the person's patterns of thinking and behaviour significantly differ from the expectations of society and are so rigid that they interfere with the person's normal functioning.)	Antisocial Personality Disorder Borderline Personality Disorder Histrionic Personality Disorder Narcissistic Personality Disorder Avoidant Personality Disorder Paranoid Personality Disorder Schizoid Personality Disorder
Adjustment Disorder (when a person develops emotional or behavioural symptoms in response to a stressful event or situation. Adjustment disorder usually begins within three months of the event or situation and ends within six months after the stressor stops or is eliminated.)	Adjustment Disorder with… - Depressed mood - Anxiety - Mixed anxiety/depression - Disturbance of conduct
Dissociative Disorders (severe disturbances or changes in memory, consciousness, identity, and general awareness of themselves and their surroundings. These disorders usually are associated with overwhelming stress, which may be the result of traumatic events, accidents, or disasters that may be experienced or witnessed by the individual.)	Dissociative Identity Disorder (AKA: Multiple Personality Disorder/ Split Personality) Depersonalization Disorder Dissociative Amnesia
Factitious Disorder: Factitious disorder is a **serious mental disorder in which someone deceives others by appearing sick**, by purposely getting sick or by self-injury. Factitious disorder also can happen when family members or caregivers falsely present others, such as children, as being ill, injured or impaired.	Imposed on self Imposed on another

SUICIDE

Screening For Suicide:

- **Must ask EVERY patient**
- "Have you had any thoughts of wanting to harm or kill yourself?"
- **Suicidal Ideation?:**
    - **Passive Ideation:**
        - would rather not be alive but has no active plan for suicide
        - Eg: "I'd rather not wake up" or "I would not mind if a car hit me"
    - **Active Ideation:**
        - "I think about killing myself"
- **Risk Assessment:**
    - **plan**: "Do you have a plan as to how you would end your life?"
    - **intent**: "Do you think you would actually carry out this plan?" "If not, why not?"
    - **past attempts**: highest risk if previous attempt in past year
- **Assess Current Ideation**:
    - **Onset and frequency of thoughts**: "When did this start?" Or "How often do you have these thoughts?"
    - **Control over suicidal ideation:** "How do you cope when you have these thoughts?" "Could you call someone for help?"
    - **Intention**: "Do you want to end your life?" Or "Do you wish to kill yourself?"
    - **Intended lethality:** "What do you think would happen if you actually took those pills?"
    - **Access to means:** "How will you get a gun?" Or "Which bridge do you think you would go to?"
    - **Time and place**: "Have you picked a date and place? Is it in an isolated location?"
    - **Provocative factors:** "What makes you feel worse (Eg: Being alone)?"
    - **Protective factors:** "What keeps you alive (Eg: Friends, family, pets, faith, therapist)?"
    - **Final arrangements:** "Have you written a suicide note? Made a will? Given away your belongings?"
    - **Practiced suicide or aborted attempts:** "Have you ever put the gun to your head?" "Held the medications in your hand?" "Stood at the bridge?"
    - **Ambivalence:** "I wonder if there is a part of you that wants to live, given that you came here for help?"

Assessment of Suicide Attempt:

- setting (isolated vs others present/chance of discovery)
- planned vs impulsive attempt, triggers/stressors
- substance use/intoxication
- medical attention (brought in by another person vs brought in by self to ED)
- time lag from suicide attempt to ED arrival
- expectation of lethality, dying
- reaction to survival (guilt/remorse vs disappointment/self-blame)

Common Clinical Presentation:

- hopelessness
- anhedonia
- insomnia
- severe anxiety
- impaired concentration
- psychomotor agitation
- panic attacks

Suicide Risk Factors Mnemonic: 'SADPERSONS':

- Sex (male)
- Age >60 yr old
- Depression
- Previous attempts
- Ethanol abuse
- Rational thinking loss (delusions, hallucinations, hopelessness)
- Suicide in family
- Organized plan
- No spouse (no support systems)
- Serious illness, intractable pain

Management of Suicidal Patients:

- **High Risk:**
  - **Who?** Patients with a plan and intention to act on the plan, access to lethal means, recent social stressors, and symptoms suggestive of a psychiatric disorder
  - Strongly consider hospitalisation
  - Never leave the patient alone
  - Remove dangerous items from the room
  - If patient refuses hospitalisation, may require an involuntary treatment order (or equivalent)
- **Lower Risk:**
  - **Who?** patients who are not actively suicidal, with no plan or access to lethal means
  - Discuss protective factors
  - remind them of what they live for
  - Make a safety plan:
    - Agreement not harm themselves
    - avoid alcohol, drugs, and situations that may trigger suicidal thoughts
    - follow-up with you at a designated time
    - Contingency planning:
      - contact a health care worker
      - call a crisis line
      - or go to an emergency department if their suicidal feelings return or intensify
- **Associated Depression:**
  - May require treatment with SSRI/SNRI
  - May require hospitalization if severe
- **Associated Alcohol Abuse:**
  - Thiamine if necessary
  - May require admission for alcohol withdrawal management +/- Benzodiazepine
- **Associated Schizophrenia/Psychosis:**
  - May require hospitalisation for psychosis management

