Source: Barlow, Durand & Hofmann (2018), Comer & Comer (2017), Hooley, Butcher, Nock & Mineka (2017), DSM-V, DSM-V-TR, Psych Pearls

Hellow, future RPm!

Doubt is definitely going to eat you this review season. I just want you to know that it is very VALID to feel that way. But always remember to go back to the reason why you are doing this.

May this reviewer help you pass the boards like it did to me and to many people that I know <3

We will be remembered ✨

Normalcy and Abnormalcy (5)

Recognizing Normal and Abnormal manifestations of behavior

- **Psychological Disorder** – psychological dysfunction within an individual associated with distress or impairment in functioning and a response that is not typical or culturally expected
- **4 D's of Psychological Disorder**

a. **Psychological Dysfunction** – refers to a breakdown in cognitive, emotional, or behavioral functioning
   - Interferes daily functioning

b. **Distress or Impairment** – individual is extremely upset and cannot function properly
   - Either to self or to others

c. **Atypical or Not Culturally Expected (Deviance)** – deviates from the average or the norm of the culture
   - Not just to the society but deviation from the person's usual behavior

d. **Dangerousness** – creates potential harm to self (suicidal gestures) and others (excessive aggression)

e. **Duration** – how long the mental state has been persisting
   - Constant fluctuation of mood, thoughts, and behaviors is normal, but if changes is sustained, persistent and pervasive, it can be concerning

- **Psychopathology** – scientific study of mental disorders
- **Clinical Psychology** – applied branch of psychology that seeks to understand, assess, and treat psychological conditions in a clinical setting
- **Abnormal Psychology** – branch of psychology that studies unusual patterns of behavior, emotions, and thought which may or may not indicate an underlying condition
- **Normal Behavior** – one behavior that is like other people in the society
  - **Normality is social conformity** – some behaviors are non-conforming but normal
  - **Normality is personal comfort**
  - **Normality is a process**
- **Criteria for determining Abnormal Behavior**
  - ✓ Norm-violation
  - ✓ Statistical rarity
  - ✓ Personal Discomfort
  - ✓ Deviation
  - ✓ Maladaptiveness
- **Clinical Assessment** – the systematic evaluation and measurement of psychological, biological, and social factors in an individual presenting with a possible psychological disorder
- **Diagnosis** – process of determining whether the particular problem afflicting the individual meets all criteria for a psychological disorder
- **Epidemiology** – study of the distribution of diseases, disorders, or health-related behaviors in a given population
- **Prevalence** – number of active cases in a population during a given period of time
- **Point Prevalence** – proportion of actual, active cases of a disorder in a given population at a given point in time
- **1 Year Prevalence** – everyone who experienced depression at any point in time throughout the entire year
- **Lifetime Prevalence** – estimate number of people who have had a particular disorder at any time in their lives
- **Incidence** – number of new cases occur over a given period of time
- **Sign** – manifestation of disease that the physicians receive
- **Symptom** – subjective representation of the complaints of the patient
- **Syndrome** – group of symptoms that occur together more often by chance

DSM-IV Axis
Axis I: Clinical Disorder
Axis II: Personality Disorders & Mental Retardation
Axis III: General Mental Conditions
Axis IV: Psychosocial & Environmental Problems

Source: Barlow, Durand & Hofmann (2018), Comer & Comer (2017), Hooley, Butcher, Nock & Mineka (2017), DSM-V, DSM-V-TR, Psych Pearls

Axis V: Global Assessment of Functioning

Theoretical Approaches in Explaining the Etiology of Psychological Disorders (20)

- **One-Dimensional –** looking for a single cause
- **Multidimensional –** looking for a systemic cause

Genetic contributions

- **Genes –** long molecules of DNA at various locations on chromosomes, within cell nucleus
  - *Chromosomes:* the chain-like structures within a cell nucleus that contain the genes
  - *Genes:* carries of the information we inherit from our parents
- 46 Chromosomes, 23 Pairs, 22 Pairs of Autosomes, 1 pair Sex Chromosomes
- XX – female, XY – male
- Dominant and Recessive
- **Phenotypes –** observable characteristics
- **Genotypes –** unique genetic makeup
- **Polymorphisms –** naturally occurring variations of genes
- **Polygenic –** influenced by multiple genes or by multiple polymorphisms of genes with any one gene having only very small effects
- **Endophenotypes –** genetic mechanisms that ultimately contribute to the underlying problems causing the symptoms and difficulties experienced by people with psychological disorders
- **Basic Genetic Epidemiology –** statistical analysis of family, twin, and adoption studies; if the disorder can be inherited and how much is attributable to genetics
- **Advanced Genetic Epidemiology –** studies the factors that influence the disorder
- **Gene Finding –** what gene influences the behavior
- **Molecular Genetics –** biological analysis of individual DNA samples; biological processes genes affect to produce symptoms of the disorder
- **Family Studies –** examine behavioral pattern or emotional trait in the context of the family
- **Proband –** family member with the trait singled out for study
  - The first person in the family to be identified as possibly having genetic disorder and who may receive genetic counseling or testing
- **Adoption Studies –** identify adoptees who have a particular behavioral pattern or psychological disorder and attempt to locate first-degree relatives who were raised in different family settings
- **Twin Studies –** usually conducted to identical twins because they share genetic makeup'
- Those people who reported more severe stressful life events and had at least one short allele of the 5-HTT gene were at greater risk of developing depression (Caspi et al., 2003) (serotonin-transporter gene)
- **Epigenetics –** factors other than inherited DNA sequence, such as new learning or stress, that alter the phenotypic expression of genes

Biological and Neurological Bases

- **Neuroscience –** study of the nervous system, especially the brain to understand behavior, emotions, and cognitive processes

	High	**Low**
Dopamine	Schizophrenia	Parkinson's
Acetylcholine		Alzheimer's (Dementia)
Norepinephrine	Mania	Depression
GABA	Relaxation	Anxiety/OCD
Serotonin	Mania	Depression Anxiety Eating Disorders
Epinephrine	Stress Sleep Disorders	Fatigue
Glutamate	Psychosis Neuron Death	Huntington's Disease
Endorphin		Eating Disorders

- **Synapse –** a tiny fluid-filled space between the axon endings of one neuron and the dendrites or cell body of another neuron
- **Agonist –** effectively increase the activity of the neurotransmitters (Excitatory)
- **Antagonist –** decrease or block neurotransmitter (Inhibitory)
- **Inverse Agonists –** produces effects opposite to those produced by the neurotransmitters
- **Reuptake –** neurotransmitter is released, quickly broken down and brought back to the synaptic cleft
- **Hormones –** chemical messengers secreted by the endocrine glands in the body
- **Neurotransmitter –** chemical messengers of the body
  a) **Glutamate (E) [memory]–** most abundant in the brain and plays a key role in thinking, learning, and memory

b) **GABA (I) [calming]**– most common inhibitory neurotransmitter in the brain and regulates mood, irritability, sleep, seizures
c) **Serotonin (I) [mood]**– regulates mood, sleep patterns, sexuality, appetite, and pain
d) **Dopamine [pleasure]**– body reward system, pleasures, achieving heightened arousal and learning
e) **Epinephrine [fight-or-flight]** – responsible for fight-or-flight response
f) **Norepinephrine [concentration]** – alertness, arousal, decision-making, attention, and focus
g) **Endorphins [euphoria]**– natural pain reliever, reduces pain
h) **Acetylcholine (E) [learning]** – regulates heart rate, blood pressure and gut motility, role in muscle contraction, memory, motivation, sexual desire, sleep, and learning

- **Brain Stem** – lower and more ancient part of the brain; essential for autonomic functioning such as breathing, heartbeat, etc.
  - **Hindbrain** – contains the medulla, pons, and cerebellum; regulates many autonomic activities such as breathing, heartbeat, and digestion
  - **Cerebellum** – controls motor coordination abnormalities associated with autism
  - **Midbrain** – coordinates movements with sensory input and contains parts of reticular activating system (contributes to sleep, arousal and tension)
  - **Thalamus and Hypothalamus** – involves in regulating behavior, emotions, and hormones
- **Limbic System** – located around the edge of the center of the brain
  - Hippocampus, Cingulate Gyrus, Septum, and Amygdala
  - **Amygdala** – emotions
  - **Hippocampus** – shrinks when a person have depression
  - Regulate emotional experiences and expressions and, to some extent, our ability to learn and to control impulses
- **Basal Ganglia** – base of the forebrain, includes caudate nucleus
  - Damage involved changing our posture or twitching or shaking
  - Related to Parkinson's Disease
- **Cerebral Cortex** – provides us with our distinctly human qualities, allowing us to look to the future and plan, to reason, and to create
  - **Left Hemisphere** – responsible for verbal and other cognitive processes
  - **Right Hemisphere** – perceiving the world around us and creating images
  - **Lobes: Frontal, Parietal, Occipital, Temporal**
  - **Prefrontal Cortex** – area responsible for higher cognitive functions
  - **HPA Axis** – Hypothalamus, Pituitary Gland, Adrenal Cortex
- **Somatic Nervous System** – controls the muscles
- **Autonomic Nervous System** – regulate cardiovascular system and endocrine system
  - **Sympathetic** – fight or flight responses
  - **Parasympathetic** – calms the sympathetic nervous system; rest and digest functions
- **Endocrine System** – glands produce hormones that is released to the blood streams
  - **Pituitary** – master gland
  - **Thyroid** – controls metabolism and growth (thyroxine)
  - **Parathyroid** – controls the levels of calcium
  - **Adrenal** – controls metabolism, blood pressure, sex development, stress (epinephrine)
  - **Pineal** – releases melatonin
  - **Pancreas** – creates insulin
  - **Testes** – makes sperm and release testosterone
  - **Ovaries** – releases estrogen, progesterone, and testosterone

Hypothalamic-Pituitary-Adrenal Axis
1. Messages in the form of *corticotropin-releasing hormone (CRH)* travel from the **hypothalamus** to **pituitary gland**
2. **Pituitary Gland** releases *adrenocorticotropic hormone (ACTH),* which stimulates the cortical part of the adrenal gland (located at the top of the kidney) to produce *epinephrine (adrenaline)* and *cortisol (stress hormone),* which is released into the general circulation
3. **Cortisol** gives negative feedback to the hypothalamus and pituitary to decrease their release of CRH and ACTH, which in turn reduces the release of adrenaline and cortisol

