

# PSYCHOLOGY

## Psychology Units 3/4

### The Nervous System

*The roles of different divisions of the nervous system (central and peripheral nervous systems and their associated sub-divisions) in responding to, and integrating and coordinating with, sensory stimuli received by the body*

- Know the diagram
- CNS: brain processes sensory info; spinal cord connect brain to PNS, receives sensory info from PNS and send to brain, receives motor info from brain to various parts of body
- PNS: entire network outside nerves in CNS
- Somatic NS: initiates skeletal movement (voluntary), carries sensory and motor info
- Autonomic NS: self-regulating/ automatic (not under voluntary control); regulates muscles controlling organs
- Sympathetic NS: increases activity in high levels of emotions/arousal, triggered by stressor, FFF
- Parasympathetic NS: decreases activity, calms body after action, dominates most of the time

*The distinction between conscious and unconscious responses by the nervous system to sensory stimuli, including the role of the spinal reflex*

- Conscious response to a sensory stimulus is a reaction that involves awareness and is voluntary
- Unconscious response to sensory stimulus is reaction that doesn't involve awareness (voluntary and automatic)
- Spinal reflex: unconscious, involuntary response that occurs automatically to certain stimulus, without any involvement of brain eg. touching something hot; allows for faster reaction time in potentially harmful situations; pain is experienced when brain processes and after hand has been withdrawn

*The role of the neuron (dendrites, axon, myelin and axon terminals) as the primary cell involved in the reception and transmission of information across the synapse (excluding details related to signal transduction)*

- Neuron is an individual nerve cell that is specialised to receive, process and transmit info to other cells in body
- Dendrites: extensions of a neurone that receive info from other neurons
- Axon: single extension that transmits info to other neurons or cells

- Myelin: white fatty substance insulating axon to promote efficiency and prevent interference with other neurons
- Terminal buttons: small structure that secretes neurotransmitters which carries chemical message to other neurons
- Synaptic gap tiny gap between dendrites of one neurons and the terminal buttons of other neuron where communication occurs

*The role of neurotransmitters in the transmission of neural information between neurons (lock-and-key process) to produce excitatory effects (as with glutamate) or inhibitory effects (as with gamma-amino butyric acid [GABA])*

- Neurotransmitters are chemical substances product by neuron carrying message to other neurons or cells
- Excitatory effect: stimulating post neuron to fire/ increase likelihood of firing eg. glutamate
- Inhibitory effect: prevent post neuron from firing/ less likely to activate or fire/ neural message less likely to continue to be transmitted eg. GABA
- All neurotransmitter have different shapes and when released into synaptic gap, just connect to dendritic receptor with same shape (lock and key process)
- Substances decreasing receptiveness of dendritic receptors to particular neurotransmitters are known as 'antagonist'
- Substances increasing receptiveness of dendritic receptors to particular neurotransmitters are known as 'agonists'

*The effects of chronic changes to the functioning of the nervous system due to interference to neurotransmitter function, as illustrated by the role of dopamine in Parkinson's disease*

- When neurotransmission goes wrong
- Parkinson's disease: neurodegenerative disease; loss of neurons in the substantial nigra responsible for producing dopamine thus reduces amount of dopamine being produced (dopamine carries messages to primary motor cortex on how to initiate motor movements); thus receives less messages and uncoordinated movements
- Symptoms: tremors, muscle rigidity, balance issues, slowness of movements

## **Stress**

*Sources of stress (eustress and distress) including daily pressures, life events, acculturative stress, major stress and catastrophes that disrupt whole communities*

- Stress: state of physic and psych arousal produced by internal or external stressor perceived by individual as challenging or exceeding ability to cope
- Stressor is a stimulus that causes stress

- Eustress is pos such reposes to stressor eg. enthusiasm
- Distress: neg psych psych response to stressor eg. anxiety or anger
- Both are high arousals governed by sympathetic NS
- Sources of stress:
  - Daily pressures: everyday little problems
  - Life events: major change in life/ alter way of life/ can be pos or neg
  - Acculturative: moved to completely new culture and trying to adapt to new culture
  - Major stressor: terrifying event for everyone involved eg. car accident, robbery
  - Catastrophe: widespread damage and distress across entire community eg. Black Saturday