AFFECTIVE DISORDERS
(Major Depression & Bipolar)

Affective Disorders = Disorders in which there is a *Major Disruption of Mood*:

- **MAJOR DEPRESSION:**
  - Mental disorder of ***SUSTAINED*** Depression of Mood, Loneliness, Despair, Insomnia, Appetite Loss, and feelings of Worthlessness, Guilt, & Hopelessness
- **BIPOLAR DISORDER (AKA: Manic-Depressive Disorder):**
  - Mental disorder characterised by ***PERIODS*** of abnormally Elevated Mood (Hyperactivity/ Talkativeness/Insomnia/↑Libido; and ***PERIODS*** of Depressed Mood

Aetiology:

- **Recognised that Pts with Depression have *Lower* levels of NA & 5HT in the CSF**
  - IE: Reinforced that *Deficient* NE & 5HT → Depression
- **+ Environmental & Social factors**

Current Hypotheses:

- ***The Amine (Monoamine) Hypothesis:**
  - Mood Disorders are due to a **Deficiency (Depression)** or **Surplus (Mania)** of at least one of three monoamine neurotransmitters **(Norepinephrine, Serotonin, or Dopamine)** in their respective pathways **(NE & 5HT are the Relevant ones here)**
  - **(NE/5HT Deficiency → Depression)**
    - ***:. Anti-Depressant Drugs all act to → Increase NA &/or 5HT Signalling***
  - **(NE/5HT Surplus → Mania)**

***Antidepressant Drug Groups:** **(*Anti-Depressant Drugs all act to → ↑NA and/or 5HT Signalling*)**

- **Tricyclic Antidepressants (TCA's)(3-Ringed Structures); & Tetracyclics (4-Ringed Structures):**
  - Block BOTH Noradrenaline AND Serotonin (5HT) Reuptake
- **Selective Serotonin Reuptake Inhibitors (SSRI's):**
  - Block Serotonin (5HT) Reuptake
- **Selective Noradrenaline Reuptake Inhibitors (SNRI's):**
  - Block Noradrenaline Reuptake
- **Monoamine Oxidase Inhibitors (MAOi's):**
  - Inhibit Monoamine Oxidase Function:
    - (IE: ↓Catecholamine Breakdown → Surplus of NE and/or 5HT → Improved Mood)

***Bipolar Drugs:**

- **Lithium (Lithium Carbonate):**
  - Used to stabilise Bipolar Disorder (Manic/Depressive)
    - – IE: Counteract both Mania & Depression
  - **Mechanism of Action:**
    - Increases Serotonin Levels → Counteracts Depression
    - Decreases Noradrenaline Levels → Counteracts Mania
- **Valproate:**
  - **Mechanism of Action:**
    - Enhance GABA's Action → Thought to Stabilise Neurotransmission in this pathway
    - → Prevents mood swings & Reduces Mania
  - **Note: Less toxic than Lithium**

DEPRESSION

Key Components Of Depression:

- Depressed mood
- Increased stress/sensitivity
- Psychomotor change
- Anhedonia
- Neurovegetative signs
- Impaired executive learning & cognitive functions

Risk Factors:

- **Sex:** F>M, 2:1
- **Family history:** depression, alcohol abuse, suicide attempt or completion
- **Childhood experiences:** loss of parent before age 11, negative home environment (abuse, neglect)
- **Personality:** neuroticism, insecure, dependent, obsessional
- **Recent stressors:** illness, financial, legal, relational, academic
- **Lack of intimate, confiding relationships or social isolation**
- **Low socioeconomic status**

K10 Scale – Quick Screening Tool:

- **10 Questions: Over the Past MONTH, How Often did you Feel...**
    - Tired for no good reason?
    - Nervous?
    - Uncontrollably Nervous?
    - Hopeless?
    - Worthless?
    - Restless/Fidgety?
    - Uncontrollably Restless/Fidgety?
    - Depressed?
    - Uncontrollably Sad?
    - Everything was an effort?
- **5 Possible Answers Each:**
    - None – 1pt /A Little – 2pts /Some – 3pts /Most – 4pts /All – 5pts; of the time
- **Score Range 10-50 – Risk of Anxiety/Depressive Disorder:**
    - 0-15 Low; 16-30 Mod; 30-50 High

DSM-5 Diagnostic Criteria for MAJOR DEPRESSIVE EPISODES:

