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A STUDY OF PSYCHOPATHOLOGY IN DEPRESSIVES

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ABSTRACT

This review assesses some of the important advances that have been made in our understanding of the psychopathology of depression. While the monoamine theory, that postulates dysfunctional noradrenergic and serotonergic systems as the underlying cause of depression, has been valuable in the development of conventional antidepressants that are thought to act by reversing these dysfunctional states, recent clinical and experimental studies have questioned this reductionist view of depression. This has led to an assessment of the role of dysfunctional endocrine and immune systems in the aetiology of depression. In addition to explaining the link between defective neurotransmitter function and the symptoms of depression, changes in the endocrine and immune axes also help to explain the link between major depression and physical ill health. In addition, experimental and clinical studies have extended the possible involvement of neurotransmitters to include the glutamate and GABA systems. Such approaches may stimulate the development of new types of antidepressants that hopefully will combine increased efficacy with shorter speed of onset and improved side effect profiles.

KEYWORDS: *Psychopathology, Depressives, important, development, antidepressants, experimental, immune systems, function, health.*

INTRODUCTION

The aim of the paper is to develop predictions or the possible neural basis of abnormalities of the self in depression. The psychopathology of the self in depression

focusing on three particular characteristics, attribution of negative emotions and increased cognitive processing of the own self. Psychopathology is defined as “the study of the origins and the course of individual patterns of behavioral

maladaptation". Contemporary approaches in developmental psychopathology endorse two currently popular etiological ideas concerning these patterns: multi-determinism and interaction. According to those ideas, psychopathologies have multiple causes that interact with one other as well as changing over time. This continual and progressive interaction among variables is transactional in nature. In the Indian year of disability, the European health policy acknowledged the key role of families in the assistance of patients with long term diseases and highlighted their unpaid economic and social contribution to health care.

Informal or lay care giving is the act of providing assistance to an individual with whom the caregiver has a personal relationship. Caregiver burden is defined as the strain or load borne by a person who cares for an elderly, chronically ill, or disabled family member or other person. It is a multi-dimensional response to physical, psychological, emotional, social and financial stressors associated with the care giving experience. Voluntary caregiver is the modern terminology in some countries for an unpaid spouse, relative, friend or



neighbor of a disabled person or child who assists with the activities of daily living and assists those unable to fully take care of themselves. As medical breakthroughs have changed, some health problems (terminal to chronic), and life spans have gradually increased, and as an average age of the population becomes older. The role of voluntary caregiver has been increasingly recognized as an important one, both functionally and economically. According to the United States national family caregivers association, more than 50 million people provide care for a chronically ill, disable or aged family member or friend during any given year. Around six million people in India provide care on an unpaid basis for a relative, friend, or neighbor in need of support due to old age, disability, frailty, or illness. The population of careers is dynamic: at least one third of all people will fulfill a caring role at some point in their life. Caring for aging parent or loved one requires time, patience, and energy, and almost always results in frustration and exhaustion. Caregivers often experience higher stress, illness and burnout than non-caregivers. Although the caregiver is preoccupied and overly concern with the changes taking place with their relatives,

there are changes that affect the caregiver that often are overlooked. Some changes are emotional changes like role reversal, role overload, changes in family system, normal routine of living is interrupted on temporary to permanent basis; physical changes like changes in home environment, more frequent travel etc.; physical symptoms and emotional symptoms like increased anger, depression, exhaustion, fatigue, isolation, withdrawal, sleep deprivation, loss of appetite etc.

REVIEW OF LITERATURE:In a study (Ekwall et al., 2009) found that male caregivers proved to be more satisfied than female caregivers. Based on satisfaction scores those satisfied had a higher proportion of male caregivers and a significantly higher amount of caregiving hours per week. They used other coping strategies than the respondents in other cluster i.e. less satisfied in using more problem solving strategies.

In a study (Hooley & Campbell, 2002), it was resulted that in both the schizophrenia as well as depressed groups, high expressed emotions' relatives attributed more control to their ill family members than did low expressed emotions' relatives. They also

behaved in a more controlling manner. Examination of patients' clinical outcomes during a 9-month follow up period revealed that high levels of behavioral control on the part of relatives significantly predicted relapse in patients with schizophrenia but not in patients with depression. Patients with schizophrenia who lived with relatives classified as highly controlling were more likely to relapse than were patients who lived with less controlling relatives. This was not the case for patients with depression.

