Psychology of Everyday
Prof. Braj Bhushan
Dr. Alok Bajpai
Department of Humanities and Social Sciences
Indian Institute of Technology, Kanpur

Lecture – 11
Mental Health Issues of Adults – I & II

In 2015-16, The National Mental Health Survey output came into being. Today we are going to pick up some issues that emerge out of the National Mental Health Survey. Now we have Dr. Bajpai who happens to be a practicing psychiatrist. So, we are not going to discuss things that have to do with the textbook knowledge of any of the issues related to mental health. We would be categorically referring to what a practitioner who has been in the field for around 28 to 29 years.

Yes.

What that practitioner feels, so we would have some specific questions which would be responded to in light of the reality, actual hardcore clinical experience. Now, if you look at the National Mental Health Survey, it reveals that approximately 15 percent of the Indian adults, they need active intervention for one or more mental health issues. Now, considering the population of India if you consider 15 percent of the Indian adults that makes a very large number and the number seems to be extraordinary large, especially if you put it in contrast with the number of psychiatrist who are available to the Indian population.

Yes.

So, then it becomes extremely challenging. Second interesting aspect if you look at the WHO estimate, the global estimate of the WHO says that more than 300 million people that would be around 4.3 percent of the world's population, they have been identified to have experience depression. And similar estimate has been made for the Indians as well which says that 1 in 20 Indians, they suffer from depression.

Now, the government of India sometime back when it is started the national mental health program, it tried to take into account issues like life skill training, like counseling in educational institutions, workplace stress management, and the focus was also

exclusively on the suicide prevention measures. Now, these are the estimates one from the global agency, one from the Indian agencies; if you look at the hardcore journals of mental health in psychology or psychiatry, you will find all these estimates which you can even find it varying from year to year.

What we are interested in discussing today is what kind of a picture, the actual clinician gets from the clinic?

Right. I read somewhere in the newspaper about couple of years back where say that WHO was predicting by 20, 30 there will be 40 percent of Indians will have depression.

Now, once we use this word depression which is in popular woke these days right, there is lot of.

Rights.

Billion-dollar industry (Refer Time: 03:44) around it, we have mentioned this depression in the previous.

Sessions also in our conversation of how clinical differs from other depressions and all. So, we have to bring that back before we.

So, when these estimates come I some of the reports have read and I am sure when they are talking about depression, they are talking of depression as per the criteria given in.

The DSM.

The DSM or.

The ICD.

ICD.

So, even within that if you look at the clinical practice, which goes from say countries like India who use ICD vis-a-vis countries which use DSM. Sometimes there is a whole lot of difference in approach like some countries would use depression as a term, common term.

So, it is depression whether it is because of adjustment disorder because of something else or endogenous depression and it has to be treated with psychotherapy or.

They are not going to the finer nitty-gritty of what depression it is, some people really went to want to find out what type of depression it is, right.

So, when we get into that exercise, then probably I do not know what these estimates really mean.

Because if they are talking of endogenous depression only, I will mention detail what endogenous means, then obviously this percentages would go up, because we will add depression from the other type of depressions also. If they are talking of depression as a larger rubric within which everything is included, then probably these estimates should hold good right.

So, we would we would try to see it is out what exactly it means without getting into the statistics, because it can be misleading.

Yes.

Time depending on what criteria have we used.

What population have we used and as you correctly said, when I entered psychiatry for training in Nimhans in 1990, we were told there only 3000 psychiatrist which was true. Now in 29 years, it would have grown to 5000, 6000.

Yes.

But the population has grown.

1.5 times so it is still less, not to talk of train clinical psychologist and the miscellany branches and all. So, it is a direct street.

And that is probably one reason why if you look at it and our larger perspective, even medical clinics have 30 to 50 percent of patients, so come to they are actually having psychiatry diagnosis and I think it is fortunate, although it is not.

Logical that anybody can write psychiatry, psychotropic medicines.

A cardiologist can write, neurology in fact they do write, because as one of my cardiologist friends says that if we start referring all cases to a psychiatrist, psychiatrist will have to work 48 hours in one day.

So, which is fine as long as they are doing a rational pharmacology, but that apart that will talk when you talk of treatment in next session maybe. So, when people come and say I am depressed or the type of depression which is popularized in magazines, in newspapers, in workshops, in TV shows, I really want to know what type what depression are they talking of, because depression per say is a state of mind which is have the hallmark as a mood symptom. So, there first we should understand what depression is for the benefit of the audience and people who are attending in this course can actually teach other people also that is how awareness grows.