- **A) ≥5 of the following symptoms have been present during the same 2 wk period and represent a change from previous functioning; at least one of the symptoms is either 1) depressed mood or 2) loss of interest or pleasure (anhedonia):**
    - Depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others
    - Markedly reduced interest or pleasure in all, or almost all, activities most of the day, nearly every day
    - Significant unintentional weight loss/weight gain, or decrease/increase in appetite nearly every day
    - Insomnia or hypersomnia nearly every day
    - Psychomotor agitation or retardation nearly every day
    - Fatigue or loss of energy nearly every day
    - Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
    - Diminished ability to think or concentrate, or indecisiveness, nearly every day
    - Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
- **B) the symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning**
- **C) the episode is not attributable to the direct physiological effects of a substance or a GMC**

DSM-5 Diagnostic Criteria for MAJOR DEPRESSIVE DISORDER:

- **A) presence of a Major Depressive Episode (Defined above)**
- **B) the MDE is not better accounted for by schizoaffective disorder and is not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder NOS**
- **C) there has never been a manic episode or a hypomanic episode**
    - **Note:** This exclusion does not apply if all of the manic-like, or hypomanic-like episodes are substance or treatment-induced or are due to the direct physiological effects of another medical condition
    - **Specifiers:** with anxious distress, mixed features, melancholic features, atypical features, mood-congruent psychotic features, mood-incongruent psychotic features, catatonia, peripartum onset, seasonal pattern
    - Single vs recurrent is an episode descriptor that carries prognostic significance. Recurrent is classified as the patient having two or more distinct MDE episodes; to be considered separate the patient must have gone 2 consecutive months without meeting criteria

DSM-5 Diagnostic Criteria for PERSISTENT DEPRESSIVE DISORDER: (Previously 'Dysthymia'):

- **A) depressed mood for most of the day, for more days than not, as indicated either by subjective account or observation by others, for ≥2 yr**
    - **Note:** in children and adolescents, mood can be irritable and duration must be at least 1 yr
- **B) presence, while depressed, of ≥2 of the following:**
    - poor appetite or overeating
    - insomnia or hypersomnia
    - low energy or fatigue
    - low self-esteem
    - poor concentration or difficulty making decisions
    - feelings of hopelessness
- **C) during the 2 yr period (1 yr for children or adolescents) of the disturbance, the person has never been without the symptoms in criteria A and B for more than 2 mo at a time**
- **D) criteria for a major depressive disorder may be continuously present for 2 yr**
- **E) there has never been a manic episode or a hypomanic episode, and criteria have never been met for cyclothymic disorder**
- **F) the disturbance is not better explained by a persistent schizoaffective disorder, schizophrenia, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder**
- **G) the symptoms are not due to the direct physiological effects of a substance or another medical condition**
- **H) the symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning**

Treatment:

- **Lifestyle:**
    - Exercise
    - Stress reduction
- **Biological:**
    - SSRIs/SNRI - Eg: Sertraline, escitalopram, venlafaxine, mirtazapine
    - Other augmenting agents – Eg: Bupropion, Quetiapine, aripiprazole, lithium
    - ECT (Considered in severe, psychotic or refractory major depressive disorder)
- **Psychological:**
    - CBT
    - Family therapy
    - Group therapy
- **Social:**
    - Vocational rehab
    - Social skills training

POSTNATAL/POSTPARTUM DEPRESSION

General Overview

- **= Non-psychotic depression occurring within 4-wks following delivery**
- **Typically lasts 2-6mths**
- **If severe, can lead to aversion to baby, suicidal and infanticidal ideation**
- Affects 12-15% of mothers
- <50% recurrence rate

Presentation:

- Anxiety/Depression
- Referral from external source (Midwives, community health)
- Inability to cope
- Husband/family member presents with concerns
- Somatic Symptoms
- Issues with children
- Irritability & Tearfulness
- Avoiding personal discussion
- Denial
- Delayed attachment
- Negative feelings to infant

Risk Factors:

- Minority groups
- Lower Socio-economic status
- Younger age
- Absence of partner
- Medical complications
- Marital problems
- History of abuse
- Not breast-feeding
- No job to return to
- Problematic births
- Reluctance to seek help

Protective Factors:

- Optimism & Self esteem
- Higher education
- Good SES
- Strong relationship with partner

Screening:

- **K10 Score** (previously discussed)
- **EPDS - Edinburgh postnatal depression scale** (10qs, 5mins, responses graded)

Management:

- **Psychotherapy** (Eg: CBT)
- **Pharmacological** (Eg: SSRI's)
- **If severe/psychotic, consider ECT**

Effect on Infant:

- Insecure infant – lack of trust, poor interaction with caregiver
- Attachment issues – discipline, behaviour & aggression problems
- Infant withdrawn, passive
- Slow to reach milestones
- High risk of mental health issues in child