- **Temperament** – refers to a child's reactivity and characteristic ways of self-regulation
  - As early as 2-3 months of age, approx. five dimensions of temperaments can be identified: fearfulness, irritability/frustration, positive affect, activity level, and attentional persistence/effortful control
- **Permissive Hypothesis** – when serotonin (norepinephrine) levels are low, other

neurotransmitters are permitted to range more widely, become dysregulated, and contribute to mood irregularities

Structure	Associated Behaviors
Corpus Callosum	Communication between right and left hemisphere
Limbic System	Attention, Emotion, "fight or flight"
Frontal Lobe	Learning, abstracting, reasoning, inhibiting
Hypothalamus	Regulation of metabolism, temperature, and emotions
Temporal Lobe	Discrimination of sounds, verbal, and speech behavior
Reticular Formation	Arousal Reactions, Information Screening
Medulla	Breathing, Blood Pressure, other vital functions
Cerebellum	Fine motor coordination, posture, and balance
Occipital Lobe	Visual Discrimination and some aspects of visual memory
Thalamus	Major relay station for messages from parts of the body, important sensations of pain
Parietal Lobe	Somesthetic and motor discriminations and functions
Sensory Strip	Integration of sensory information from various parts of the body
Motor Strip	Regulation of voluntary movement

Learning

- **Classical Conditioning –** type of learning in which neutral stimulus is paired with response until it elicits that response
  - **Unconditioned Stimulus –** natural stimulus
  - **Unconditioned Response –** natural or unlearned response
  - **Conditioned Stimulus –** newly conditioned event introduced
  - **Conditioned Response –** response from the conditioned stimulus
  - **Extinction –** without CS showed long enough, the behavior could be eliminated
- **Stimulus Generalization –** strength of the response to similar objects or people is usually a function of how similar these objects or people are
  - E.g., You are afraid of fury dogs because they once attacked you. Now, whenever you see something fury, your body trembles, you cannot breathe properly and wanted to go away.
- **Introspection –** Edward Titchener; subjects report their inner thoughts and feelings after experiencing certain stimuli
- **John B. Watson –** founder of behaviorism
  - Little Albert
- **Systematic Desensitization –** patients were gradually introduced to the objects or situations they feared so that their fear could extinguish
- **Operant Conditioning –** behavior changes as a function of what follows the behavior (rewards or punishment)
  - B.F. Skinner
  - Edward Thorndike – Law of effect (behavior can be strengthened or weakened)
  - **Reinforcement –** reward
  - **Shaping –** process of reinforcing successive approximations to a final behavior or set of behaviors
- **Social Learning –** Albert Bandura
  - *Modeling/observational learning:* process of learning in which an individual acquires responses by observing and imitating others
  - Observational learning
  - *Social Cognitive Theory:* people observe models, learns chunks of behavior, and mentally put chunks together into complex new behavior patterns
  - Albert Bandura
  - Hitting Doll experiment
  - **Self-Efficacy –** person's confidence in their own abilities to accomplish their goals
- **Learned Helplessness –** when rats or other animals encounter conditions over which they have no control, they give up attempting to cope and seem to develop the animal equivalent of depression
  - Martin Seligman and colleagues
  - People make an attribution that they have no control, and become depressed
  - Causes: coercive, ineffective, inconsistent parents, media violence, peer rejection
  - **Internal:** negative effects due to internal failings
  - **Stable:** even after a particular negative events pass, additional bad things will "always be my fault" remains
  - **Global:** attributions extend across a variety of issues

Source: Barlow, Durand & Hofmann (2018), Comer & Comer (2017), Hooley, Butcher, Nock & Mineka (2017), DSM-V, DSM-V-TR, Psych Pearls

- **Learned Optimism** – if people faced with considerable stress and difficulty in their lives, nevertheless, display optimistic, upbeat attitude, they are likely to function better psychologically and physically
- Positive Psychology

- **Prepared Learning** – we have become highly prepared for learning about certain types of objects or situations over the course of evolution because this knowledge contributes to the survival of the species
  - Learning from ancestors
- **Hopelessness Theory** – desirable outcomes will not occur, and that the person has no responses available to change this situation

Cognitive theories with Psychoanalytic

- **Fear** – fight or flight response
  - Evolutionary adaptation
  - White with fear, trembling, faster breathing, increase in glucose, pupil dilate, hearing become more acute, digestive system stops, pressure to urinate, defecate, vomit to reduce waste materials
- **Introjection** – direct all their feelings for the loved one, including sadness and anger, toward themselves
- **Symbolic or Imagined Loss** – person equates other kinds of events with the loss of a loved one
  - Does not necessarily involve death of a person
  - E.g., an athlete got injured and can no longer do the sport they have been doing for a long time
  - *Introjected Loss:* actual death of a person
- **Attributional Style** – ways in which people explain the cause of events within their lives

Internal-External – who or what is responsible for the event - whether something unique about the person (internal) or something about the situation caused the event (external)
Stable-Unstable – perceived permanence of the cause - an event can be viewed as constant and likely to happen again (stable) or it only happens once (unstable)
Global-Specific – universal throughout your like (global) or specific to a part of your life (specific)

- **Cognitive Theory of Depression** - persons susceptible to depression develop inaccurate/unhelpful core beliefs about themselves, others, and the world as a result of their learning histories
  - Depressed people consistently think in illogical ways and keep arriving at self-defeating conclusions
  - Tends to **Overgeneralize** (draw broad negative conclusions on the basis of single insignificant event) [**Cognitive Bias]**
  - **Depressive Cognitive Triad:** depressed people make cognitive errors in thinking negatively about themselves, immediate world, and their future
  - **Beck Hopelessness Scale**
  - **Negative Schema:** an enduring negative cognitive system about some aspects of life
  - **Self-Blame Schema:** people feel personally responsible for every bad happenings
  - **Negative Self-Evaluation Schema:** "can never do anything correctly"
  - **False Consensus Effect/False Consensus Bias:** people tend to overestimate the extent to which their opinions, beliefs, preferences, values, and habits are normal and typical of the others ("Everyone shares the same opinion as me,")

Negative Cognitive Styles:
Dichotomous Thinking/Absolutist/Black and White Thinking - seeing only of the extremes of things, never the middle - "either I ace this test or fail,"
Overgeneralization - making generalizations about a negative aspect - "bagsak ako sa physics, hindi na ko makaka-graduate ng college,"
Personalization - tendency for individuals to relate external events to themselves, even when there is no basis for making this connection - egocentric thinking, everything is about him - "kasalanan ko kung bakit umiyak yung bata"
Selective Abstraction - focuses on the negative - detail is taken out of context and believed whilst everything else in the context is ignored - /almost good feedback except for one /focused on that single feedback
Arbitrary Inference - evident when depressed individuals emphasize the negative rather than the positive aspects of a situation - only accepts negative thoughts - no logical reasoning - interpreting a situation when there is no factual evidence - /passed, "chamba", /negative "kasalanan ko kasi"

Source: Barlow, Durand & Hofmann (2018), Comer & Comer (2017), Hooley, Butcher, Nock & Mineka (2017), DSM-V, DSM-V-TR, Psych Pearls

Labeling and Mislabeling
- portraying one's identity on the basis of imperfections and mistakes made in the past and allowing them to define one's true identity - /bullied for being dark-skinned, "I am ugly."
Minimization
- downplaying the significance of an event or emotion - common strategy in dealing with feelings of guilt - **"**Parang nakakarami ka na ah," "Luh parang tanga, sampung bote pa lang"
Magnification
- effects of one's behaviors are magnified - /may konting mantsa sa damit, "Iniisip siguro nila hindi ako naglalaba,"

- **General Adaption to Stress Theory** – understanding the relationship between stressful events and the body's response to stress
  - **Alarm:** fight-or-flight response
  - **Resistance:** coping mechanisms
  - **Exhaustion:** body defenses resources are depleted
  - Hans Selye
- **Stress-Appraisal/Cognitive Appraisal Theory** – stress is a two-way process, it involves a production of stressors and the response of an individual subjected to these stressors
- **Primary Appraisal:** an individual tends to ask questions like, "What does this stressor and/or situation mean?", and "How can it influence me?"
  - Understanding the stressor
- **Secondary Appraisal:** involves those feelings related to dealing with the stressor or the stress it produces
  - Deals with the stressor
  - Starts to assess internal and external resources available to solve the problem
  - **Positive:** *"I can do it if I do my best,"*
  - **Negative:** *"I cannot do it."*

Memory Disorders
Anosognosia: no memories of his own illness
Confabulation: filling in memory gaps with imaginary experiences
Disorientation: cannot identify or recognize time, places, and persons
De Javu: unfamiliar perceived as familiar
Jamais Vu: familiar perceived as unfamiliar
Hypermnesia: increased memory
Paramnesia: false or perverted memory
Amnesia: loss of memory

- **Types of Amnesia:**

1. **Biogenic** – caused by brain damage or disease
   - **Retrograde** – inability to retrieve information that was acquired before (remote memory loss)
   - **Anterograde** – inability to transfer new information from the short-term store to long-term store (recent memory loss)
2. **Psychogenic or Dissociative or Functional** – caused by psychological trauma, repressed memories
   - **Generalized** – origin is rare psychological disorder and spontaneous recovery from amnesia in a comparatively short period of time
   - **Localized** – no memory of specific events
   - **Selective** – can only recall only small parts of the events
   - **Situation-Specific** – result of severely stressful event, as part of PTSD
   - **Global** – cannot recall both past and present; total memory loss

- **Memory** – the process by which we encode, store, and retrieve information
  - **Declarative:** factual information
  - **Procedural:** skills and habits
  - **Semantic:** general knowledge and facts, logic
  - **Episodic:** events that occur in a particular time, place, or context
- **Three-System Approach to Memory** – information must travel if it is to be remembered
  - **Sensory:** initial storage of information, perceived by the senses
  - **Short-Term Memory:** holds info for 15 to 20 seconds
  - **Long-Term Memory** – stores on a relatively permanent basis, although, at times, it can be difficult to retrieve
- **Chunks** – meaningful grouping of stimuli that can be stored as a unit in STM
- **Rehearsal** – repetition of information that has entered the STM
  - **Repetitive:** as long as it is repeated, it states in the STM
  - **Elaborative:** transfers info to LTM
- **Tip-Of-The-Tongue Phenomenon** – inability to recall information that one realizes one knows
- **Retrieval Cue** – allow us to recall more easily
  - **Recall:** memory task in which specific information is retrieved
  - **Recognition:** individual is presented with a stimulus and asked whether they have been