When you talk of depression it has 2 or 3 components, one component is essentially the core compete core symptom is of change in mood.

So, is it say long-lived state of sadness which many people classify as depression.

Or what clinicians will say as persistent sadness?

I will because this persistent and long-lived also will change the type of depression. So, what is important is a first should have a change in mood right, second, it can accompany with a certain set of thought processes and third bodily symptoms.

So, this thought processes will basically derail them from.

They.

Things which they were very masochistic about.

So, what actually happening sadness all of us know, but normally if you feel sad like in grief reaction for example, like an Elisabeth Kubler-Ross said that people go through grief all of us go through and there are certain stages which everybody has to go through that stage can large for 2 hours to 2 days to 20 days to whatever, but at certain point of time the grief itself can covert to depression.

So, the depression of grief is a normal phenomenon, losing a job normal phenomena, all of us get depressed, but the brain has this homeostatic capacity reorganizing capacity,

where the brain will bounce back. So, no sadness will remain for very long, no happiness will remain for very long. So, these states of mind keep altering as far as mood is concerned, all of us know that right.

But for some people with reason or without reason, it can turn into depression. Now, what are the situation which can cause depression, there are something called life events, everything is a life event actually, every life event has certain amount of weighted value of causing a certain amount of a stress that life event if most people suffer, they will land some amount land into some amount of mood change that we call adjustment disorder.

Which can be a brief depressive reaction losing a job, divorce, children going away, everybody feels that is a brief depressive reaction right. So, but sadness persist beyond the average change what it should be, self-limiting people bounce back, but the same adjustment disorder can lead to a prolonged depressive disorder also. So, duration you see it is actually does not matter.

Whether, so this is one type of depression. The second is what we use to call neurotic depression which we called as dysthymia is a low amount of depression and people continue to function and all these difference depressions vary from what we call endogenous depression, which is the part of recurrent depressive disorder, where people keep having episodes of depression with or without reason right. They can have once in a year, once in 6 months, many in a year or maybe with the gap of 3, 4 year they lot of variables in frequency and intensity or as a part of bipolar illness, which can people can have depression as well as.

Mania.

Mania. Now, what is the difference between this depression vis-a-vis this dysthymia or endogenous depression, I think it is a quality it is a qualitative difference. The qualitative differences is there is a pervasive sadness in endogenous depression, I am talking using the old-time terms, but they are the best to explain all this. Something which arises biologically like a switch on you can sleep well in the night and next morning you can get up you have depressive episode, people who have this depressive episode know it very well nothing makes them happy that sadness interferes in almost everything right.

Whereas in dysthymia or grief depressive reaction people have sadness, but they can still carry on with their activity and something, something gives them pleasure, something gives them some happiness so that is as far as boot component is concerned. The cognitive component the thought component ideas of hopelessness, ideas of worthlessness, guilt.

Right, dark future, so loss of interest that is pervasive sadness only, this can happen in all type of depression, but they are short-lived people still some hope or something makes them for sometime, whereas in endogenous depression this thoughts are they form a envelope under which all thoughts are push again complying to the pervasive sadness thing.

And the third is the disturbance in biological function psychomotor agitation or psychomotor retardation, which hardly happens in dysthymia and grief depressive reaction. We just do not feel like you just cannot get up and do things and you cannot do willful things. Sleep disturbance which can be on both ends either total lack of sleep or excessive sleep reverse virginity function, loss of weight in spite of normal appetite right. All this happens mostly in the endogenous depression, because endogenous depression is entirely biological thing. It can get precipitated by an external event, but still the quality of depression would determine.

Now, one can ask like lot of psychiatry what difference does it make, if it is depression you have to treat it, but it does make a difference because of the prognosis because of the future unfolding of the illness that is we have to tell the patient, we have to see the pattern. For dysthymia if you treat for 6 month they are out, they are out; there is no reason for them to go back to dysthymia whereas an endogenous depression depressive episodes will keep bouncing back, so patient should know.

Say if for the common man, who has to struggle day in and day out for his or her own survival.

Right.

Who finds life to be extremely challenging.

Right.

And despite their best effort, they still have to put in lot of hard effort to get the basic minimum in their life.

Right.

And this might be a source of sadness to many.

In fact.