*Models of stress as a biological process, with reference to Selye's General Adaptation Syndrome of alarm reaction (shock/counter shock), resistance and exhaustion, including the 'fight-flight-freeze' response and the role of cortisol*

- FFF: involuntary, physical, automatic response to stressor which we interpret as threat to ready body to fight or run from stressor activated by SNS (adrenaline and noradrenaline released) short term
- Freeze response: can't fight or flight/ really overwhelming, occurs when both SNS and PNS in states of high arousal and battling for dominance
- Cortisol: long term management of stressor
- HPA axis: hypothalamus stimulates pituitary gland and stimulates adrenal glands to try and deal with stressor
- Energises body allowing it to better deal but can reduced efficiency of immune system (high level of cortisol in bloodstream)

### GAS

- Stage 1: alarm reaction: first encounter with stressor  
 shock: ability to deal with stressor decreases below usual levels  
 counter-shock: adrenaline or cortisol being released into bloodstream
- Resistance: ability to deal with stressor rises above normal/ sickness may occurs at the end
- Exhaustion: extreme fatigue and extreme sicknesses
- Strengths: links stress to disease, clear 3 phrases common to all stressors, incorporates exhaustion stage
- Limitations: assume all have same response, doesn't take into account cognitive viewpoint causing different reactions

*Models of stress as a psychological process, with reference to Richard Lazarus and Susan Folkman's Transactional Model of Stress and Coping (stages of primary and secondary appraisal) Lazarus and Folkman*

- Primary appraisal: judge significance of event e.g.. is it important, will it effect me? Is it irrelevant, positive or stressful?  
If stressful, determine whether harm/loss, threat or challenge (development/growth)  
Secondary appraisal: judgement of ability to cope with stressor  
Have the resources to cope (no stress) or don't have the resources (stress)
- Strengths: takes into account individual differences eg. encountering a spider, active rather than passive role
- Limitations: difficult to tests, often undertaken simultaneously (appraisal stages)

*Context-specific effectiveness, coping flexibility and use of particular strategies (exercise and approach and avoidance strategies) for coping with stress*

- Context specific effectiveness: coping strategy matching stressor eg. stressed for exam would be to study but after exam would be wishful thinking/ sleeping
- Coping flexibility: how well individual matches strategy to stressor/ changing strategies if necessary
- Exercise: produce beta endorphins to promote relaxation and wellbeing
- Approach strategies: confront and deal with source of stress eg. seeking help
- Avoidance strategies: distant self from stressor and deal indirectly with it eg. wishful thinking

### Tips

- Understand different divisions
- Know how neurotransmitters work and explain lock and ket process/ difference between agonist and antagonist
- Understand three stages of GAS
- Know difference between primary and secondary appraisal

### **AOS 2: Learning**

*Neural plasticity and changes to connections between neurons (including long-term potentiation and long-term depression) as the fundamental mechanisms of memory formation that leads to learning*

- Neural plasticity: ability for brain to change itself over time
- LTP: strengthening of synaptic connections over time enhancing communication
- LTD: decrease in strength of synaptic connections when connection is not used often

- Physiological changes: LTP increases neurotransmitters production and more dendritic receptors whereas LTD less neurotransmitters and less dendritic receptors

*The role of neurotransmitters and neurohormones in the neural basis of memory and learning (including the role of glutamate in synaptic plasticity and the role of adrenaline in the consolidation of emotionally arousing experiences)*

- Neurohormones: same as neurotransmitters but realised into bloodstream as opposed to synaptic gap and is generally faster eg. adrenaline can be both
- Glutamate excitatory which enhance neural transmission and plays crucial role in synaptic plasticity promote growth and strengthening of neurons LTP
- Consolidation: process of making new memory after learning; adrenaline can enhance consolidation of long etc emotional memories/ more likely to be remembered

### 3 Types of Learning

*Classical conditioning as a three-phase process (before conditioning, during conditioning and after conditioning) that results in the involuntary association between a neutral stimulus and unconditioned stimulus to produce a conditioned response, including stimulus generalisation, stimulus discrimination, extinction and spontaneous recovery*