Roick et al., (2007) found that family burden was associated with patients' symptoms, male gender, unemployment and marital status, as well as caregivers coping abilities, patient contact and being a patient's parent. However, even when these attributes were controlled for, British caregivers reported more burden than German caregivers. They further concluded that national differences in family burden may be related to different healthcare systems in Germany and British support for patients with schizophrenia may be shifted from the professional to the informal healthcare sector more in Britain than in Germany. Caregiver-burden studies with longitudinal designs offer inconsistent

findings. While burden was found to be lower at 6 months follow up in relatives of schizophrenic patients with predominantly positive symptoms, it was found to be stable among those of patients with predominantly negative symptoms.

Magliano et al., (2006) studied a total of 709 relatives of patients with schizophrenia and 646 relatives of patients with physical diseases. In both the groups, the consequences of care giving most frequently reported as present were constraints in social activities negative effects in family life and a feeling of loss. Objective burden was similar in the two groups, while, subjective burden was higher in schizophrenia. Social support was lower among relatives of patients with schizophrenia than among those of the other group.

Parabiaghi et al., (2007) found that baselines levels of family burden were high in worrying and urging domains. 51% of caregivers experienced significant emotional distress. Both overall burden and emotional distress improved. Higher patient's psychopathology, higher numbers of patients rated needs; patients lower global functioning and patients' poorer quality of life were found to be related to the severity

of family burden. The only significant predictor of caregivers' burden at follow-up was the baseline level of caregivers burden itself.

Magliano et al., (2002) found that family burden was found lower in Northern Italy. However, after controlling for psychosocial interventions, differences in family burden among the three geographical areas disappeared (northern, central and southern Italy). Family burden was associated with patients levels of disability and manic/hostility symptoms and with professional and social network support received by the family.

Hanzawa et al., (2008) found that burden of care was significantly associated with general health status of the (57 mothers of schizophrenia) caregivers and difficulty in life.

Roick et al., (2006) showed that interpersonal differences (patients' positive and negative symptoms, relatives' coping abilities, and patient contact) and interpersonal changes (relatives' coping abilities, patients' negative symptoms and utilization of community care) predicted family burden.

Jungbauer et al., (2003) with a qualitative study showed that burden in parents of patients with schizophrenia are closely interconnected with the course of patients' illness.

Kohn et al., (2005) suggested that less perceived burden, increased caregiver support, and to a lesser extent, expressed emotions explain approximately one-fifth of the variance in patient functioning, thus demonstrating the importance of family factors for seriously mentally ill patients' outcomes.

Dutton et al., (2000) in a study that explores the psychological distress of caring for a dying family member and examines the difference in depression, anxiety, health, social and occupational functioning, and social support among hospice caregivers and community controls found that caregivers reported experiencing higher levels of depression, anxiety, anger and health problems than controls. Hospice care giving was associated with deterioration in physical health and in social and occupational functioning. The comparisons between adult children and spouse caregivers revealed that levels of psychological and physical

morbidity were very similar for the two generation of caregivers.

Biegel et al., (1997) in their study examined the predictors of depressive symptomatology among 103 caregivers of persons with chronic mental illness. The research indicated that insufficiency of overall social support was the most powerful predictor of caregiver depressive symptomatology. In addition, higher level of burden was associated with greater levels of caregiver depressive symptomatology. Higher level of client behavioral problems and insufficient support from family members and mental health professionals related to the care giving role was more associated with higher levels of caregiver depressive symptomatology through their associations with caregiver burden.

Laidlaw et al., (2002) found that the stress levels and burden of caregivers living apart were similar to those who were living together with patients. Around 25% of both the groups met the criteria for having a mental disorder on General Health Questionnaire.

In Falloon et al., (1993) Buckingham study, caregivers' likelihood of having a mental

disorder was lower being found in only 10% of caregivers, perhaps reflecting that there was a caregiver support system in place and that less severe mental disorders were included. This variable can also be targeted by psychosocial strategies including communication and social skills training.

Prtoric et al., (2006) found that avoidance is a coping strategy that best predicts anxiety, and expressing feelings is a significant predictor of depression. The research strongly indicates that problems in family interactions are more associated and better predictors of depression than anxiety. Results show that the two disorders are distinct and that they are characterized by unique coping and family profiles.