Do you proceed as.

In fact, it is not.

It is not.

It is not.

Because people have human mind as huge resilience, otherwise if you look at the society often you will wonder how do people live in such scholar, poverty with so many problems, but most people are living. The very fact is the society it is still 10 percent by social political condition 20 percent should do it, but they are not that means, because they are not having an illness, because.

So, a common man can still be convinced that irrespective of the odds that one is experiencing in life.

Yes.

One is the situation does not make you vulnerable to depression.

Vulnerable.

It has only limited role.

Vulnerability all of us have because through the common genetic pool we all have inherited the same genes, if these are these are genetic illness, the endogenous depression is we also have it. The question is that we if we have a morbid risk of say 1 or 2 percent if nobody in my family has had depressive episode or what do you call a depressive spectrum disorder like alcohol, suicide, mood disorder, then I will still have a risk of

morbid risk of 1, 2, 3 percent, but if somebody in my family has had a illness that means, just like a genes getting activated.

Lot of these genes actually are silent genes by methylation or by epigenetics, they get triggered on. So, if my somebody if in my first-degree relative or second-degree relative has had depressive, my risk will go up to 18 percent, 20 percent whatever understand. But still why is the role of epigenetics important, because even as I said in one of the term monozygotic twins also do not have 100 percent concordance, from the same embryo they will have 80 percent whatever the statistics here that mean the some play of environment also.

So, if you have a illness and your gene is switched on you have it; if you do not have it, you do not have it, but that is why while I am talking of endogenous I am not talking of adjustment disorder. Adjustment disorder I think we have called it as illness, but it all depends on the dimension thing how much you suffer in face of a live event, how much you can now here something beyond secondary comes in.

What is your own resilience and coping strength, same set of see people who come to our clinic not if you look sit and watch people, sometimes we will wonder that I am also having similar problem, I am not taking medicine. Maybe and I am working and I am advising him and doing whatever, may be my mind in same situation has enough resilience to move on right, but in some other situation it may not be so.

So, everybody has is differential. So, depression then it begins it is not a homogenous depression which is an illness. So, psychiatric needs full of this range and it is a clasions duty to actually differentiate and tease this out, because if you do not tease out, agreed that the treatment is anti-depressant, but for how long.

When, what is going to happen, everybody wants to know that. Now, kid who has failed or is undergoing some academic problem; obviously, will be depressed to some extent, whether we call him having a mental illness, now this tendency which has increased over time to label I am not saying that do not treat it. Even if he is having a problem of living, problem due to situation is still we have to help him with same medicines, but a question is a medicine dosage time duration, whether the now a person who is having endogenous depression, no amount of CBT or anything works in the initial stage.

We know it from mild to severe right, we have to treat it, but a kid who is not study you can give some medicines some amount of therapy CBT. So, if so that means, psychiatric still remains at the same point, we have to learn to look at the whole person. Now, this common terminology which people use as depression I am sure it is not endogenous depression, because these terminologies have become very popular.

Especially this term is so generously used.

Right. If we relate this to I am pure depression you see endogenous depression rest all are mixed with the anxiety if you look at it, but we do not put a diagnosis of mixed anxiety depression on everybody. So, anxiety is qualitatively different is not it.

Yes.

Is the certain amount of restlessness, apprehension, certain agitation, certain. So, while sadness is like a dark cloud enveloping your mind temporarily, anxiety is the jumpiness which comes due to uncertainty.

Right. So, the people are not supposed to know, they cannot differential between what is anxiety and what is depression. So, often when people come and they say I am depressed, one of my teacher taught me this he used to ask this people what do you mean by depression, people will say they know English and internet, they will say anxious. So, it is always better to ask them, ask them what do you mean by depression, because his or her conception of depression may be different from what I am thinking as depression.

So, is it that substantial percentage of the patients who come to the clinic, they have found a label for their own would state and.

Yes, absolutely.

They call it depression.

Absolutely as I said 70, 80 percent people are having problems of living. Why medicalization of all this is happening is because that ease of treatment, 6 weeks of antidepressant you are out of it, but that does not mean that you have depression.

All of us need some amount of help at some point of time is not it?

That is true.

And even people who are treating need it at times.

In fact, psychology talks about different kind of resources.

Yes.

And when group resources are given utmost importance.

So, at the social level you have certain resources which are supposed to be exploited as and when some member in that community take a dip.

Right.