Source: Barlow, Durand & Hofmann (2018), Comer & Comer (2017), Hooley, Butcher, Nock & Mineka (2017), DSM-V, DSM-V-TR, Psych Pearls

exposed to it in the past or to identify it from the list of alternatives

- **Levels-Of-Processing Theory** – degree to which new materials is mentally analyzed
  - **Implicit Memory:** can be recalled automatically without thinking
  - **Explicit Memory:** requires conscious retrieval of information
- **Constructive Processes** – memories are influenced by the meaning we give to them
  - **Autobiographical:** episodes from our own lives
  - **Flashbulb Memories:** specific or surprising events that are so vivid in memory it as if they represented a snapshot of the event
- **Forgetting** – permits us to form general impressions and recollections
  - Helps us avoid being burdened and distracted by trivial stores of meaningless data
  - **Failure of Encoding:** failure to pay attention and place information in memory
  - **Decay:** loss of information due to non-use
  - **Cue-Dependent Forgetting:** insufficient retrieval cues
  - **Proactive Interference:** learned earlier disrupts the recall of newer material; you forget the new info
  - **Retroactive Interference:** difficulty in recalling info learned earlier because of later exposure to different material; you forget the old info
- **Learned Helplessness (Martin Seligman) –** if they learn that nothing they do helps them avoid the shocks, they eventually become helpless, give up, and manifest an animal equivalent of depression
  - Anxiety is the first response to a stressful situation
  - The depressive attributional style is (1) internal, (2) stable, (3) global
- Aaron T. Beck suggested that depression may result from a tendency to interpret everyday events in a negative way
  - **Depressive Cognitive Triad** – they make cognitive errors in thinking negatively about themselves, their immediate world, and their future
  - Series of negative events in childhood, individuals may develop deep-seated negative schema, an enduring negative cognitive belief system about some aspect of life
- **Lewinsohn's Behavioral Theory -** depression is caused by a combination of stressors in a person's environment and a lack of personal skills

diathesis-stress model

- **Diathesis-Stress Model** – individuals inherit tendencies to express certain traits or behaviors, which may then be activated under conditions of stress (Eric Kandel)
  - **Diathesis** – a condition that makes someone susceptible to developing disorder (vulnerability)
  - **Stress** – the response or experience of an individual to demands that he or she perceives as taxing or exceeding his or her personal resources
  - The higher vulnerability, the lesser life stress needed to trigger traits
  - Disturbances stem from a genetic predisposition triggered by stress

Predisposing Factor – cause of a disorder (i.e., situations that trigger the development of the disorder)
Precipitating Factor – factors that allow the disorders to develop (i.e., factors that could contribute to the development of a disorder)
Protective Factor – reduces the severity of the problems
Perpetuating Factor – factors that maintain the problem once established

Gene-Environment Interaction

- **Gene-Environment Correlation Model** – people might have genetically determined tendency to create the environment risk factors that trigger a genetic vulnerability
- In most cases, genetic factors are not necessary and sufficient to cause mental disorders but instead can contribute to a vulnerability or diathesis to develop psychopathology that only happens if there is a significant stressor in the person's life
- **Epigenetics** – study how your behavior and environment can cause changes that affect your genes work
- **Reciprocal Gene-Environment Model** – claims that people with a genetic predisposition to a disorder may also have a genetic tendency to create environmental factors that promote the disorder

3 kinds of Gene-Environment Correlations
Passive Gene-Environment – parent provide for their children is influenced partly by the parents' genotypes
Evocative Gene-Environment – child's genotype evokes certain kind of reactions from other people

Source: Barlow, Durand & Hofmann (2018), Comer & Comer (2017), Hooley, Butcher, Nock & Mineka (2017), DSM-V, DSM-V-TR, Psych Pearls

- Genetic makeup may affect the reactions of other people to a child and, hence, the kind of social environment that the child will experience
Active Gene-Environment – children's genotype influence the kinds of environment they seek

Role of culture, social interactions, and interpersonal factors in the development

- **Sociogenic Factors:**
  a. Unemployment
  b. Poverty
  c. Crime
  d. Poor Educational Level
- People who are isolated and lack social support or intimacy in their lives are more likely to become depressed when under stress and to remain depressed longer than people with supportive spouses or warm friendships
- People's online relationships tend to parallel their offline relationships
- **Family Systems Theory** – family is a system of interacting parts who interact with one another in consistent ways and follow rules unique to each family
  - Structure and communication patterns of some families actually force individual members to behave in a way that otherwise seems abnormal
- An individual's behavior, whether normal or abnormal, is best understood in the light of the individual's unique cultural context
- **Multicultural Perspective** – each culture within large society has a particular set of values and beliefs, as well as special external pressures, that help account for the behavior and functioning of its members (Culturally Diverse Perspective)

Suicide

- **Suicide** – self-inflicted death in which the person acts intentionally, directly, and consciously
- **Death Seekers** – clearly intend to end their lives at the time they attempt suicide
  - May last only a short time
- **Death Initiators** – clearly intent to end their lives, but they act out of a belief that the process is already under the way and that they are simply hastening the process
- **Death Ignorers** – do not believe that their self-inflicted death will mean the end of their existence
- **Death Darers** – experience mixed feelings, or ambivalence, about their intent to die, even at the moment of their attempt, and they show this ambivalence in the act itself
  - Their risk-taking behavior does not guarantee death
- **Subintentional Death** – a death in which the victim plays an indirect, hidden, partial, or unconscious role
- Suicide is officially the 11th cause of death in US
- **Suicidal Ideation** – thinking seriously about suicide
- **Suicidal Plans** – formulation of a specific method for killing oneself
- **Suicidal Attempts** – the person survives from attempts
- Emile Durkheim's Suicide Types:
  a. Altruistic – formalized suicides**;** dishonor to self, family, or society
  b. Egoistic – loss of social supports as an important provocation for suicide
  c. Anomic – result of marked disruptions, such as sudden loss of job
  d. Fatalistic – loss of control over one's own destiny
- Freud believed that suicide indicated unconscious hostility directed inward to the self rather than outward to the person or situation causing the anger
- If a family member committed a suicide, there is an increased risk that someone else will also
- Low levels of serotonin is associated with suicide and with violent suicide attempts (low levels of serotonin is linked with impulsivity, instability, and the tendency to overreact to situation)
- The stress of a friend's suicide or some other major stress may affect several individuals who are vulnerable because of existing psychological disorders
- **Hopelessness** – pessimistic belief that one's present circumstances, problems, or mood will not change
- **Dichotomous Thinking** – viewing problems and solutions in rigid either/or terms
- Common triggering factors:
  ✓ Stressful events
  ✓ Mood and thought changes
  ✓ Alcohol and other drug use
  ✓ Mental disorders
  ✓ Modeling
- One of the signs of suicides is when the client are giving away their prized possessions

Psychological Disorders and Specific Symptoms based on DSM-5 (50)

- **Ego-Syntonic** – actions that align with the client's personal goals, values, and beliefs
- **Ego-Dystonic** – actions that are inconsistent with the client's ego

Source: Barlow, Durand & Hofmann (2018), Comer & Comer (2017), Hooley, Butcher, Nock & Mineka (2017), DSM-V, DSM-V-TR, Psych Pearls

- **Primary Gain** – psychological disorder manifesting physically
- **Secondary Gain** – they act sick because they want external reinforcement (malingering)

Differentiating Anxiety disorders

Separation Anxiety Disorder (≥ 4 wks, C; ≥ 6 mos, A)

- concerns with real or imagined separating from attachment figures
- separation may lead to extreme anxiety and panic attacks
- not entirely responsible for school absences or school avoidance
- do not attend school so they won't be separated with their attachment figure
- fear of possible separation is the central thought
- concerned about the proximity and safety of key attachment figures
- develops after life stress, bullying and a history of parental overprotection and intrusiveness
- heritable
- highly co-morbid with GAD and Specific Phobia in children
- for Adults, common comorbidities inc. phobia, PTSD, Panic Disorder, GAD, SAD, Agora, OCD, Prolonged Grief Disorder, PD (Dependent, Avoidant, and OCPD), MDE and Bipolar Disorders
- at least 4 weeks (children) or 6 months or more (adults)

Selective Mutism (≥ 1 month)

- rare childhood disorder
- characterized by a lack of speech in one or more setting in which speaking is socially expected
- restricted to a specific social situation
- a child could speak in one setting but cannot/do not in another setting
- not better explained by communication disorder
- only diagnosed when a child has established a capacity to speak in some social situations
- learn to perform avoidance and safety behaviors to avoid disasters
- children with selective mutism are almost always given an addtl. Diagnosis of another anxiety disorder (usually, Social Anxiety)
- increased abnormalities in the auditory efferent neural activity during vocalization
- parents are described to be overprotective or more controlling
- at least 1 month

Specific Phobia (≥ 6 months)

- irrational fear of a specific object or situation that markedly interferes with an individual's ability to function
- acquired through direct experience, experiencing in false alarm, and observation
- it only fears one setting, unlike Agoraphobia (which requires 3 settings), then Specific Phobia-Situational can be diagnosed
- usually develops during childhood
- there may be genetic susceptibility to certain category of specific phobia
- Animal, Natural Envi, and Situational-Specific Phobias ~ Women > Men
- Blood-Injection-Injury Phobia ~ Women = Men
- increased risk for the development of other disorder such as other anxiety disorders, depressive and bipolar disorders, substance related disorders, somatic disorders, and PD
- 6 months or more

Social Anxiety Disorder (≥ 6 months)

- fear or anxiety about possible embarrassment or scrutiny
- can have panic attacks but it is cued by social situations
- typically have adequate age-appropriate social relationships and social communication capacity
- Self-medication with substances is common
- *Blushing:* hallmark physical response of Social Anxiety Disorder
- heritable
- *Paruresis:* difficulty peeing in public restrooms or with people nearby
- Chronic Isolation in the course of Social Anxiety Disorder may result to MDD
- frequently co-morbid with BDD and Avoidant PD
- In children, comorbidities with high-functioning ASD and Selective Mutism are common
- 6 months or more