#### 1. Classical conditioning

UCS: produces AUTOMATIC response

UCR: involuntary response

NS: does not produce predictable response

CS: once classically conditioned NS

CR: learned response produced by CS; similar to the UCR but produced by CS alone

Before: UCS MAKES UCR

During: UCS+NS=UCR

After: CS=CR

- Acquisition: overall process during which person learns to associate NS with UCS and NS should be produced half a second before UCS
- Stimulus general: tendency for another stimulus similar to CS to produce response similar to CR
- Stimulus discrimination: only respond to CS
- Extinction: slow decrease in strength as UCS no longer presented with CS
- Spontaneous recovery when CR reappears when CS is presented after extinction, CR tends to be weaker than original

Little Albert

#### Ethical issues

- Informed consent: mother didn't know they were creating fear response
- Withdrawal rights: suffered from clear distress but still unable to withdraw from experiment

*Operant conditioning as a three-phase model (antecedent, behaviour, consequence) involving reinforcers (positive and negative) and punishment (including response cost) that can be used to change voluntary behaviours, including stimulus generalisation, stimulus discrimination and spontaneous recovery (excluding schedules of reinforcement)*

## 2. Operant Conditioning

- Consequences of behaviour determines likelihood of reoccurrence
- Antecedent: stimulus that prompts behavior
- Behaviour: VOLUNTARY but not in CC
- Consequence: affecting likelihood of whether behaviour will be performed again
- Reinforcement always strengthens behaviour, more likely to be carried out in future  
positive: apply something positive; negative: taking away something unpleasant to strengthen behaviour eg. taking Panadol
- Punishment: always decreasing likelihood of behavior
- Positive: adding in something to weaken behaviour eg. running extra laps; response cost/ negative: taking away something pleasant to weaken behaviour
- Stimulus generalisation: correct response made to slightly different antecedent
- Stimulus discrimination: only performing behaviour to original antecedent stimulus
- Extinction: continually not reinforcing correct behaviour
- Spontaneous recovery: producing correct behaviour to antecedent stimulus again after extinction

Voluntary in operant: Active

Involuntary in CC: Passive

*Observational learning as a method of social learning, particularly in children, involving attention, retention, reproduction, motivation and reinforcement*

## 3. Observational Learning:

- Learning through model's behaviour and using the consequences of their behaviour to guide their own behaviour
1. Attention: pay close attention to model's behaviour and consequences
  2. Retention: remember behaviour that wants to be reproduced
  3. Reproduction: mental and physical ability to perform behaviour
  4. Motivation: motivates or desire to perform behaviour
  5. Reinforcement: influences motivation in future (vicarious or self or )

*The 'Little Albert' experiment as illustrating how classical conditioning can be used to condition an emotional response, including ethical implications of the experiment*

### Bandura: Social learning

- If a person sees a model being reinforced for aggressive behaviour, they are more likely to be aggressive themselves
- If a person sees a model being punished for being aggressive behaviour, they are less likely to be aggressive themselves
- Boys generally more aggressive than girls

### **Memory**

*The multi-store model of memory (Atkinson-Shiffrin) with reference to the function, capacity and duration of sensory, short-term and long-term memory*

- Know the diagram
- Sensory memory: detects all sensory information (iconic and echoic)
- STM: if pay attention to sensory memory and temporarily stored aka. working memory with duration of 15-30 seconds and 5-9 items
- LTM: encoded STM
- Implicit: retrieving without awareness such as procedural memory (motor skills) eg. ride bike, cc memory eg. fear responses
- Explicit: retrieving with awareness such as semantic memory (facts and knowledge) e.g.. definitions, episodic memory (experiences or events) eg. 21st bday party
- Hold unlimited amount and hold potentially forever

*Interactions between specific regions of the brain (cerebral cortex, hippocampus, amygdala and cerebellum) in the storage of long-term memories, including implicit and explicit memories*

- LTM stored all around cerebral cortex
- Long term explicit memories are distributed through the cerebral cortex (episodic and semantic) in the cortex where the relevant info was first processed eg. visual processed by occipital and sounds stored in temporal
- Hippocampus: consolidating long term explicit memories/ not involved in implicit memories and doesn't store any LTM
- Amygdala: involved in the formation of emotional memories; attaching emotional info to memories
- High level of adrenaline released when emotionally aroused and more likely to be remembered in future