And the moment you dip down suddenly there this forces these resources gets activated, which will help provide helping hand and you are pulled out.

Religion.

Biggest of all.

That is true, this is.

Temples, gods.

That is true and besides there you have.

Suppose, you have a very close supporting system in your family for example, but that is given the fragility of human thought process, there is no guarantee that you will not have a conflict in the family.

You can have a conflict with spouse, your brother, mother, anybody.

That is true.

Especially in the country like India the chances are very high, because people live in almost the emerge relationship. So, if west is suffering from problems of loneliness, we are suffering from problems of godliness.

So, what happens when the support system which has been keeping you against lot of other odds, you get into this conflict, where do you go?

Also I think now when you have to the responsibility of maintaining a set of relationships at the same time, you also have the difficulty of.

Maintaining.

Maintaining stabilizers stability in the system.

Absolutely.

So, always there would be some degree of triviality that will come to your mind.

Yes. So, here comes in what the concept we are talking of normalcy and abnormalcy is last time (Refer Time: 23:43).

Is not it, lot of people actually come to psychiatrist or mental health professional or whatever and that is why they are not sure whether should take medicine or talk or whatever, they do not want to take medicine most people, they want to come and talk and find the solution, because they have reached the point of either exhausting their resources or the resources itself has gotten into conflict with them.

Right. And then they really do not know imagine of a imaginary take a imaginary hypothetical situation, god for example, they may be a god people (Refer Time: 24:26) does not matter. If your thought gets into conflict with god suppose and your mind says god is not there, where do you go. So, either you evolve aesthetic strategy for yourself, believe totally in rationality and all, but do this rational people never get depressed, do we have any data to suggest that I do not think.

In fact now if you look at the theoretical side of these things what different kind of model suggest is that whenever anybody in the world has life challenging situations. Life challenging situations would be situations which even has the capability of distorting your valuable leave system. So, your entire investment in a belief called god or entire say belief invested in a social system like say husband-wife relationship and mothers-child relationship. So, there might be life challenges when these basic components that you have defined and you so strongly hook to, it also gets challenge.

Absolutely. So, it is like your whole brain network which are formed.

They just go in a sort of unpredictable collapse which is you your mind does not know.

What do you do then.

So, great degree of indecisiveness things that your banking upon suddenly you realize (Refer Time: 26:05).

No more there.

No more there

And so emotional brain has to respond to as I said, you also said in the past lecture, as what is the essential function of the brain to help to survive, it does not want you to get extinct although knowing very well that. So, sadness I think it is a lot of this illnesses have been a productive mechanism.

And why do you think so?

Because all of us know what sadness is, assume you.

Also know, I also know it. When you become sad actually, you do less you actually.

So, your active engagement reduces.

Active engagement reduces. So, at best you will not be versioning the situation further.

Right. So, what is the biggest risk in depression suicide. Suicide, so when even sadness is not able to settle you down right, then what you doing do something then your ideas of hopelessness may push you to doing things.

Which may cause a reparable dimension.

So, self-harming tendency as to be change.

Self-harming tendency, aggression, aggression can happen in depression-like lot of kids they do not know what depression is, they become very aggressive. Lot of conduct problem is secondary to emotional disorder, which people do not realize.

When I tell parents that the kid is actually if you want a term for it, is undergoing emotional disorder which is depression, this is how can be depressed, how does a kid does, he internalizes it and it becomes aggressive or all that jumpiness. So, nature I crocodile does he get depressed.

No, we do not know.

That dog may be, horse may be that means, as emotional brain is started developing over time it would have if we were talking of theory evolution, then it would have slowly find tuned these emotions and they would not have come in one day. Find tuned is emotions against the external environment in survival. So, you let us try to because we are talking to for common people in day to day life is there a creative use of depression. I personally think that if you look at the whole you know this common myth of madness related to creativity and genius, this is a common myth. It is a myth nevertheless, I do not know whether most people who are genius really have bipolar, some of them we know they had right.

But then let me give you an example, may be within next just continuing this if you look at lot of poetry and one of the prime examples of this poetry is. So, anyway we will talk of this prime example which comes to my mind is look at this Urdu poet Ghalib, he had alcohol problem right. Lot of this poetry, lot of this Urdu poetry if you look at it, talks of the huge amount of pessimism in it, but in that same pessimism it gives a new dimensions of thinking.