Panic Disorder (≥ 1 month)

- cannot be diagnosed unless full symptom panic attacks were experienced
- norepinephrine activities are irregular
- abrupt surge of intense fear or discomfort out of nowhere, with no triggers
- followed by persistent concerns about more attacks or the consequences of it or maladaptive change in behavior related to the attacks
- women > men

Source: Barlow, Durand & Hofmann (2018), Comer & Comer (2017), Hooley, Butcher, Nock & Mineka (2017), DSM-V, DSM-V-TR, Psych Pearls

Agoraphobia (≥ 6 months)

- developed after a person has unexpected panic attacks
- fear in two or more situations (public transpo, open spaces, enclosed spaces, standing in line, being outside of the home alone) due to thoughts that escape might be difficult or no one will help them in case panic-like symptoms would manifest
- has the strongest and most specific association with the genetic factor that represent proneness to phobia
- 90% of individuals with agoraphobia also have other mental disorders
- 6 months or more

Generalized Anxiety Disorder (≥ 6 months)

- difficulty to control worry
- excessive anxiety and worry occurring more days than not for at least 6 months, about a number of events or activities
- "the world is a dangerous place"
- intense cognitive processing in the frontal lobes, particularly in the left hemisphere
- intense worrying may act as avoidance
- worry whether or not they are judged/evaluated
- fear circuit is excessively active
- decreased GABA activity

Differentiating Trauma-and-Stressor Related Disorders

Reactive Attachment Disorder

- withdrawn toward adult caregivers
- evident before age 5 years
- history of severe social neglect
- *Persistent:* more than 12 months
- *Severe:* when a child exhibits all symptoms of the disorder, with each symptom manifesting at relatively high levels
- significantly impairs young children's abilities to relate interpersonally to adults or peers
- co-morbid with cognitive delays, language delays and stereotypies
- internalizing symptoms may also co-occur

Disinhibited Social Engagement Disorder

- actively approaches and interacts with unfamiliar adults
- can be distinguished from ADHD by not showing difficulties in attention or hyperactivity
- *Persistent:* more than 12 months
- *Severe:* when a child exhibits all symptoms of the disorder, with each symptom manifesting at relatively high levels

Posttraumatic Stress Disorder (≥ 1 month)

- exposure to actual death, injury or sexual violence (direct experience, witness, learning that the event happened to a close family, repeated exposure)
- more than 1 month
- heightened activity in the HPA axis
- requires trauma exposure precede the onset of the symptoms
- *With Delayed Expression:* if full criteria are not met until at least 6 months after the event
- too much use of dissociation

Acute Stress Disorder (3 days ≤ ∞ ≤ 1 month)

- exposure to trauma (direct experience, witness, learning that event occurred to close fam, repeated exposure)
- 3 days to 1 month after trauma exposure
- if the symptoms persists for more than 1 month and meet the criteria for PTSD, then PTSD will be diagnosed

Adjustment Disorder (within 3 months)

- development of emotional or behavior symptoms in response to identifiable stressors occurring within 3 months of the onset of the stressors
- If symptoms persist beyond 6 months after the stressor or its consequences have ceased, the diagnosis will no longer apply (Other specified Trauma- and Stressor-Related Disorder)
- May sometimes be diagnosed instead of bereavement if bereavement is judged to be out of proportion to what would be expected or significantly impairs self-care and interpersonal relations
- persons from disadvantaged life circumstances experience a high rate of stressors and may be at risk for adjustment disorders

Prolonged Grief Disorder (nearly everyday)

- death, at least 12 months, of a person close to the bereaved individual (6 months for children)
- focused on loss and separation from a loved one rather than reflecting generalized low mood
- distress from a deceased person
- heightened by increased dependency on the deceased prior to death
- women >>>
- increased tobacco and alcohol use and other medical conditions
- co-morbid with MDD, PTSD and substance-use disorders (also, Separation Anxiety Disorder)

Source: Barlow, Durand & Hofmann (2018), Comer & Comer (2017), Hooley, Butcher, Nock & Mineka (2017), DSM-V, DSM-V-TR, Psych Pearls

Differentiating OCD-Related Disorders

Obsessive-Compulsive Disorder

- *Obsessions*: intrusive and mostly nonsensical thoughts, images, or urges that the individual tries to resist or eliminate
- *Compulsions*: thoughts or actions used to suppress the obsessions and provide relief
- *Sensory Phenomena:* physical experiences that precede compulsions
- common to avoid people, places, and things that trigger OC
- *Accommodation:* involvement of family and friends in compulsive rituals
- risks: perinatal events, premature birth, tobacco use during pregnancy, sexual and physical abuse or other environmental factors like infectious agents
- Tic Disorders is common to co-occur in patients with OCD
- obsessions usually do not involve real life concerns and can include one, irrational, or magical content
- In BDD and Tricho, the compulsive behavior is limited to hair pulling or distortions in absence of obsessions
- obsessions and compulsions are not limited to concerns about weight and food
- Compulsions are usually preceded by obsessions, tics are often preceded by premonitory sensory urges

Body Dysmorphic Disorder

- preoccupation with some imagined defect
- imagined ugliness
- *with muscle dysmorphia:* preoccupied with the idea that his or her body build is too small
- have ideas or delusions of reference
- associated with high levels of anxiety, social avoidance, depressed mood, negative affectivity, rejection sensitivity, and perfectionism
- as well as low extroversion and low self-esteem
- associated with abnormalities in emotion regulation, attention, and executive function
- excessive appearance-related preoccupations and repetitive behaviors that are time-consuming
- can be co-morbid with eating disorders, MDD, Social Anxiety, and substance-related disorders

Hoarding

- difficulty discarding or parting with possessions
- *Prader-Willi Syndrome*: characterized by severe hypotonia, poor appetite, and feeding difficulties in early infancy, followed in early childhood by excessive eating and gradual development of morbid obesity
- *With Excessive Acquisition:* if difficulty discarding possessions is accompanied by excessive acquisitions of items that are not needed or for which there is not available space
- other common features: indecisiveness, perfectionism, avoidance, procrastination, difficulty planning, and organizing tasks
- Animal Hoarding
- not direct consequence of neurodevelopmental disorder, nor delusion, nor psychomotor retardation, fatigue, or loss of energy

Trichotillomania

- should not be diagnosed when hair removal is performed solely for cosmetic reasons
- may be triggered by feelings of anxiety of boredom, may be preceded by an increasing sense of tension or may lead to gratification, pleasure, or sense of relief when the hair is pulled out
- hair pulling does not usually occur in the presence of other individuals, except immediate family members
- disorder is more common in individual with OCD and their first-degree relatives
- diagnosis will be OCD, if there is obsession of symmetry
- someone with ASD could have hair-pulling behaviors when frustrated or angry, so if it's impairing then it can be diagnosed as stereotypic movement disorder
- note the delusion or hallucination, if then, psychotic disorder
- accompanied by MDD and Excoriation disorder

Excoriation

- skin-picking
- note delusion or tactile hallucination
- In absence of deception, excoriation disorder can be diagnosed if there are repeated attempts to decrease or stop skin picking

Explaining Somatic Symptom Disorders

Somatic Symptom Disorder

- one or more symptoms cause distress and disruption of daily life
- chronic, influenced by the number of symptoms, age, level of impairment, and any comorbidity
- cognitive features include attention focused on somatic symptoms, attribution of normal bodily sensations to physical illness, worry about illness, a

Source: Barlow, Durand & Hofmann (2018), Comer & Comer (2017), Hooley, Butcher, Nock & Mineka (2017), DSM-V, DSM-V-TR, Psych Pearls

self-concept of bodily weakness, and intolerance of bodily complaints
- typically present to general health services rather than mental health services
- more frequent in individuals with few years of education and low socioeconomic status
- ineffectiveness of analgesics, history of mental disorders, unclear palliative factors, persistence without cessation, and stress
- must be accompanied by excessive or disproportionate thoughts, feelings, or behavior
- focus is on the distress that particular symptoms cause
- individual's belief that somatic symptoms might reflect serious underlying physical illness are not held with delusional intensity
- with enhanced perceptual sensitivity to illness cues

Illness Anxiety Disorder (≥ 6 months)

- preoccupation with having or acquiring serious illness
- usually minimal to no symptoms, mild intensity
- interpret ambiguous stimuli as threatening
- develop in the context of a stressful life
- People who develop these disorders tend to have a disproportionate incidence of disease in their family when they were children
- co-occurs with anxiety disorders, OCD, and depressive disorders
- history of child abuse and neglect
- 2-3x more common in women
- Panic Disorder and depressive disorders commonly co-occur with Conversion Disorder
- also, Somatic Symptom Disorder

Conversion Disorder (Functional Neurological Symptom Disorder)

- altered voluntary motor or sensory function
- incompatibility between the symptom and recognized neurological or medical conditions
- unexpected neurological disease cause for the symptoms is rarely found at follow-up
- too much use of denial

Psychological Factors affecting other Medical Conditions

- medical symptom is present
- psychological or behavioral factors affect medical condition
- psychological or behavioral factors are judged to affect the course of medical condition
- Psychological factors affecting other medical conditions is diagnosed when the psychological traits or behaviors do not meet criteria for a mental diagnosis

Factitious Disorder

- *Imposed on Self:* individual present himself or herself as ill
- *Imposed on Another*: presents another individual as ill
- absence of obvious rewards
- *Malingering*: false medical symptoms or exaggerating existing symptoms in hopes of being rewarded

Evaluating DID from other Disorders

Depersonalization-Derealization Disorder

- *Depersonalization:* your perception alters so that you temporarily lose the sense of your own reality, as if you are in a dream watching yourself
- *Derealization:* your sense of external world is lost; thing may seem to change shape or size, people may seem dead or mechanical
- characterized by the presence of constellation of typical depersonalization/derealization symptoms and the absence of manifestations of illness anxiety disorder
- must precede the onset of major depressive epi or clearly continues even after its resolution
- when symptoms occur ONLY during panic attacks, it must not be diagnosed with D/DD