Other Postpartum Distresses:

- **Post-partum Anxiety**
- **Postpartum OCD**
- **Postpartum Psychosis (Hallucinations & Delusions)**
- **Baby Blues**

BIPOLAR DISORDERS

Bipolar 1 vs Bipolar 2 Disorder:

- **BIPOLAR 1 DISORDER:**
  - disorder in which at least one manic episode has occurred
  - if manic symptoms lead to hospitalization, or if there are psychotic symptoms, the diagnosis is BP I
  - commonly accompanied by at least 1 MDE but not required for diagnosis
  - time spent in mood episodes: 53% asymptomatic, 32% depressed, 9% cycling/mixed, 6% hypo/manic
- **BIPOLAR 2 DISORDER:**
  - disorder in which there is at least 1 MDE, 1 hypomanic and no manic episodes
  - while hypomania is less severe than mania, Bipolar II is not a "milder" form of Bipolar I
  - time spent in mood episodes: 46% asymptomatic, 50% depressed, 1% cycling/mixed, 2% hypo/manic
  - Bipolar II is often missed due to the severity and chronicity of depressive episodes and low rates of spontaneous reporting and recognition of hypomanic episodes

Classification – Based on the most recent mood episode:

- **Manic**
- **Hypomanic**
- **Depressed**

DSM-5 Criteria for MANIC EPISODE:

- **A) a distinct period of abnormally and persistently elevated, expansive, or irritable mood, and abnormally and persistently increased goal-directed activity or energy, lasting ≥1 wk and present most of the day, nearly every day (or any duration if hospitalization is necessary)**
- **B) during the period of mood disturbance and increased energy or activity, ≥3 of the following symptoms have persisted (4 if the mood is only irritable) have been present to a significant degree and represent a noticeable change from usual behaviour**
  - inflated self-esteem or grandiosity
  - decreased need for sleep (Eg: feels rested after only 3 h of sleep)
  - more talkative than usual or pressure to keep talking
  - flight of ideas or subjective experience that thoughts are racing
  - distractibility (Ie: attention too easily drawn to unimportant or irrelevant external stimuli)
  - increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
  - excessive involvement in pleasurable activities that have a high potential for painful consequences (Eg: engaging in unrestrained shopping sprees, sexual indiscretions, or foolish business investments)
- **C) the mood disturbance is sufficiently severe to cause marked impairment in social/occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features**
- **D) the episode is not attributable to the physiological effects of a substance or another medical condition**
- **Note:** A full manic episode that emerges during antidepressant treatment but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a manic episode, and therefore, a bipolar I diagnosis
- **Note:** Criteria A-D constitute a manic episode. At least one lifetime manic episode is required for the diagnosis of bipolar I disorder

HYPOMANIC EPISODES:

- Criterion A and B of a manic episode is met, but duration is ≥4 d
- Episode associated with an uncharacteristic change in functioning that is observable by others but not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization
- Absence of psychotic features (if these are present the episode is, by definition, manic)

DSM-5 Diagnostic Criteria for MAJOR DEPRESSIVE EPISODES:

- **A) ≥5 of the following symptoms have been present during the same 2 wk period and represent a change from previous functioning; at least one of the symptoms is either 1) depressed mood or 2) loss of interest or pleasure (anhedonia):**
    - Depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others
    - Markedly reduced interest or pleasure in all, or almost all, activities most of the day, nearly every day
    - Significant unintentional weight loss/weight gain, or decrease/increase in appetite nearly every day
    - Insomnia or hypersomnia nearly every day
    - Psychomotor agitation or retardation nearly every day
    - Fatigue or loss of energy nearly every day
    - Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
    - Diminished ability to think or concentrate, or indecisiveness, nearly every day
    - Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
- **B) the symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning**
- **C) the episode is not attributable to the direct physiological effects of a substance or a GMC**

Treatment:

- **Lifestyle:**
    - Education regarding illness
    - Regular check-ups
    - Contingency planning for manic episodes
    - Regular routine (Sleep/exercise)
- **Biological:**
    - Eg Lithium, Anticonvulsants (valproate, carbamazepine), antipsychotics
    - ECT if refractory
    - **Treating/Preventing Mania:** Lithium, Valproate, Carbamazepine
    - **Treating Depression:** lithium, lurasidone, quetiapine, lamotrigine, antidepressants (only with mood stabilizer), ECT
    - **Mixed Episode/Rapid Cycling:** multi-agent therapy, lithium or valproate + SGA (lurasidone, aripiprazole, olanzapine)
- **Psychological:**
    - Psychotherapy
    - CBT
    - Family therapy
- **Social:**
    - Vocational rehab/Leave of absence from school/work
    - Financial capacity assessment
    - Avoid drugs/ETOH
    - Sleep routine

Prognosis:

- suicide rate ~15% (worse in mixed states)
- Bipolar is chronic with relapses
- can achieve high level of functioning between episodes
- may switch rapidly between depression and mania without any period of euthymia in between
- high recurrence rate for mania – 90% will have a subsequent episode in the next 5 yr
- long term follow-up of BP I – 15% well, 45% well with relapses, 30% partial remission, 10% chronically ill

PERSONALITY THEORIES

PERSONALITY THEORIES

What is Personality?