Do you consider that it is a pessimistic say collection of words with pessimistic ideas or is it like say life philosophy, which of course is not on a illiterate state, most of things now when.

Agreed.

You go to the philosophical state.

Agreed.

You do not have that illiterate state of mode.

Agreed.

And most of the poetry was also.

Same with mythology also.

That Indian mythology, Indians is always up build they always talk of evolution and nirvana and positivity to get moksha and all that.

Where is if we look at the western (Refer Time: 30:43) philosophy, it will always with some pessimism. Now, if we consider this as normal, obviously the sadness in it.

So, this same amount of sadness in a individual what does it becomes a illness.

In fact, see like those of us who have that interest in poetry, say like I love to listen to Ghalib's a poetry. Now, I understand that if you go by a hard core classification is the state of sadness which is being represented, but when I hear it, it does not give me a state of sadness which gets induced in (Refer Time: 31:25) it gives a different kind of peace, serenity.

Because it is philosophical.

Because it is philosophical.

So, it takes off your sadness.

But I am talking about the mind which was creating it.

In what emotional state that mind was creating.

This lines.

This lines. So, in happiness lot of things got created.

But happiness itself we know is not a very sustained state.

But.

If you look at the one the students ask the last time whether, why we are chasing happiness.

Right. Probably it is the brain mechanism which are doing it, brain as to bring to it homeostasis, the brain itself does not like that dysphoria the not feeling comfortable and more or less the societal stuff also. If you are sitting quiet see the number of people who would come and ask you, why are you so sad, why are you so sad, there may be days when I do not want to talk, there may be days when I am feeling sad I am private. Now, we go back to what you are asking when we talked of it about 2, 3 talks back what was the concept of normal see and this and that the traditional thought never not asking you to get to happiness and all that.

They are asking to bear this, because probably what was Gautama Buddha saying , he was telling to detach from all these allow these things to come and go, but we are living in a age where there is a lot of premium on happiness, premium on being politically correct, a premium on your best performance, so that expression of different mentally states is not so freely allowed.

So, let me give an example in clinical practice we often I get youngsters who are not studying well, may be they having some problem which is fine, they will find out (Refer Time: 33:38) with some help and all that, but people want a label for it and they want to guaranty that whether you will get or not, now I find it very difficult to answer what we will get ok; first you have to define what is ok, right.

So, I look at depression as different way some psychiatrists may agree, some may not agree although we treat everybody who comes to us, but a pure clinical depression when I am say clinical, I mean endogenous depression is a breach in the continuity of a mood state with a entirely different mood state, rest all are variations which goes slightly (Refer Time: 34:16) slightly out of control.

We treat them in anti-depression, we treat them in cognitive behavior therapy, we treat them, but they should not be taken as something some sky has fallen, because people also have to be taught, especially sitting in a country like India where the sources are limited in the population is must that these type of struggles will happen. Something comes we have to try to get out of it, do the best it is like cricket now, you have to you missed out the shot.

Keep chasing, keep chasing the target.

You have to hit the next ball, what you do some ball you will bold out that is alright, but you have another inning to play. So, people should be when they go to a doctor what they should do is tell them their problems not get too much of labeling into them that, because this these are also autosuggestions. If you keep telling yourself that I am depressed, mind is very mind need just mind just needs categorizations.

So, the brain has is very bad habit neuroscience also almost knows it now, what is the brain doing it is taking all data inside a very millions of data points and as it grows up in time scale right from 0 to 500 milliseconds, what is doing it is throwing of the thing labeling it with covering it up with emotions, comparing it with past memory, evaluating it on threat value and then forming a new dimension and presenting it to conscious brain. So, right from million data point it has to categorize input, otherwise brain does not categorize everything than nothing matters not even psychiatry; if everything is fluid, what does it matters.

But then it makes the individual in a mood state which is more chaotic, which we cannot bear.

Which our mind does not bear.

And therefore, we need to do this.

So, brain does not want uncertainty. So, it has to keep doing something which we will give you certainty, whether that certainty in itself means anything or not is a philosophical question; what if you get it that is a philosophical question. For most people they have to live in the world and keep so best of the mind so just flow.

I wanted to take you back to poetry and sadness.

Yes.

Psychology says that when you adverse experiences of life and if you are successful in sublimating it, then you come forward with creative outcomes like poetry.

Right.

So, your own lived experience which was not so happy instead of making you sad or depressed makes you creative and your entire life experience mixed with life philosophy.