Dissociative Amnesia

- inability to recall important autobiographical information, usually of traumatic or stressful nature, that is inconsistent with ordinary forgetting
- usually localized or selective amnesia for specific events, then generalized, if entire life history
- *Dissociative Fugue:* memory loss revolves around specific incident, an unexpected trip; individuals just take off and later find themselves in a new place, unable to remember why or how you got there
- If a person experiencing PTSD cannot recall part or all of specific trauma event and that extends to beyond the immediate time of the trauma, comorbid diagnosis of DA may be warranted
- there must be no true neurocognitive deficits
- too much use of repression

Dissociative Identity Disorder

- disruption of identity characterized by two or more distinct personality states
- *host personality:* the person who becomes the patient and asks for treatment; developed later

Source: Barlow, Durand & Hofmann (2018), Comer & Comer (2017), Hooley, Butcher, Nock & Mineka (2017), DSM-V, DSM-V-TR, Psych Pearls

- *switch:* transition from one personality to another
- extreme subtype of PTSD
- *Hypnotic Trance:* tend to be focused on one aspect of their world and they become vulnerable to suggestions by the hypnotist
- present with comorbid depression, anxiety, substance abuse, self-injury, or another common symptom
- early life trauma represent as risk factor
- several brain regions have been implicated in the pathophysiology of DID, including the orbitofrontal cortex, hippocampus, parahippocampal gyrus, and amygdala
- does not have a classic bipolar sleep disturbance
- Individuals with schizophrenia have low hypnotic capacity, whilst, individuals with DID have highest hypnotic capacity among all clinical groups
- appear to encapsulate a variety of severe personality disorder features
- too much use of dissociation
- comorbid with PTSD, depressive disorders, substance-related disorders, feeding and eating disorders, etc.
- most common forms of functional neurological symptom disorder include nonepileptic seizures, gait disturbances, and paralyses

Illustrating Depressive Disorders

Unipolar Disorders

Disruptive Mood Dysregulation Disorder (3x or more/week, ≥ 12 months)

- recurrent temper outburst (verbally or behaviorally) that are grossly out of proportion
- 3 or more times/week
- irritable or angry most of the day
- 12 or more months, at least 2 settings
- onset should be after 6 yrs-18yrs
- factors associated with disrupted family life
- family history of depression may be a risk factor
- do not occur exclusively during MDE
- bipolar = episodic, DMDD = persistent
- diagnosis cannot be assigned to a child who has ever experienced full-duration hypomanic or manic episode (irritable or euphoric) or who has ever had a manic or hypomanic episode lasting more than 1 day
- presence of severe and frequently recurrent outburst and persistent disruption in mood between outburst
- severe in at least one setting and mild to moderate to second setting
- children with DMDD should not have symptoms that meet criteria for BD, as in that context, only the bipolar disorder diagnosis should be made
- if children have symptoms that meet criteria for ODD or IED and DMDD, then only DMDD is the diagnosis

Major Depressive Disorder (≥ 2 weeks)

- at least 2 weeks of either anhedonia or depressed mood
- associated with high mortality
- hyperactivity in HPA axis and it appears to be associated with melancholia, psychotic features, and risks for eventual suicide
- "other specified depressive disorder" can be made in addition to the diagnosis of psychotic disorder, if the depressive symptoms meet full criteria for MDE
- in schizoaffective, delusions or hallucinations occur exclusively for 2 weeks without MDE
- Seasonal, Catatonic, Melancholic
- other disorders with which MDD co-occurs are substance-related disorders, panic disorder, GAD, PTSD, OCD, AN, BN, and Borderline PD

Persistent Depressive Disorder (Dysthymia) (≥ 2 yrs)

- depressed mood for at least 2 years
- if full criteria for a MDE has been met at some point during the period of illness, a diagnosis of MDD would apply. Otherwise, a diagnosis of "other specified depressive disorder" or "unspecified depressive disorder" should be given
- a separate diagnosis of PDD is not made if the symptom occur only during the course of the psychotic disorder
- *Double Depression:* suffer from both MDE and PDD with fewer symptoms

Premenstrual Dysphoric Disorder

- majority of menstrual cycles, at least 5 symptoms must be present
- delusions and hallucinations have been described in the late luteal phase of the menstrual cycle but are rare

- **Seasonal Affective Disorder** – episodes must have occurred for at least 2 yrs with no evidence of nonseasonal MDE during that period of time
  - Cabin fever
- **Integrated Grief** – acute grief, the finality of death and its consequences are acknowledged and the individual adjusts to the loss
- **Complicated Grief** – this reaction can develop without preexisting depressed state

Source: Barlow, Durand & Hofmann (2018), Comer & Comer (2017), Hooley, Butcher, Nock & Mineka (2017), DSM-V, DSM-V-TR, Psych Pearls

- Bipolar disorder may simply be a more severe variant of mood disorders
- Depression and mania appear to be the world's first documented mental illnesses
- **Aretaeus of Cappadocia –** combined these two groups of symptoms into bipolar disorder by stating that mania was a worsened state of melancholia
- **Theophile Bonet –** began using the term *melancholicus mania* in 1679
- **Willis –** described Melancholia and Mania as distempers of raving in his writing
- **Emil Kraeplin –** employed a unifying approach to the classification of mood disorders, resulting in bipolar disorder being subsumed within the category of *manic-depressive insanity* (MDI)
  - Individuals with this diagnosis experienced mild residual states after recovery from individual episodes and mild fluctuations between episodes
  - Adolf Meyer, Karl Abraham, and Melanie Klein, were some of the first to make references to manic-depressive symptoms in children
- Things to consider in the Dx of Depressive Disorder DUE to another med condition:
  - ✓ No depressive prior to the onset of medical condition (e.g., before Manny was diagnosed with cancer, he never experienced depressive episodes)
  - ✓ the probability that a medical condition has a potential to cause a depressive disorder

Bipolar Disorders

Bipolar I (Manic, ≥ 1 week)

- at least 1 manic episode (elation and euphoria)
- children should be judged according to his or her own baseline in determining whether a particular behavior is normal or evidence of manic episode
- first ep usually MDE
- factors that should be considered: family history, onset, medical history, presence of psychotic symptoms, history of lack of response to antidepressant treatment or the emergence of manic episode during antidepressant treatment
- The diagnosis is "Bipolar I disorder, with psychotic features" if the psychotic symptoms have occurred EXCLUSIVELY during manic and major depressive episodes
- Symptoms of mania in BP1 occur in distinct episodes and typically begin in late adolescence or early adulthood
- When any child is being assessed for Mania, it is essential that the symptoms represent clear change from the child's typical behavior
- Symptoms of mood lability and impulsivity must represent a distinct episode of illness, or there must be a noticeable increase in these symptoms over the individual's baseline in order to justify an additional diagnosis of BP1
- Young people who meet DSM-5 diagnostic criteria for BP display significant impairment in functioning, including previous hospitalization, MDD, treatment with medications, and co-occurring disruptive behavior and anxiety disorder
- Youths may show irritability and rage or silly, giddy, overexcited, overly talkative behavior
- generally shorter than MDE, lasting from 4-6 months if left untreated
- most frequently comorbid disorders are anxiety disorders, alcohol use disorder, other substance disorders, and ADHD
- high rates of serious co-occurring and often untreated medical conditions

Bipolar II (Hypomanic, ≥ 4 days)

- MDE + Hypomanic episodes
- often begins with depressive episodes
- highly recurrent
- once hypomanic episode has occurred, it never reverts back to MDD
- BP2 is distinguished from cyclothymic disorder by the presence of one or more hypomanic episodes and one or more MDE
- common feature is impulsivity
- heightened levels of creativity during hypomanic episodes
- perform more poorly than healthy individuals on cognitive tests, may contribute to vocational difficulties
- more often than not associated with one or more co-occurring mental disorders, with anxiety disorders being the most common
- risk tends to be highest among relatives of individuals with BPII, as opposed to individuals with BP1 or MDD

Cyclothymic Disorder (≥ 2 years, ≥ 1 year for Children and Adolescents)

- milder but more chronic version of bipolar disorder
- do not meet the complete criteria for depressive symptoms and hypomanic symptoms

- MDD, BP1, and BP2 are more common among first degree biological relatives of indivs with cyclothymic disorder
- substance-related disorders and sleep disorders may be present in individuals with cyclothymic disorder

- Adolescents with Mania often have complex presentations that include psychotic symptoms
- Adolescents may have prolonged early course and a poorer response to treatment
- Children often seem to exhibit a very rapid fluctuation in mood symptoms, especially when such symptoms are co-morbid with other disorders
- Irritability in children with BD is very severe, persistent, highly disabling, and often associated with violence
- Clients experience difficulties in emotion regulation
- Emotional Overregulation also is related to behavioral inhibition and may lead to internalizing problems in children
- **Emotion Reactivity** – refers to individual differences in the threshold and intensity of emotional experience, which provide clues to an individual's level of distress and sensitivity to the environment
  - Increased in children with bipolar disorder
- **Emotion Regulation** – involves enhancing, maintaining, or inhibiting emotional arousal, which is usually done for a specific purpose or goal
- **Dysregulation** – means that existing control structures operate maladaptively
- Emotions help young children learn more about themselves and their surroundings, as part of learning to identify and monitor their feelings and behavior

Explaining Eating and Sleeping Disorders

Eating Disorders

Pica (≥ 1 month)

- eating of non-nutritive, nonfood substances for at least 1 month
- no biological abnormalities found
- neglect, lack of supervision, and developmental delay can increase the risk for this condition
- inappropriate to the developmental age
- co-morbid with ASD, ID, and to some degree, schizo and OCD
- can be associated with trichotillomania and excoriation, which the skin or hair is typically ingested

Rumination Disorder (≥ 1 month)

- repeated regurgitation of food for at least 1 month
- infants with rumination disorder display characteristic position of straining and arching the back with head held back, making sucking movements with their tongue (give an impression of pleasure or satisfaction)
- irritable and hungry between episodes
- features: weight loss and failure to make expected weight gains
- re-chewed, re-swallowed, or spit-out
- not attributable to gastrointestinal or other medical condition
- self-soothing or self-stimulating
- can occur in the context of a concurrent medical condition or another mental disorder