- Release of noradrenaline in amygdala signal to hippocampus that stronger encoding is needed
- Cerebellum storing of implicit memories

*Methods to retrieve information from memory or demonstrate the existence of information in memory, including recall, recognition, relearning and reconstruction*

- Recall: reproducing info that is stored in LTM eg. short answer question
- Free recall: not given any cues or required to recall in any order
- Serial recall: involved producing info in order in which it was learnt
- Cued recall: involves use of cues
- Recognition: identify correct info from amongst alternatives that include incorrect info eg. MC questions
- Relearning: learning info again that has been previously learnt, most sensitive retrieval method

*The reconstruction of memories as evidence for the fallibility of memory, with reference to Loftus' research into the effect of leading questions on eye-witness testimonies.*

- Memories can be reconstructed over time
- Loftus: leading question contains some correct answer so memories become reconstructed to include that information
- Eye-witness testimonies: inaccurate and not as true as we think it is

*The effects of brain trauma on areas of the brain associated with memory and neurodegenerative diseases, including brain surgery, anterograde amnesia and Alzheimer's disease*

- Anterograde amnesia: unable to form new long term explicit memories after trauma occurs; -DAMAGE TO HIPPOCAMPUS (encodes new explicit info)
- Damage to amygdala: may not remember emotions associated to memory
- Cerebral cortex: varies depending on which part of cortex is damaged
- Cerebellum: loss of conditioned motor responses or reflexes
- damages to certain brain structures
- Alzheimer's Disease: death or deterioration of brain trauma which causes memory decline, gradual loss cog and social skills and personality changes
- An accurate diagnosis can only be made AFTER death detected through autopsy



- Shrunken brain, build up of amyloid plaques, build of tangles, low level of acetylcholine (4 symptoms shown in autopsy shown in someone with Alzheimer's)

*The factors influencing a person's ability and inability to remember information, including context and state dependent cues, maintenance and elaborative rehearsal and serial position effect*

- Context dependent cue: Environ cues triggering memory, more likely to recall certain memory in the same enviro it was learnt.
- State dependent cue: individual state in which knowledge was learnt is more likely to be recalled in same state

### Serial Position Effect

- Better for start and end of list as compared to middle of list
- Primacy effect: items at start of list more likely to be rehearsed and move to LTM
- Recency effect: items at end of list still present in STM thus more likely to be recalled when reproduced immediately

Classic question: How does serial position fact support multi-storey model of memory? state primacy and recency effect in relation to LTM and STM

Maintenance: repeating over again; increasing duration of STM

Elaborative: link new info to info already in LTM to increase

### Tips

- Memory is heavily examined on
- Practice using scenarios
- Pos and neg reinforcement
- Know model of memory well

### **Consciousness**

*Consciousness as a psychological construct that varies along a continuum, broadly categorised into normal waking consciousness and altered states of consciousness (naturally occurring and induced)*

- Varies along a continuum from total awareness to total lack of awareness; always lie somewhere on continuum at any given time
- NWC: any state associated to being awake and aware of surroundings
- ASC: noticeably different to NWC less aware and alert (naturally or induced eg.drugs)

*The measurement of physiological responses to indicate different states of consciousness, including electroencephalograph (EEG), electromyograph (EMG), electro-oculograph (EOG) and other techniques to investigate consciousness (measurement of speed and accuracy on cognitive tasks, subjective reporting of consciousness, including sleep diaries, and video monitoring)*

1. Measuring consciousness with physiological responses (must know definitions)
  - EEG: detects, amplifies, records electrical activity of brain in the form of brainwaves
  - EMG: dare activity of muscles (movement and tissue)
  - EOG: dare muscles that control eye movements
2. Speed and accuracy on cog tasks
  - Measure speed and accuracy and lower score is generally ASC whereas as better score is generally NWC
3. Subjective reporting: self-report and sleep diaries but can be biased
4. Video monitoring: used in conjunction with physiological responses