Right.

Gets spend down in the form of a poetry, which derives lot of appreciation from others.

Yes.

And your own sadness when you relook at it in terms of the output that it has yielded, you also feel happy about it.

So, you means so what you are essentially saying that all art whether its poetry or anything has to true art not, the copying.

Not the copying part.

Has some angst in it that angst is very important, otherwise I mean you just so may be once what I think is a poets, they may be creating this out of sadness, but once they are able to write it in separate it from them, then the look at it objectively.

And then the philosophy emerges.

So, is there a possibility for a common man say like concept of right now we were talking about know group resources.

Yes.

People who are of the habit of talking about their problems with others.

Right.

Or people who have other mode of disclosure, like.

Yes.

Maintaining a diary.

Yes.

Or even going to a place of worship and narrating the problem to the god or in certain religion where you have an option of a confessing it to priest or somebody in the place of worship.

So, whenever you have an option of self-disclosure, is it that those people.

No, it helps.

Those people are likely to manage their episodes of psychiatry.

I think there are plenty number of studies where people say loneliness increases depression, increase the risk of cardiac thing, those are the physical sequelae of all that. Disclosure sharing that is all human mind is homosapien at least are social animals not by social definition, they by biological definition otherwise mirror neurons would not have existed, empathy would not have existed.

If you see somebody crying or child falling, you cry; it its very simple, you see the Nazi films the film made on all the holocaust, why do you cry there, we have not been to Germany unless it was a previous birth.

We do not know.

So, I feel very bad when I see that all of us cry, imagine schindler's list or take any film or see the atrocities on black people or see little bit stuff which has been made on partition right. So, all your questions about why partition happened, why people killed each other are all intellectual question which come later, first this is lump in the throat.

And that is why if you hear of somebody having cancer this that, you feel bad.

Why? You are not having cancer, but we still feel bad. I think that is a common share of emotions which the whole humanity has. So, understanding philosophically is part two of the story.

Coming back to your clinic, when you come to see different age group of patients suffering from various kinds of depression usually what is this spread the youngsters, the adults?

I will actually do with child adolescent, but nobody can purely practice that because of the crowd and all. So, I get lot of youngsters and kids are normally brought by parents and all that. But I get lot of teenagers from school to even to institute like IIT and

medical college and all. Too young adults 35, 40 that the huge spread of this people towards the end who towards old age who come are either having a late onset biological depression or maybe some social psychological causation of the whole thing. Out of this again as I said they maybe 10-15 percent which is the statistics who are having recurrent depressive disorder and all, but most people are depressed because of the life situations, and then not able to find out of way.

Now is not finding out of way, is not that there are no ways let us be very clear. Is not that there are no ways, but again as I just said this is a societal thing. In our times the stakes are very high say 100, 150, 200 years back last time this kid was asking whether they were right at that, it is not about question they were able to live they were anxieties always, they were depressions always, but the phase of life were slow.

And I remember when we were kids in 60s, 70s and all that, it is something happened wonderful. If it did not happened, you feel sad and move on largely is not it, but that is gone now. So, people put things at stake. And when that does not happen there mind will go into a sort of sudden heightened anxiety or depression. And then the mind see what is the problem with this mind states, there is no problem actually it is a mind state, it will go off.

The problem is in that mind state, your brain stops seeing alternatives right, when brain stops seeing alternative, obviously, your action becomes limited. Because it just wants to go in a certain way. See what happens when people fall in love and they are not allowed to marry and all, they are common situation in India, is not it. I get girls being brought by parents, they will say please tell her not to marry that boy, and are somebody separated because in love is and love I think is the nearest psychological problem to any illness.

Their mind is not able to see a life without the other person.

Is not it?

Even when we know it is a dopamine surgeon after sometime it will go down and that is why people will come and say here nobody comes alone unlike US and Australia, there family is. You have been trying to explain so no amount of explaining works. Even if intellectually the person may be understanding, but emotionally what is your emotional brain is just firing, because for the emotional brain it has become a matter of survival.

So, logical thought can be wrapped up in a negative emotion, and then all logic will work towards that.

And which age group of patients usually demand less of medication and more of.

Youngster.

Other kind of.

Youngster, students, they can. It is easy for us to talk to them. And once they make a repo, their show that you are trying out to help them, there will be slightly more demanding also. But again pure medication works only for endogenous depression. Because you have to tell kids that you have to take a little bit of medicine, still if they are having a problem, make a timetable, go and study, talk it out, hang out with friends and all that, you have to tell kids.