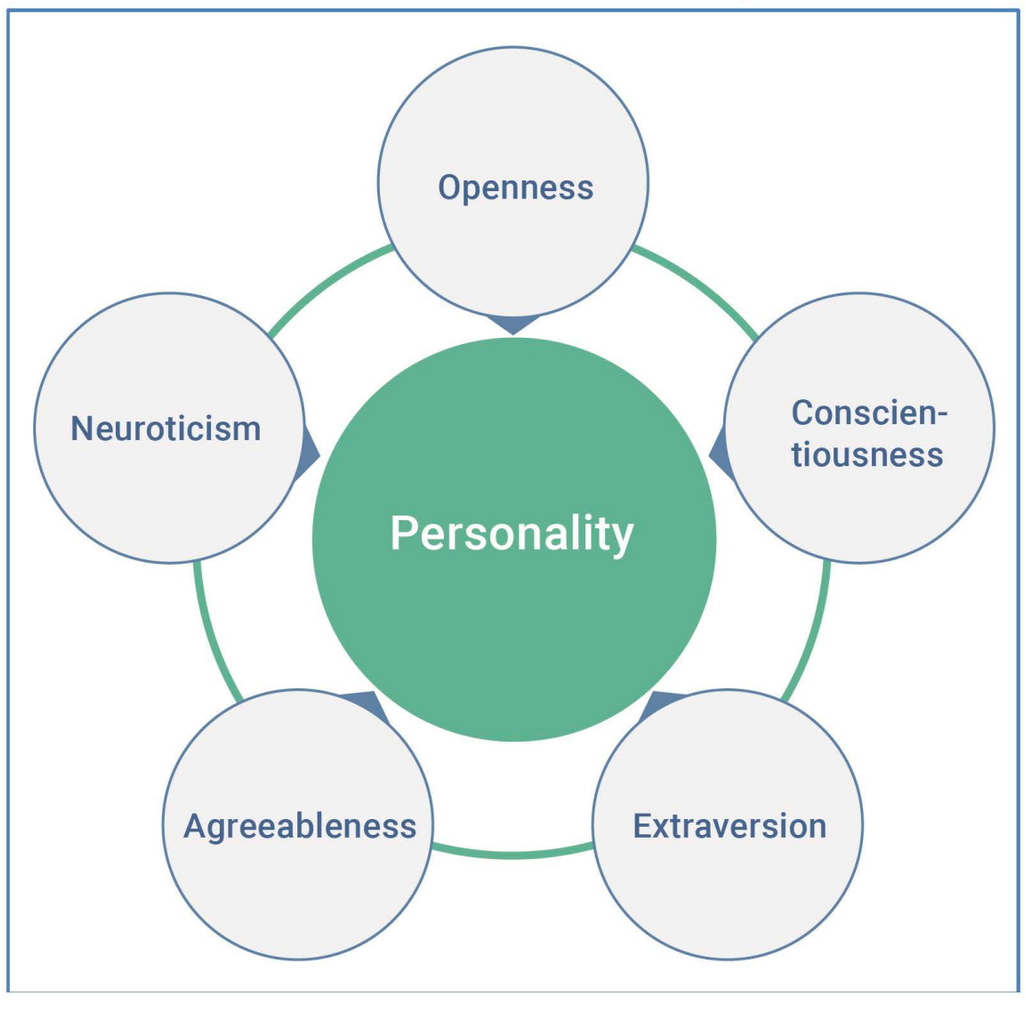
- "Qualities of an individual that are shown in their way of behaving in a wide variety of circumstances
- IE: A mental picture of someone's mind that allows us to predict the way they behave

Personality Theories:

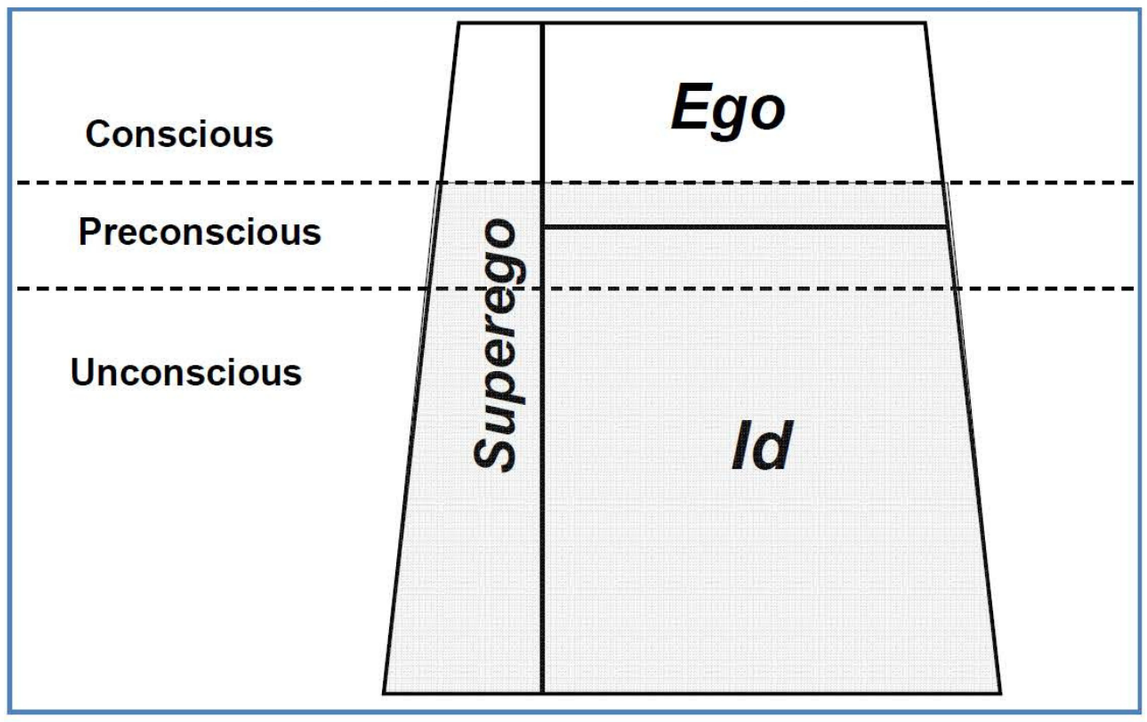
- **Trait Theory:**
  - **Synopsis:**
    - People can be described in terms of enduring ***underlying qualities***
    - These qualities are thought to be:
      - Independent
      - Stable
      - Have a Neurological & Biological Basis
  - **"State" Vs "Trait":**
    - State = How you are right now
    - Trait = How you tend to be over your whole life
  - **Traits include:**

Moody	Sociable	Reserved
Rigid	Easygoing	Careful
Pessimistic	Aggressive	Peaceful
Passive	Optimistic	Reliable
Thoughtful	Anxious	Impulsive

    - **Hans Eysenk's Version:**
      - Introversion Vs Extraversion
      - Neurotic Vs Emotionally Stable
      - Psychotic Vs Impulse Control
    - **The "5 Factor Theory":**
      - Neuroticism (Worried, Highly Strung)
      - Extraversion (Sociable, Affectionate)
      - Openness (Independent, Creative)
      - Agreeableness (Good-Natured, Trusting)
      - Conscientiousness (Reliable, Organised)
  - **How is it Measured?**
    - Self-Report Questionnaires – Identify stable, enduring personality traits
      - Objective
      - Lots of Yes/No Questions about Feelings & Behaviour