*Changes in a person's psychological state due to levels of awareness, controlled and automatic processes, content limitations, perceptual and cognitive distortions, emotional awareness, self-control and time orientation*

	<b>NWC</b>	<b>ASC</b>
Awareness	higher level of awareness	lower level of awareness
Content limitations	more restricted content in consciousness	less restricted eg. dreams
Perceptual and cognitive distortions	realistic perceptions of world	vivid if drugs but dulled if meditation
Emotional awareness	normal emotions	inappropriate expression of emotions
Self-control	able to control self	lower self-control
Impaired reasoning and memory	functions normally	impaired reasoning and memory
Time orientation	normal	disoriented

- Controlled processes: require mental effort when task is new or difficult requiring high levels of awareness
- Automatic processes: lower levels of awareness or consciousness for familiar tasks without interference
- Selective attention: focus on specific stimulus and excluding all others
- Divided attention: completing multiple things at the same time without interfering each other

*Changes in levels of alertness as indicated by brain waves patterns (beta, alpha, theta, delta) due to drug induced altered states of consciousness (stimulants and depressants)*

- Stimulants: drugs that increase activity in the CNS and rest of body; increase beta activity and decrease alpha, theta and delta activity increase in freq and decrease in amp
- Depressants: drugs that decrease activity in CNS and rest of body; increase alpha, theta and delta activity and decrease in beta increase amp and decrease freq

*The effects on consciousness (cognition, concentration and mood) of one night of full sleep deprivation as a comparison with effects of legal blood-alcohol concentrations*

- 17hrs is 0.05%
- 24hrs is 0.10%
- Classic question: explain why sleep deprivation is dangerous in driving in relation to BAC

## **Sleep**

*Sleep as a regular and naturally occurring altered state of consciousness that follows a circadian rhythm and involves the ultradian rhythms of REM and NREM Stages 1–4 sleep excluding corresponding brain wave patterns and physiological responses for each stage*

- Sleep is ASC
- Circadian: follow 24hr rhythm eg. overall sleep-wake cycle
- Ultradian: part of cycle less than 24hr in duration eg. one sleep cycle in sleep episode
- More REM with each ultradian throughout night
- Less stage 3 and 4 throughout night
- Ultradian rhythms increase slightly throughout sleep episode

### NREM sleep

- 4 stages (do not need to know brainwaves and physio responses associated with each stage)
- The deeper in NREM stage, the harder to wake

*Theories of the purpose and function of sleep (REM and NREM) including restoration theory and evolutionary (circadian) theory*

- Restoration theory: sleep aims to repair and restore after depleting activities during the day NREM 3 and 4: really important for restoring body; REM: restoring brain
- Evolutionary theory: Sleep evolved over time to protect us at most dangerous part of day
- Evolved to we sleep at night because most dangerous time as we can't see
- Criticism: lack of awareness during sleep may increase danger as unaware of surrounding

*The differences in sleep across the lifespan and how these can be explained with reference to the total amount of sleep and changes in a typical pattern of sleep (proportion of REM and NREM)*

#### Changes to sleep across the lifespan

- Total sleep time decreases across lifespan
- Total amount of REM sleep decreases across lifespan
- Total amount of deep sleep (stage 3 and 4) decrease across lifespan

*Changes to a person's sleep-wake cycle and susceptibility to experiencing a circadian phase disorder, including sleep-wake shifts in adolescence, shift work and jet lag*

- Circadian phase disorder: mismatch between own sleep pattern (biological sleep clock) and desired sleep pattern
- Sleep-wake cycle shift in adolescence: delayed release of melatonin 2hrs
- Shift work: consistent working at night, struggle to obtain same quality or quantity of sleep as other
- Jet lag: fly across timelines causing mismatch between own sleep pattern and that of environment

*The effects of partial sleep deprivation (inadequate sleep either in quantity or quality) on a person's affective (amplified emotional responses), behavioural and cognitive functioning*

#### Partial sleep deprivation

- Affective functioning: emotions eg. amplified emotional responses easily angry or happy
- Behavioural functioning: feel fatigue and sleepy during awake, reduced motor co-ordination
- Cognitive functioning: impaired decision making, reduced alertness and concentration