You have to tell a young girl of 20, she has a problem. And you see the problem some solution will emerge, something will happen the world. So, what during that time, you have to just sustain them to hang out, distract yourself or if there is exam after 1 month and you are not able to study, what is the option you go and study.

I have two more questions to you. We do not as I said in the beginning we are not going into hard core textbookies kind of analysis here.

Right.

Textbooks will serve that purpose.

Right.

But just for the purpose of enlightening others and the self. In psychology, there is lot of investment in terms of assessment of the clinical picture. With respect to depression also there are large number of tools both which are western tools, adapted tools, in fact, indigenous tools are also available. How frequently are these tools used in actual practice?

Nobody uses, nobody has time in first place. And people want to use may be, but use all the data finally for research thing.

So, that is the reason I ask you is it that.

Also.

There is a disconnect between the academic side of.

The academic side of psychology, the psychology, psychiatry, all these a emerged from psychology in psychiatry also have a pressure of proving themselves to be scientific.

Yes.

Nobody accept them as scientific because the same English or whatever languages being used by people who were nonscientific spiritual gurus of chaos. So, poet may actually heal you, good novel can heal you, people find more soulless from war and peace reading from Gandhi. So, psychiatry and psychology are under tremendous pressure to be absorbed into sciences unfortunately, because the moment you do it you are getting into a reductionist approach. All these stuff is just to prove and categorize the mental phenomena as in to mathematics and physics. Even mathematics and physics are not complete right, those are no mathematic there no Godel's theorem, so they are hidden variables.

Physics whatever we know, but physics also takes a full cycle in goes to quantum where it is not known, nobody, nobody can visualize what quantum is. What we know is the mathematics of quantum. And based on mathematics technology has been done. So, this time psychiatry and psychology are under tremendous pressure. So, everything has to be classified everything has to be on a scale. Doing this will cause this; living lonely will cause this, but none of these things trust me and I am not saying that one should not study psychology, we should study someday we will know that,

Now, we are attempts to make the budding researches.

Yes.

Understand that there is right as of now there is a disconnect between the practice.

Yes.

And academic read of depression.

That is because of this because when you use a reductionist approach, if you try to convert it to clinical, clinical is not working on the reductionist approach, because there is no causes known. Ultimate reductionist approach will be knowing the causes, causes we do not know. When even when we give serotonin reuptake inhibiters or dopamine blockers which treat, but if you ask any offers can you just measured it and quantify, we do not have a way of quantifying it right, we are in a situation, so that is a disconnect.

The other disconnect is that brain although we are trying to do it with imaging with neurophysiology with models based on mathematics and physics, and but overall how that the brain really creates this complex wave of thinking and all is we do not still do not know. Where is the mind placed. And I think audience who is listening to us should answer this, where is your mind, inside your head or outside your head.

Because if it just inside your head, then why are we getting we are so entangled with external world, because your mind itself the network of the brain itself is formed with external influences. So, it is totally embedded in context. So, brain functions like this. We are trying to define the natural processes of brain through psychology. Psychiatry is trying to deal with illnesses what we call illnesses in our times someday, someday we may prove with this nothing called depression.

So, that is the disconnect. And psychology is evolving on cognitive behavior therapy and behavior modification based on your the description by psychology actually, not going description of psychiatry trust me. If you just try hard and think, what therapy has been evolved based on the psychiatry description.

Cognitive behavior therapy, then cognition and behavior have been described by psychology or not psychiatry right. If you try to modify behavior you already knew behaviors, a dog's behavior does not know psychiatry (Refer Time: 51:10).

In fact Turning theory know came much early.

That is what I am saying.

That is true that is true.

So, I think the disconnect happens in the natural process of psychology and psychiatry.

And also as you said you know there is some degree of compulsion because the demand supply ratio is disproportionate.

Or for example, take Rorschach test or thematic apperception test, what is the basis, the basis is I think it all came from (Refer Time: 51:42). He was talking of psychology on the brain processes placing the whole complex aberrations into psychiatry. Psychiatry has huge influence of (Refer Time: 51:58), they may be agree or you may not agree. Now he is proven being proven right also because neuroscience is saying half of it is unconscious. Well, cognitive theory is when they came, they over through (Refer Time: 52:09). Am I right?