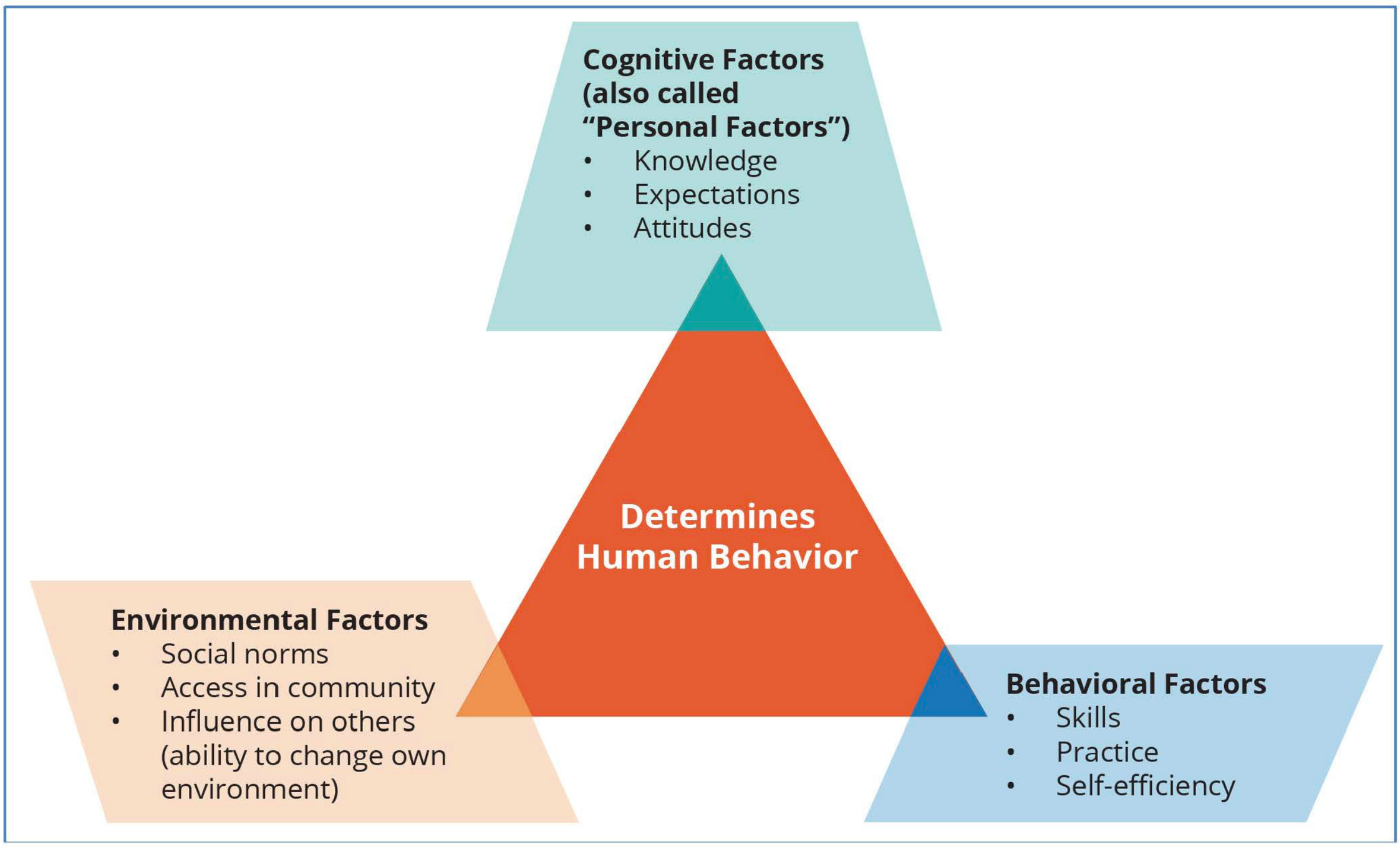
- **Psychoanalytic & Developmental Theories:**
  - **Synopsis:**
    - Personality is a compromise between ***Instinctive Biological Urges*** Vs ***Social Prohibitions***
    - Consists of the **3 Freudian** aspects:
      - The "Id" ("It") Desire
      - The "Ego" ("I/me") Choice
      - The "Superego" ("Over me") Reality/Morality