**People who are sleep deprived tend to perform poorly on simple tasks, but may still perform reasonably on complex tasks**

*The distinction between dyssomnias (including sleep-onset insomnia) and parasomnias (including sleep walking) with reference to the effects on a person's sleep-wake cycle*

- Dysomnia: difficulty initiating or maintaining sleep  
eg. sleep-onset insomnia leads to partial sleep deprivation
- Parasomnia: inappropriate activity during sleep  
eg. sleepwalking during stage 3 and 4

*The interventions to treat sleep disorders including cognitive behavioural therapy (with reference to insomnia) and bright light therapy (with reference to circadian phase disorders).*

### CBT

- Used to treat insomnia
- Change the way people think and change their behaviour
- Change negative thought into more realistic and positive thoughts
- Using behavioural strategies: sleep hygiene and stimulus control therapy

### Bright light therapy

- Helps with circadian phase disorders
- Change release of melatonin; decrease melatonin release which will shift sleep-wake cycle in one way or another

### Tips

- Know definitions
- Know general effects due to changes in consciousness
- REM sleep decreases across lifetime, NREM increases
- REM sleep increase across sleep episode, NREW decreases throughout sleep episode

## **Mental Health**

*Mental health as a continuum (mentally healthy, mental health problems, mental disorders) influenced by internal and external factors that can fluctuate over time*

- Mental health lies on a continuum ranging from mentally healthy to mental disorder with everyone lying in between
- Mentally healthy: generally productive, contributing to society, positive well-being, good resilience
- Mental health can be affected by internal or external factors

*The typical characteristics of a mentally healthy person, including high levels of functioning, social and emotional well-being and resilience to life stressors*

### Mentally healthy characteristics

- High level of functioning: good independent living skills
- High level of social wellbeing: forming relationships and connecting with others
- High level of emotional wellbeing: express appropriately and detect in other

- High levels of resilience: bounce back from stressors

*Ethical implications in the study of, and research into, mental health, including informed consent and use of placebo treatments*

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*The distinction between predisposing risk factors (increase susceptibility), precipitating risk factors (increase susceptibility and contribute to occurrence), perpetuating risk factors (inhibit recovery) and protective factors (prevent occurrence or re-occurrence)*

#### 4P factor model

- Predisposing: increase susceptibility to developing mental healthy disorder eg. genetics
- Precipitating: increase susceptibility to and contribute to occurrence of particular mental disorder
- Perpetuating: maintain MHD and inhibits recovery from disorder
- Protective: reduce likelihood of occurrence of MHD

*The influence of biological risk factors including genetic vulnerability to specific disorders, poor response to medication due to genetic factors, poor sleep and substance use*

#### Bio factors

- Genetics (predispose)
- Poor response to medication (perpetuate)
- Poor sleep
- Substance use

*The influence of psychological risk factors including rumination, impaired reasoning and memory, stress and poor self-efficacy*

#### Psycho factors

- Rumination: dwelling on negative thought without confronting source or fixing the problem (perpetuating)
- Impaired reasoning and memory: problems with STM eg. struggling to attend appointments (perpetuating)
- Stress: increases susceptibility to developing MHD dependent on individual
- Self-efficacy: belief in ability to perform activities to accomplish certain goal

*The influence of social risk factors including disorganised attachment, loss of a significant relationship and the role of stigma as a barrier to accessing treatment*

#### Social factors

- Disorganised attachment: odd behaviour of infants increasing levels of anxiety in future, increase inner turmoil and affect emotions

- Loss of significant relationship: losing someone close leading to grief and upset
- Stigma: can't seek treatment or judged negatively by society and consequently don't seek treatment and perpetuate

#### *The concept of cumulative risk*

- cumulative risk: total risk to mental health from combined effects of multiple bio, psycho, and social factors
  - The more risk factors one is exposed to, the higher the chance of suffering from MHD
  - Weigh up between risk factors and protective factors

#### Phobia

- Specific type of MHD

*The distinctions between stress, phobia and anxiety; variation for individuals with stress, phobia and anxiety on a mental health continuum*