Avoidant/Restrictive Food Intake Disorder

- eating or feeding disturbance
- lack of interest in eating food
- dependence on enteral feeding or nutritional supplements
- risks: familial anxiety
- A/RFID co-morbid with ASD has male predominance
- requires that the disturbance of intake is beyond that directly accounted for by physical symptoms consistent with medical condition; the eating disturbance may also persist after being triggered by medical condition and following resolution of the medical condition
- if eating problems is the focus, then A/RFID, if weight, then Anorexia Nervosa
- might precede the onset of Anorexia Nervosa
- *Food Avoidance Emotional Disorder*
- co-morbid with Anxiety disorders, ADHD, ID

Anorexia Nervosa

- fear of gaining weight
- subtypes: binge-eating/purging type and restricting type
- associated with stressful life event
- additional diagnosis of BDD may be considered if the distortion is unrelated to body shape and size (there is a separation distortion in mind happening)
- amenorrhea and cardiovascular problems
- very underweight
- Bipolar, Depressive, and anxiety disorders commonly co-occur with Anorexia Nervosa
- Alcohol use Disorder and other substance disorder may also be co-morbid with Anorexia, especially those with binge eating/purging type

Source: Barlow, Durand & Hofmann (2018), Comer & Comer (2017), Hooley, Butcher, Nock & Mineka (2017), DSM-V, DSM-V-TR, Psych Pearls

Bulimia Nervosa (once a week, for 3 months)

- recurrent episodes of binge-eating then purging to prevent weight gain
- binge-eating for at least once a week for 3 months
- normal weight
- chronic purging can result to enlargement of salivary gland caused by repeated vomiting, causing chubby face
- electrolyte imbalance that may lead to arrythmia, seizures, and renal failure

Binge-Eating Disorder (once a week, for 3 months)

- recurrent episodes of just binge eating
- do not show marked or sustained dietary restriction designed to influence body weight and shape between binge-eating episodes
- consume more calories in laboratory studies of eating behavior and have greater functional impairment, lower quality life, more subjective distress, and greater psychiatric comorbidity
- usually overweight
- most common comorbid disorders – MDD and alcohol use disorder

Elimination Disorders

Enuresis

- repeated voiding of urine in bed, voluntary or intentional
- on nocturnal, voiding usually happens during REM Sleep
- enuretic events most commonly occur in the early afternoon on school days or after returning to school
- developmental delays, including speech, language, learning, and motor skills delay are present in a portion of children with enuresis

Subtypes:
Nocturnal (monosymptomatic enuresis)
Diurnal (Urinary Incontinence)
Nocturnal and Diurnal (nonmonosymptomatic enuresis)

Encopresis (one event each month for ≥ 3 months)

- repeated passage of feces into inappropriate places
- feels ashamed and may wish to avoid situations that might lead to embarrassment
- Enuresis is often present in children with encopresis, particularly in children with encopresis, without constipation and overflow incontinence

Subtypes:
With constipation and overflow incontinence
Without constipation and overflow incontinence

Sleeping Disorders

- **Dyssomnias** – difficulties in getting enough sleep, problems with sleeping when you want to and complaints about the quality of sleep
- **Parasomnias** – characterized by abnormal behavior or physiological events that occur during sleep
- **REM Sleep** – during which the majority of typical story-like dreams occur (20%-25% of total sleep)

NREM Sleep Stage 1 (N1) – transition from wakefulness to sleep and occupies about 5% of time spent asleep in healthy adults

NREM Sleep Stage 2 (N2) – characterized by specific electroencephalographic waveforms (sleep spindles and K complexes), occupies about 50% of time spent sleep

NREM Sleep Stage 3 (N3) – slow wave sleep; deepest level of sleep

- **Sleep Continuity** – overall balance of sleep and wakefulness during night of sleep

Sleep Latency – amount of time required to fall asleep

Wake after Asleep onset – the amount of awake time between initial sleep onset and final awakening

Number of awakenings

Sleep Efficiency – ratio of actual time spent asleep to time spent in bed

- **Sleep Architecture** – amount and distribution of specific sleep stages
  - Measures the amount of REM sleep and each NREM sleep stage, relative amount of REM sleep and NREM sleep stages, and latency between sleep onset and the first REM period

Insomnia (3 nights/week, ≥ 3 months)

- difficulty initiating and maintaining sleep
- early-morning awakening with inability to return to sleep
- at least 3 nights/week, for at least 3 months
- *Rebound Insomnia:* sleep problems re-appearing, but sometimes worst
- situational, persistent, or recurrent, episodic

Hypersomnolence Disorder (3x/week, ≥ 3 months)

- excessive sleepiness despite having at least 7 hours of main sleep
- recurrent periods of sleep or lapses into sleep within the same day
- take longer naps, have trouble waking from naps, and do not feel alert afterward
- at least 3x/week, for at least 3 months

Narcolepsy (3x/week, ≥ 3 months)

Source: Barlow, Durand & Hofmann (2018), Comer & Comer (2017), Hooley, Butcher, Nock & Mineka (2017), DSM-V, DSM-V-TR, Psych Pearls

- recurrent episodes of irrepressible need to sleep, lapsing into sleep, or napping with cataplexy, hypocretin deficiency, and evidence from polysomnography showing REM sleep latency less than or equal to 15 mins
- 3x/week, for at least 3 months

Obstructive Sleep Apnea Hypopnea

- at least 4 obstructive apneas or hypopneas per hour of sleep or evidence from polysomnography of 15 or more obstructive apneas and/or hypopneas per hour of sleep
- *Apnea:* absence of airflow
- *Hypopnea:* reduction in airflow

Central Sleep Apnea

- evidence by polysomnography of 5 or more central apneas per hour of sleep
- *Cheyne-Stokes Breathing:* an abnormal pattern of breathing characterized by progressively deeper, and sometimes faster, breathing followed by a gradual decrease that results in a temporary stop in breathing called an apnea

Sleep-Related Hypoventilation

- Polysomnography demonstrates episodes of decreased respiration associated with elevated CO2 levels

Circadian Rhythm Sleep-Wake Disorders

- persistent or recurrent pattern of sleep disruption due to alteration of the circadian system or misalignment between the endogenous circadian rhythm
- leads to excessive sleepiness or insomnia, or both

Non-REM Sleep Arousal Disorders

- incomplete awakening from sleep: sleepwalking or sleep terrors
- cannot remember anything when they woke up
- occur mostly in childhood and non-rem sleeps
- produce rapid and complete awakening without confusion, amnesia, or motor activity

Nightmare Disorder

- repeated occurrences of extended, extremely dysphoric, and well-remembered dreams that usually involve efforts to avoid threats to survival, security, or physical integrity
- upon awakening, they become oriented and alert
- appear in children exposed to acute or chronic psychosocial stressors
- occur during REM Sleep

REM Sleep Behavior Disorder

- repeated episodes of arousal during sleep associated with vocalization and/or complex motor behaviors
- during REM sleep
- upon awakening, the individual is completely awake, alert, and not confused

Restless Legs Disorder (3x/week, ≥ 3 months)

- urge to move the legs, usually accompanied or in response to uncomfortable and unpleasant sensations of the legs
- during rests
- sense of relief during the movement
- worse in evening
- 3x/week, for at least 3 months

Evaluating Sexual dysfunctions, Paraphilic disorders, and Gender Dysphoria

Sexual Dysfunctions

Delayed Ejaculation (≥ 6 months)

- delay or absence of ejaculation
- associated with highly frequent masturbation, use of masturbation techniques not easily duplicated by a partner, and marked disparities between sexual fantasies during masturbation and the reality of sex with a partner
- less coital activity, higher levels of relationship distress, sexual dissatisfaction, lower subjective arousal, anxiety about their sexual performance, and general health issues than sexually functional men
- at least 6 months
- either lifelong or acquired, generalized or situational
- common in severe forms of MDD

Erectile Disorder (≥ 6 months)

- difficulty having, maintaining erection and decrease in erectile rigidity
- low self-esteem, low self-confidence, and a decreased sense of masculinity, and may experience depressed mood
- strongly associated with feelings of guilt, self-blame, sense of failure, anger, and concern about disappointing one's partner
- decreased sexual satisfaction and reduced sexual desire
- co-morbid with other sexual disorders, anxiety and depressive disorders
- at least 6 months

Female Orgasmic Disorder

- delay or absence of orgasm and reduced intensity of orgasmic sensations
- greater difficulty communicating about sexual issues
- high levels of sexual satisfaction despite rarely or never experiencing orgasm

Source: Barlow, Durand & Hofmann (2018), Comer & Comer (2017), Hooley, Butcher, Nock & Mineka (2017), DSM-V, DSM-V-TR, Psych Pearls

- may have co-occurring sexual interest/arousal difficulties
- at least 6 months
- either lifelong or acquired, generalized or situational

Female Sexual Interest/Arousal Disorder (≥ 6 months)

- absent/reduced interest in sexual activity
- associated with problems in experiencing orgasm, pain experienced during sexual activity, infrequent sexual activity, and couple-level discrepancies in desire
- no sexual thoughts or fantasies, no initiation, no sexual excitement or pleasure during sex
- distressing low desire is associated with depression, thyroid problems, anxiety, urinary incontinence, and other medical factors
- at least 6 months

Genito-Pelvic Pain/Penetration Disorder (≥ 6 months)

- difficulties in vaginal penetration during intercourse
- vaginal pain during intercourse or penetration attempts
- anxiety about anticipating vulvovaginal or pelvic pain
- frequently associated with other sexual dysfunctions, particularly reduced sexual desire and interest
- pattern of avoidance is similar to that seen in phobic disorders
- at least 6 months

Male Hypoactive Sexual Disorder (≥ 6 months)

- persistently deficient or absent sexual/erotic thoughts or fantasies and desire for sexual activity
- sometimes associated with erectile and/or ejaculatory concerns
- rarely the sole sexual diagnosis in men
- at least 6 months

Premature (Early) Ejaculation (≥ 6 months)

- ejaculation approx. 1 min following vaginal penetration or even before the individual wishes it
- complain a sense of lack of control over ejaculation and report apprehension about their anticipated inability to delay ejaculation on future sexual encounters
- associated with erectile problems
- at least 6 months and must be experienced on almost all or all occasions

Paraphilic Disorders

Voyeuristic Disorder (≥ 6 months)

- intense arousal from observing an unsuspecting naked person for at least 6 months
- nonconsensual
- childhood sexual abuses, substance misuse, and sexual preoccupation/hypersexuality
- at least 18 yrs old