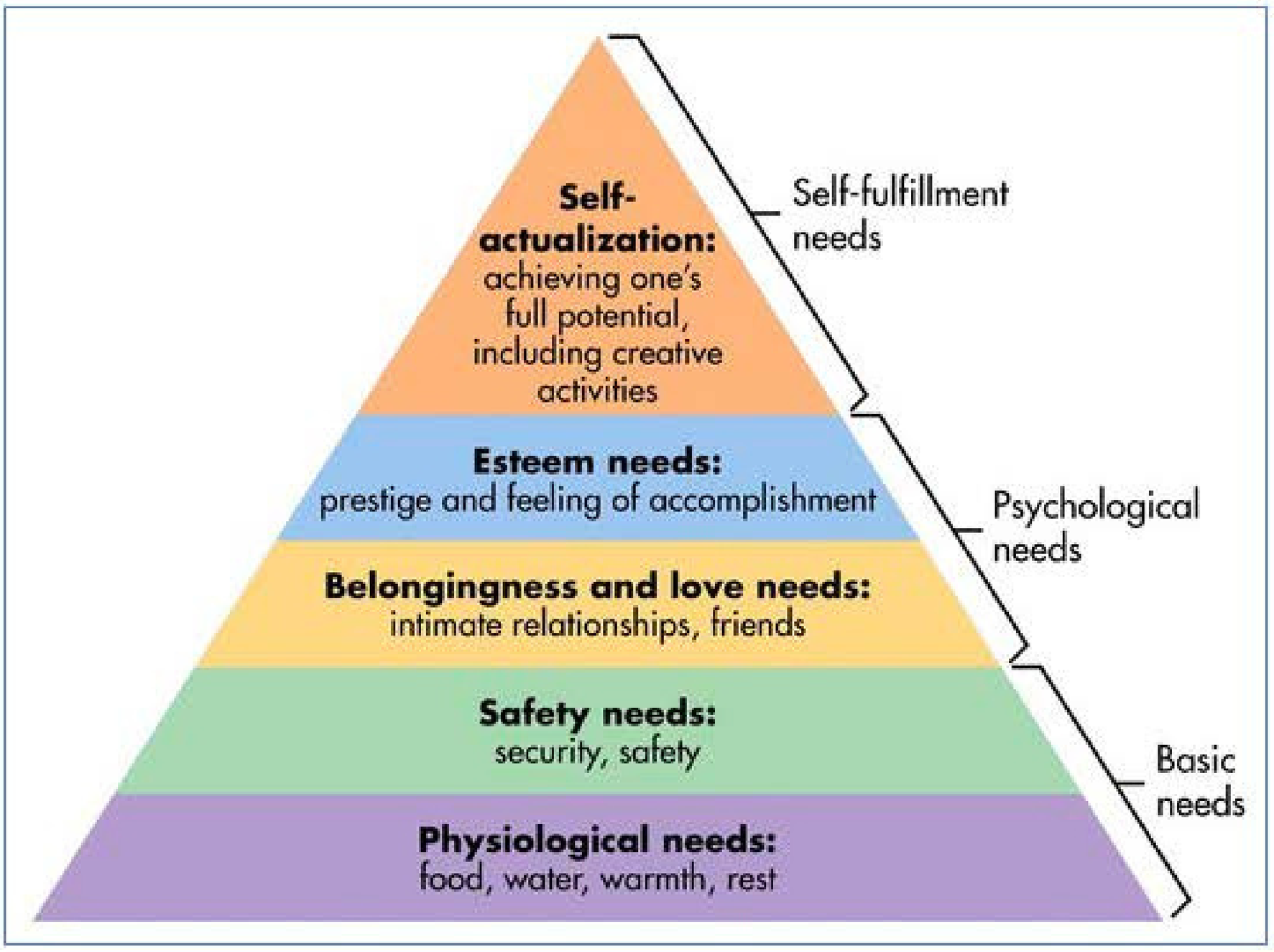
    - Consists of the **5 Stages of Desire** (or 'Libido'):
      - Oral Stage
      - Anal Stage
      - Phallic Stage
      - Latency
      - Genital Stage

        Note: Personality Problems result from failure to resolve conflicts between 'Desire' & 'External Constraints'
    - Involves the concept of **Defences:** (Keeping intolerable fears/desires out of consciousness)
      - Denial
      - Repression
      - Projection
      - Rationalisation
      - Etc
    - Involves the concept of **Unconscious Re-Enactment:**
      - One's thoughts/feelings about **Past Relationships** (Eg: With parents) get re-enacted in **Present-Day Relationships** (Eg: With partners)
    - Involves the **Bowlby & Attachment Theory:**
      - "The primary instinct isn't sexual, rather the desire for ***closeness, comfort & protection***
      - "Personality can be traced back to the ***Mother-Child Relationship***"
      - "Your childhood attachment influences the way you conduct relationships as an adult
  - **How is it Measured?**
    - Aim: To Identify Unconscious Wishes, Fears & Defences:
      - Detailed Biographical History
      - Projective Tests
      - Dreams
      - Transference (Feelings from early childhood relationships are "transferred" to present day relationships

- **<u>Social-Learning Theory:</u>**
  - **Synopsis:**
    - Behaviour is driven by:
      - **Reward & Punishment**
      - **Beliefs & Expectations**
    - We learn from Direct & Indirect Experience (observing others)
      - Observational Learning
      - Social Rewards for Behaviour
      - Self-Efficacy – Comes from experiences of success & social reinforcement
    - Encompasses the '**Locus of Control'** theory:
      - Internal Locus – you are responsible for your feelings/actions/destiny
      - External Locus – the actions of others are the reason for your feelings/actions/etc
  - **Where Beliefs & Expectations Come From:**
    - Experience (Reward & Punishment)
    - How people have treated us (Past & Present)
    - Social Role (Race/Class/Gender/Stigma)
  - **How is it Measured?**
    - Clinical Interview - Subject is asked to clarify his/her:
      - Beliefs
      - Behaviour Patterns
      - Expectations about themselves



- **Humanistic Theory:**
  - **Synopsis:**
    - Concerned with:
      - Present & Future (Not Past)
      - The Person's Motivation
      - The Person's Potential (Not their deficits/flaws)
      - The Person's Individuality (Uniqueness)
    - "Everyone has the capacity to fulfil their own potential"
    - Concerned with **The Hierarchy of Needs:**
      - Note: one can only achieve the 'Self Actualisation Need' (IE: Fulfilment) after they meet the first 4 needs
  - **Aim:** to understand a person's experience & self-concept



  - **How is it Measured?**
    - **How: Clinical Interview:**
      - Person's self-description
      - Observation of Non-verbal Communication
      - Empathy