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*The relative influences of contributing factors to the development of specific phobia with reference to: gamma amino butyric acid (GABA) dysfunction, the role of stress response and long-term potentiation (biological); behavioural models involving precipitation by classical conditioning and perpetuation by operant conditioning, cognitive bias including memory bias and catastrophic thinking (psychological); specific environmental triggers and stigma around seeking treatment (social)*

#### Bio factors

- GABA dysfunction: more likely to have low levels of GABA and increased activation of excitatory effect and anxiety
- Stress response: FFF activated
- LTP: strengthening of synaptic connections constantly; joining fear response and stimulus

#### Psycho factors

- Behavioural models: precipitation of CC=creates phobia and perpetuation by OC=maintained through avoidance behaviour and negatively reinforced by removing unwanted feelings (explain using appropriate terminology)
- Cognitive bias: illogical or incorrect way
- Memory bias: remembering negative events of stimulus much more vividly than neutral
- Catastrophic thinking: exaggerating event and predicting the worst possible outcome



### Social factors

- Specific enviro trigger: traumatic and negative experience with phobic stimulus in past and is often what causes the phobia
- Stigma: reluctant to admit to avoid judgement and don't seek treatment thus perpetuates phobia

*Evidence-based interventions and their use for specific phobia with reference to: the use of short-acting anti-anxiety benzodiazepine agents (gamma-amino butyric acid [GABA] agonists) in the management of phobic anxiety and relaxation techniques including breathing retraining and exercise (biological); the use of cognitive behavioural therapy (CBT) and systematic desensitisation as psychotherapeutic treatments of phobia (psychological); psychoeducation for families/supporters with reference to challenging unrealistic or anxious thoughts and not encouraging avoidance behaviours (social)*

### Treatments and Interventions

- Bio interventions
    - Benzodiazepines: activate effects of GABA (agonists) to decrease activation of post neurons and therefore promote calmness and relaxation
    - Breathing retraining: breathe in slow and controlled way when exposed to phobic stimulus
    - Exercise: promote relaxation and reduce anxiety levels, provide distraction
  - Psycho interventions
    - CBT: changing negative dysfunctional thoughts associated to phobia by supporting with evidence and hence reduce avoidance behaviours
    - Systematic desensitisation: gradual exposure to phobic stimulus
1. Taught relaxation technique eg. controlled breathing
  2. Create fear hierarchy ranking least-feared to most-feared
  3. Pairing each event with relaxation technique until whole hierarchy is complete
- Social interventions
    - Psycho-education: educating individual and those around them about phobia (challenge unrealistic thoughts and

*Resilience as a positive adaption to adversity including the relative influence of protective factors with reference to: adequate diet and sleep (biological); cognitive behavioural strategies (psychological); support from family, friends and community (social) maintaining mental health*

### Bio factors

- Adequate diet
- Adequate sleep

### Psycho factors

- CBT: pos behaviour strategies

### Social factors

- Support from family, friends, community

*Models of behaviour change with reference to the transtheoretical model including the stages of pre-contemplation, contemplation, preparation, action and maintenance/relapse.*

### Transtheoretical model

- How people intentionally change behaviour to achieve health-related goal
1. pre-contemplation: not thinking about changing behaviour
  2. contemplation: weighs up pros and cons
  3. preparation: planning to change within 30 days
  4. action: actually makes change to behaviour
  5. maintenance: showed desired behaviour for 6 months and avoiding relapse

### Tips

- Create summary sheet to know which category factor fall into
- Cumulative risk: multiple factors equals significant risk
- CBT: practice writing out 3-4 sentence answer summarising it
- Phobias are precipitated by CC and perpetuated by OC

### **Exam**

- 50 marks MC
- 70 marks short answer
- Chapter summaries
- Practice exams and practice questions
- Practice doing exam at 9am to mimic exam conditions
- Learn basics and know knowledge well
- Skim notes in the morning of the exam
- Use reading time well (15mins)
- Think about extended response time
- Start with MC questions as they are easier and quicker (warms up brain)
- Spend 20-30 mins for extended response question (2-3 pages)
- Skip tricky questions but never leave questions blank especially MC
- Link back to question if possible eg. use the name of person in question
- Read over exam a couple of times