Exhibitionistic Disorder (≥ 6 months)

- intense arousal from exposing genitals to an unsuspecting person for at least 6 months
- nonconsensual

Frotteuristic Disorder (≥ 6 months)

- intense arousal from touching or rubbing genitals against nonconsenting person for at least 6 months
- nonconsensual

Sexual Masochism (≥ 6 months)

- intense sexual arousal from the act of being humiliated, beaten, bound, or otherwise made to suffer for at least 6 months

Sexual Sadism (≥ 6 months)

- intense sexual arousal from the physical suffering of another person for at least 6 months

Pedophilic Disorder (≥ 6 months)

- intense sexually arousing fantasies, urges, or behaviors involving prepubescent child or children for at least 6 months
- has ACTED on these urges
- at least 16 yrs old and at least 5 yrs older than the child or children

Fetishistic Disorder (≥ 6 months)

- intense sexual arousal from either the use of nonliving objects or highly specific focus on nongenital body parts for at least 6 months
- not limited to cross-dressing or sex toys

Transvestic Disorder (≥ 6 months)

- intense arousal from cross-dressing for at least 6 months

Gender Dysphoria

Gender Dysphoria (≥ 6 months)

- marked incongruence between one's experienced/expressed gender and assigned gender, for at least 6 months
- intersexuality or hermaphroditism
- slightly higher levels of testosterone or estrogen at certain critical periods of development
- show elevated levels of anxiety, disruptive, impulse-control, and depressive disorders

Source: Barlow, Durand & Hofmann (2018), Comer & Comer (2017), Hooley, Butcher, Nock & Mineka (2017), DSM-V, DSM-V-TR, Psych Pearls

Explaining Substance-Related and Addictive Disorder

- **Substance –** chemical compounds that are ingested to alter mood or behavior
- **Psychoactive substances –** alter mood, behavior, or both
- **Substance Use –** ingestion of psychoactive substances in moderate amounts that does not significantly interfere with social, educational, or occupational functioning
- **Substance Intoxication –** physiological reaction to ingested substances
- **Substance Use Disorders –** how much of a substance is ingested is problematic
- **Physiological Dependence –** meaning the use of increasingly greater amounts of the drug to experience the same effect (tolerance) and a negative physical response when the substance is no longer ingested (withdrawal)

Alcohol – produced when certain yeast react with sugar and water, then fermentation takes place
- depressant
- inhibitions are reduced and we become more outgoing
- with more drinking, alcohol depresses the brain which impedes the functioning
- *Withdrawal Delirium (Delirium Tremens):* condition that can produce frightening hallucinations and body tremors
- *Breathalyzer:* measures levels of intoxication
- GABA seems to be particularly sensitive to alcohol
- The Glutamate system is involve why alcohol affects our cognitive abilities
- Two types of organic brain syndromes may result from long-term alcohol use: **Dementia** and **Wernicke-Korsakoff Syndrome** (Confusion, loss of muscle coordination, and unintelligible speech, believed to be cause by a deficiency of thiamine)
- *Fetal Alcohol Syndrome*
- *Alcohol Dehydrogenase:* metabolize alcohol
- *Korsakoff syndrome***:** is a chronic memory disorder caused by severe deficiency of thiamine (vitamin B-1).
- Korsakoff syndrome is most caused by alcohol misuse, but certain other conditions also can cause the syndrome

Four-Stage Model for the progression of Alcoholism:
1. **Pre-Alcoholic Stage –** drinking occasionally with few serious consequences
2. **Prodromal Stage –** drinking heavily but with few outward signs of a problem
3. **Crucial Stage –** loss of control, with occasional binges
4. **Chronic Stage –** primary daily activities involve getting and drinking alcohol

Caffeine – most common psychoactive substance
- "gentle stimulant"
- found in tea, coffee, soda, and cocoa products

Cannabis (Marijuana) – reactions include mood swings or even dream-like experiences
- chronic and heavy users report tolerance, especially to euphoric high: they are unable to reach the levels of pleasure they experienced earlier

Hallucinogens – most common, "LSD" produced synthetically in the laboratory
- others: psilocybin (mushroom), lysergic acid amide (seeds of morning glory plant), dimethyltryptamine (DMT), and mescaline
- Phencyclidine (PCP) is snorted, smoked, or injected intravenously, and it causes impulsivity and aggressiveness

Inhalant – solvents, aerosol sprays, gases, nitrites, usually found at home or workplace

Opioid – natural chemicals in the opium poppy that have narcotic effect (relieves pain and induce sleep)
- includes natural opiates, synthetic variation, and the comparable substances that occur naturally in the brain
- also includes Heroin

Sedative-, Hypnotic-, or Anxiolytic- - calming, sleep-inducing, and anxiety-reducing
- includes barbiturates and benzodiazepines
- barbiturates and benzodiazepines relax the muscles and can produce mild feeling of well being
- combining alcohol with these substances can be fatal (Manilyn Monroe case)

Stimulant – most commonly consumed psychoactive drugs in US
- includes caffeine, nicotine, amphetamines, and cocaine
- *Amphetamine:* can induce feelings of elation and vigor and can reduce fatigue; prescribed to people with narcolepsy and ADHD
- another variants of Amphetamine are Methylene-dioxymethamphetamine or ecstasy club drug (makes you feel euphoric) and methamphetamine (crystal meth)

Source: Barlow, Durand & Hofmann (2018), Comer & Comer (2017), Hooley, Butcher, Nock & Mineka (2017), DSM-V, DSM-V-TR, Psych Pearls

- *Cocaine:* increases alertness, produces euphoria, increases blood pressure and pulse, and causes insomnia and loss of appetite
- Intranasal use and oral use of substances result in more gradual progression occurring over months to years

Tobacco – contains nicotine
- linked with signs of negative affect such as depression, anxiety, and anger
- being depressed increases your risk of becoming dependent on nicotine and, at the same time, being dependent will increase your risk of becoming depressed

- Acute alcohol withdrawal occurs as an episode usually lasting 4-5 days and only after extended periods of heavy drinking
- Withdrawal is rare for individuals younger than 30 years
- The symptoms of an alcohol-induced mental disorder are likely to remain clinically relevant as long as the individual continues to experience severe intoxication or withdrawal
- Genetic factors may affect how people experience and metabolize certain drugs
- Positive and Negative Reinforcement
- **Opponent-Process Theory** – an increase in positive feelings will be followed shortly by an increase in negative feelings and vice versa
- **Expectancy Effect** – expectancies develop before people actually use drugs, perhaps as a result of loved one's use, advertising, etc.
- Treatment: Nicotine replacement therapy, Bupropion, Naltrexone, Acamprosate, Disulfiram, Methadone, Buprenorphine, Aversion Therapy, In-patient treatments, Aversion Therapy, etc.
- **Cross-Tolerance** – tolerance for a substance has not taken before as a result of using another substance similar to it
- **Synergistic Effect** – an increase of effects that occurs when more than one substance is acting on the body at the same time

Gambling Disorder (within 12 months)
- persistent and recurring gambling behavior
- at least 4-symptoms within 12 months
- Onset can occur during adolescence or young adulthood but in other individuals it manifests during middle or even older adulthood
- Progression appears to be more rapid in women than in men
- An additional diagnosis of gambling disorder should be given only if the gambling behavior is not better explained by manic episodes
- associated with poor general health

Explaining Disruptive, Impulse-Control disorders, and Conduct Disorder

Oppositional Defiant Disorder (≥ 6 months
- angry irritable mood, argumentative/defiant behavior against authority figure for at least 6 months
- annoys others
- blames others for his/her mistakes
- two of the most co-occurring conditions w ODD are ADHD and CD
- precedes the development of conduct disorder, common in children with the childhood-onset subtype
- conveys risk for the development of anxiety disorders and MDD
- increased risk for a number of problems in adjustment as adults
- less severe than CD and do not include aggression towards people, property (IED)
- co-morbid with ADHD
- diagnosis should not be made if the symptoms occur exclusively during the course of a mood disorder
- if criteria for DMDD are met, then DMDD is given even if all criteria for ODD are met

Intermittent Explosive Disorder (2x/week, for 3 months)
- behavioral outburst, failure to control aggressive impulses
- verbal aggression, physical aggression twice weekly for a period of 3 months
- at least 6 yrs of age
- quite common regardless of the presence of ADHD or other disruptive, impulse-control, and conduct disorders
- depressive disorders, anxiety disorders, and substance use disorders are associated
- presence of serotogenic abnormalities, globally and in the brain, specifically in areas of limbic system and orbitofrontal cortex
- amygdala responses to anger stimuli are greater
- volume of gray matter in several frontolimbic regions is reduced
- Also, should not be made in children and adolescents ages 6-18 years, when the impulsive aggressive outbursts occur in the context of an adjustment disorder

Source: Barlow, Durand & Hofmann (2018), Comer & Comer (2017), Hooley, Butcher, Nock & Mineka (2017), DSM-V, DSM-V-TR, Psych Pearls

- A diagnosis of DMDD can only be given when the onset of recurrent, problematic, impulsive aggressive outburst is before age of 10 years
- A diagnosis of DMDD should be made for the first time after 18 years
- Aggression in ODD is typically characterized by temper tantrums and verbal arguments with authority figures, whereas IED are in response to a broader array of provocation and include physical assault
- co-morbid with depressive disorders, anxiety disorders, PTSD, Bulimia, Binge-eating, and substance use disorder

Conduct Disorder

- repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated
- often bullies, initiates fights, physically cruel, destroying properties, theft, serious violation of rules
- Onset may occur as early as the preschool years, but the first significant symptoms usually emerge during the period from middle childhood through middle adolescence
- ODD is the most common precursor to the childhood-onset type
- Physically aggressive symptoms = childhood
- Nonaggressive symptoms = adolescence
- May be diagnosed in adults, though onset is rare after age 16 years
- Childhood-onset type predicts a worse prognosis and an increased risk of criminal behavior in adulthood
- When criteria for both ODD and CD are met, both diagnoses can be given
- When criteria for both ADHD and CD are met, both diagnoses can be given
- Individuals with conduct disorder will display substantial levels of aggressive or nonaggressive conduct problems during periods in which there is no mood disturbance, either historically or concurrently
- If criteria for both IED and CD has been met, the diagnosis of IED should be given only when the recurrent impulsive aggressive outbursts warrant independent clinical attention
- CD is diagnosed only when the conduct problems represent a repetitive and persistent pattern that is associated with impairment in social, academic, or occupational functioning