But neuroscience is saying 90 percent of the process are unconscious.

But I think you know this is just a process of evolution of thoughts.

Exactly.

In any stream of knowledge.

Exactly that is the disconnect is because of this. If you look at the (Refer Time: 52:27), where do finds all the in that.

Let so, you do not find.

We do not find.

But look at the other problem, all of the neuroscience is and I mentioned this in my book also, all of the neuroscience is still is deriving definitions from psychology only and trying to find that out, psychology side emotions. So, psychology when it said emotions, it took it back 5000 years into epics and to neuroscience. Psychology changes inside the nothing call emotion. What do you do all the depression will vanish. So, what I am saying this is all working definitions in one way of the other.

So, what we are communicating to the audience is that ok, different disciplines and approach adopted by different discipline, it has the meaning, but as of now we do see disconnect.

We should but that does not mean that interdisciplinary work cannot be done because ultimately if you are in a clinical setup, whether you are in clinical psychologist or psychiatrist the ultimate purpose is to find device the best possible mode of helping the person was come to you. And depression is the key example. The other example which almost connect to depression is anxiety.

Now, anxiety can happen because of lot of things right anxiety goes by the Yerkes-Dodson curve which the inverted you. Some of you may know it. A little bit of anxiety profiles you to act. The same anxiety becomes too much incapacitates you. As a students for students in if you have an exam, obviously, you have to have some anxiety, otherwise you will not study. Am I right?

But after you studied, good or bad and you sleep well, go and you see the first question you get some bit of anxiety you do not know the answer. So, concentrate more move on to the second question, you may not be able to do the first one that is alright. But if your anxiety becomes so much on the first question itself that it just blocks your mind, because anxieties also abnormal mental state. The brain starts like (Refer Time: 54:54). And it reaches the point where your mind just your reading the second question, you not able to understand, you hands a stuck troubling mouth goes dry, sweating that is almost a panic attack all right, then that anxiety is bad. So, there is always a good stress and there is a bad stress. Bad stress.

In fact, answer it you know describes it you are use stress and distress.

Use stress.

Use stress is a positive side of stress, and distress is the.

Negative side of.

Opposite side of distress.

Come. So, this is a normal variation in life, but you do not treat the good stress, you teach people to handle that we all know. And you have to treat the bed stress through medicine, through relaxation techniques, through behavior techniques. But there is a third situation also is something called panic attack. What is panic attack suddenly that your mind will go into a state where you will feel like as if your dying, your choking,

your heartbeat going fast all that will happen is the self-limiting think it will go on and settle down, but in that if you go in jump in a panic state, you will die.

But nobody dies with the panic attack. Now, this panic is state can accompany sudden situations where it becomes a phobic disorder. Phobia by definition is a irrational fear of a situation that can be imaginary. Like if you go to height, your mind starts anticipating or even if you have a phobia for height you sit and your mind will start think of height, your mind will go into an anxiety that is one of the treatments also right.

Exposure in (Refer Time: 56:44).

Right. So, given that, so this is a whole range of an anxiety think normal anxiety, heighten anxiety, panic attack. Panic attack is to 30 percent people can happen on its own without any trigger. Now, whether this some internal trigger thought or something which actually takes off and then causes it or it just happens on it own, we have to the person is unable tell most of thing. Some people are very clearly able to tell that we go to a market and a mind becomes like this. There are phobias with panic attack, phobias without panic attack, or phobias illness. Again some phobias are blood phobias is genetic thing, social phobia is a genetic thing, market agoraphobia where people feel that the whole market is closing down on the that is a genetic thing.

But one kids are developing the certain fears which are natural fears. First fear which kids know is fear of depth there has been a experiment with make a.

Check it ground where suddenly at certain point of time the depth appears although the ground is flat, the kid will go and stop there right, darkness snakes. But most people when they grow their mind as they learn, they get out of this fear natural fears.

Then there is a condition fear you are not afraid of dog, the kids will play with dogs mothers will shout on bite or somebody will bite. So, that dog and fear depending on what emotional intensity it is will turn into a phobia. But we normally ignore all these things and keep moving, but in the states of dire thing crisis it comes up. So, that so many fears in which humans minds live.

So, let us in the next.

Right.

Discussion let us take of these issues.

And talk about them at depth.

Maybe look at it some illness which are normally termed in anxiety and probably try to tell people what this maybe pick up some illness and all right.

Thank you.