Clark (2002) concluded that caregivers with low individual and family hardiness had more depression than those high in both resources. In a sample of 67 caregivers of disabled adults with high functional impairment, one-third of caregivers reported moderate to high fatigue, and 40% had scores indicating possible clinical depression. Individual hardiness was negatively associated with depression and fatigue; coping strategies did not mediate the relationship.



Piccinelli et al., (2000) found that adverse experiences in childhood, depression and anxiety disorders in childhood and adolescence, socio cultural roles related to adverse experiences, and psychological attributes related to vulnerability to life events and coping skills are likely to be involved. Genetic and biological factors and poor social support, however, have few or no effects in the emergence of gender differences.

Heru& Ryan, (2002) found that despite reporting significant amounts of strain and burden, caregivers felt that care giving was rewarding, 72% of the caregivers scored positively for depressive symptoms. Caregivers who reported poor family functioning had dysfunction in all areas of family functioning and were significantly likely to report depressive symptoms.

BURDEN: The deinstitutionalized movement which started in the middle of this century recognizes the detrimental effects of prolonged hospitalization, developments in psycho pharmacotherapy, psychotherapy and social treatments of chronic mental illness like schizophrenia. This gave impetus to the community care of patients. Treating the patient in the least

restrictive environment and consumer empowerment has made social functioning and social performance important concepts for patients as well as their caregivers. The concept of family's role in chronic mental illness has also undergone a dramatic shift from etiological agent to copier and responder with the care of mentally ill people at home being encouraged the family members feel an increased burden of care. However, comparatively few people have looked at the impact of the psychiatrically ill member on the rest of the family or how they cope up with their situation. The existence of a burden indicates the breakdown of reciprocal arrangement that people maintain in their relationships, such as one person is doing more than his fair share. Social burden as defined by Platt refers to the presence of problems, difficulties or adverse events which affect the psychiatric patient's significant others. While numerous definitions of burden exist in literature, all these share a common underlying frame of reference i.e. the problems related to or caused by the illness behavior of the patient which affect the family. Thus, Brown defines burden as the impact of living with a (psychiatric) patient on the way of life and health of family



members; and Pai&Kapur defined it as the difficulties faced by the family of a psychiatric patient.

PREVALENCE:The prevalence of caregiver burden has been described in multiple surveys. Results of a 1992 study by the Carers' National Association indicated that one of every two caregivers had financial burdens and two of every three were in ill health themselves (Dean, 1995). Other studies show that a large majority of caregivers have experienced fatigue, frustration, and stress as a result of care giving,(Stuckey et al.,1996; Dean et al.,1995) two third believe that care giving has put a strain on their marriage(Stone et al.,1987) and one fourth have felt despair as a result of the care giving experience.

SOCIETAL PRESSURES:An understanding of caregiver's perception of the burden, its impact, and his or her willingness to accept help is essential to the evaluation process. The caregiver's sex and ethno cultural background (Braun et al., 1998) often become significant factors in determining the extent of burnout. The "feminization of care giving," that is, the societal expectation that women will be

caregivers, has resulted in women providing care in over 75% of cases. The remaining 25%, male caregivers, are often inadequately prepared for the role. Cultural expectations also shape perceived responsibilities that affect help-seeking behavior (e.g., designating a specific family member as the caregiver and frowning upon seeking help from community programs or even other family members). Caregivers often are torn between satisfying these cultural and sex-related pressures and meeting their own personal needs.

CONCLUSION: The role of personality trait variation in psychopathology and its influence on the outcome of psychotherapy is a burgeoning field. However, thus far most findings were based on controlled clinical trials that may only poorly represent real-world clinical settings due to highly selective samples mostly restricted to patients with major depression undergoing antidepressive medication. Focusing on personality and psychopathology in a representative naturalistic sample of psychotherapy patients is therefore worthwhile. These include for instance the stability of personality traits in a heterogeneous naturalistic sample of

psychotherapy outpatients with diverse mental disorders other than major depression, the predictive validity of informant ratings of personality problems and how informant ratings of personality compare to corresponding self-reports. The influence of level of dysfunction has emerged to be non-significant. Disorders like depression and schizophrenia are perceived as adverse life events for the whole family, as nature of chronic mental illness makes it difficult to cope up with, by the caregivers. The interactional effect (group*dysfunction) revealed that caregivers scored markedly high on depression. Likewise, caregivers of depressives experienced more guilt than schizophrenics. This finding is in the expected direction since caregivers themselves feel guilty from the viewpoint of a family member suffering from group of disorder, regardless of sex.

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