Pyromania

- purposeful fire setting on more than one occasion
- make considerable advance prep for starting a fire
- arousal before the act
- fascination to fire and its situational context
- not done for monetary gain or etc.
- separate diagnosis is not given when fire setting occurs as part of CD, manic episode, or antisocial personality disorder
- high co-occurrence of substance-use disorders, gambling, depressive and bipolar disorders, and other disruptive impulse-control, and conduct disorders

Kleptomania

- failure to resist impulses to steal objects that are not need for personal use
- there is an attempt to resist the impulse to steal, and they are aware that the act is wrong and senseless
- increase tension before committing the theft
- pleasure after committing the theft
- often feels depressed or guilty about the thefts
- associated with compulsive buying and depressive, bipolar, anxiety, eating, personality, substance-use and other disorders

Illustrating the different Personality Disorders

Cluster A

Paranoid

- excessively mistrustful and suspicious of others, without justification
- problems with close relationships
- overt argumentativeness, in recurrent complaining, or by hostile aloofness
- need to have a high degree of control over those around them
- rigid, critical of others, and unable to collaborate, although they have great difficulty accepting criticism themselves
- more common among relatives who have schizophrenia
- maybe due to early mistreatment or traumatic childhood experiences
- associated with prior history of childhood mistreatment, externalizing symptoms, bullying, and adult appearance of interpersonal aggression
- "I cannot trust people"
- too much use of projection
- Males = Females
- may experience brief psychotic episodes
- may develop MDD, Agoraphobia, and OCD
- most common co-occurring PD appear to be schizotypal, schizoid, narcissistic, avoidant, and borderline

Schizoid

Source: Barlow, Durand & Hofmann (2018), Comer & Comer (2017), Hooley, Butcher, Nock & Mineka (2017), DSM-V, DSM-V-TR, Psych Pearls

- detachment from social relationships and limited range of emotions
- difficulty expressing anger, even in response to direct provocation, which contributes to the impression that they lack emotion
- tendency to turn inward and away from the outside world
- childhood shyness is reported as a precursor to later personality disorder
- "Relationships are messy and undesirable"
- Males > Females
- sometimes, experience brief psychotic episodes

Schizotypal

- typically socially isolated and behave in ways that would seem unusual to many of us, and they tend to be suspicious and to have odd beliefs
- *ideas of reference:* false beliefs that random or irrelevant occurrences in the world directly relate to oneself
- have odd beliefs or engage in magical thinking
- associated with childhood mistreatment and could be resulted from PTSD symptoms
- "It is better to be isolated from others"
- Males > Females
- often seek treatment for the associated symptoms of anxiety or depression rather than PD

Cluster B

Histrionic

- tend to be overly dramatic and almost to be acting
- express emotions in an exaggerated manner
- characterized by social dominance
- more likely to get divorced or never get married
- have tendency to get bored with their usual routine
- histrionic and antisocial co-occur more often
- "ako ang bida"
- Females > Males

Borderline

- moods and relationships are unstable, and usually they have poor self-image
- have pattern of undermining themselves at the moment the goal is about to be realized
- may feel more secure with transitional object than interpersonal relationships
- often feel empty and are great risk of dying by their own hands
- often engage to suicidal behaviors
- tend to have turbulent relationships, fearing abandonment but lacking control over their emotions
- often intense, going from anger to deep depression in a short time
- prevalent in families with history of mood disorders
- if co-occurs with mood disorders, both are diagnosed
- recovery is more difficult and less stable
- "sad gorl iz me"
- Females = Males
- common co-occurring disorders incl. depressive and bipolar disorders, substance use disorders, anxiety disorders, eating disorders, PTSD, and ADHD

Narcissistic

- they consider themselves different from others and deserve special treatment
- unreasonable sense of self-importance and are so preoccupied with themselves that they lack sensitivity and compassion
- grandiosity
- very sensitive to criticism
- interpersonal relations are typically impaired because of problems related to self-preoccupation, entitlement, need for admiration, and relative disregard for sensitivities of others
- "I am the greatest in the world"
- Males > Females

Antisocial

- characterized as having history of failing to comply with social norms
- at least 18 years of age
- evidence of CD before 15 years old
- irresponsible, impulsive, and deceitful
- lacking in conscience and empathy, selfishly take what they want and do as they please, violating social norms and expectations
- CD will be given if the criteria for Antisocial PD is not met
- *Underarousal Hypothesis:* psychopaths have abnormally low levels of cortical arousal
- *Fearlessness Hypothesis*: psychopaths possess a higher threshold for experiencing fear than most other individuals
- **"**I am entitled to break rules"
- Males > Females
- may experience dysphoria, incl. complaints of tension, inability to tolerate boredom, and depressed mood

Source: Barlow, Durand & Hofmann (2018), Comer & Comer (2017), Hooley, Butcher, Nock & Mineka (2017), DSM-V, DSM-V-TR, Psych Pearls

Cluster C

Avoidant
- extremely sensitive of the opinion of others and although they desire social relationship, their anxiety leads them to avoid - they are likely to misinterpret social responses as critical, which in turn confirms their self-doubts - low self-esteem and hypersensitivity to rejection - have insecure attachment style characterized by desire for emotional attachment - extremely low self-esteem cause them to be limited with friendships and dependent to those they feel comfy with - feel chronically rejected by others and pessimistic about their future - negative self-concept - Social Anxiety Disorder – negative evaluations - "If they knew the real me, they would reject me" - Females > Males
Dependent
- rely on others to make ordinary decisions and even important ones which results in an unreasonable fear of abandonment - characterized by pessimism and self-doubt and tend to belittle their abilities and assets - take criticism and disapproval as proof of their worthlessness and lose faith in themselves - agree with other people's opinion just to be not rejected - feel uncomfortable or helpless when alone - "I need people to survive and be happy" - Females > Males
Obsessive-Compulsive
- perfectionist - fixation on things being done "the right way" - this preoccupation with details prevents them from completing much of anything - need to control - when criteria for both OCD and OCPD are met, both can be given - "I am perfectionist, everything should be done under my control and liking" - Males > Females

Illustrating Schizophrenia

- **John Haslam –** superintendent of a British Hospital who outlined a description of the symptoms of Schizophrenia in his book *Observations on Madness and Melancholy*
- **Philippe Pinel –** French physician who described cases of schizophrenia
- **Benedict Morel –** used the term *demence precoce* meaning early or premature loss of mind to describe schizophrenia
- **Emil Kraepelin –** unified the distinct categories of schizophrenia under the name *Dementia Praecox*
  - Combined several symptoms of insanity that had usually been viewed as reflecting separate and distinct disorders:
    a. **Catatonia –** alternating immobility and excited agitation
    b. **Hebephrenia –** silly and immature emotionality
    c. **Paranoia –** delusions of grandeur or persecution
  - Distinguished *dementia praecox*
  - Also noted the numerous symptoms in people with dementia praecox, including hallucinations, delusions, negativism, and stereotyped behavior
- **Eugen Bleuler –** introduced the term schizophrenia ("splitting of mind")
  - Associative Splitting
- **Positive Symptoms:**
  1. **Delusions –** misrepresentation of reality (disorder of thought content)

Persecutory – belief that one is going to be harmed, harassed and so forth
Referential – certain gestures, comments, environmental cues, and so forth are directed at one-self
Grandiose – when an individual believes that he or she has exceptional abilities, wealth, or fame
Erotomanic – when an individual believes falsely that another person is in love with him or her
Nihilistic – conviction that a major catastrophe will occur
Somatic – focus on preoccupations regarding health and organ function
Thought Withdrawal – thoughts have been "removed" by outside force
Thought Insertion – thoughts have been put into one's mind
Delusions of Control – one's body or actions are being acted on or manipulated by some outside force
Capgras Syndrome – person believes someone he or she knows has been replaced by a double
Cotard's Syndrome – the person believes he or she is dead
Clerambault Syndrome - characterized by the delusional idea, usually in a young woman, that a man

Source: Barlow, Durand & Hofmann (2018), Comer & Comer (2017), Hooley, Butcher, Nock & Mineka (2017), DSM-V, DSM-V-TR, Psych Pearls

whom she considers to be of higher social and/or professional standing is in love with her
Fregoli Syndrome – a person holds a delusional belief that different people are in fact a single person who changes his or her appearance or is in disguise

- **Motivational View of Delusions –** look at these beliefs as attempts to deal with and relieve anxiety and stress
- **Deficit View of Delusions –** sees these beliefs as a resulting from brain dysfunction that creates these disordered cognitions or perceptions

2. **Hallucinations –** experience of sensory events without any input from the surrounding environment

Auditory Hallucination – most common form experienced by people with schizophrenia
Autoscopic Hallucination - individual experiences, all or part of the person's own body appeared within the external space, viewed from his/her physical body
Hypnagogic Hallucination – happens during sleep
Ictal Hallucination – associated with temporal lobe foci
Hypnopompic Hallucinations – happens when waking up

- Most active part during Hallucination is Broca's Area (speech production)

- **Negative Symptoms –** usually indicate absence or insufficiency of normal behavior

Avolition – inability to initiate and persist activities
Anhedonia – lack of pleasure
Asociality – lack of interest in social interactions
Flat Affect/Affective Flattening – do not show emotions when you would normally expect them to

- **Disorganized Symptoms**

Disorganized Speech – individual may switch from one topic to another (derailment or loose associations) or answers to questions may be related or completely unrelated (tangentiality) - *Circumstantiality:* excessive and irrelevant detail in descriptions with the person eventually making his/her point **"Kumuha ako ng Koko Crunch sa sm, katabi ng honey gold flakes, nasa taas niya yung kellogs, color green yung milo.. masarap yung Koko Crunch,"** - *Concrete Thinking:* unable to abstract and speaks in concrete, literal terms **Kapag sinabihan mo siya ng "Break a leg", iisipin niya na babaliin niya dapat ang legs niya** 🦿
- *Clang Associations:* are groups of words chosen because of the catchy way they sound, not because of what they mean **"Gusto ko ng arrozcaldo, na apurado pero bugbog sarado na may champorado at biglang dehado,"** - *Loose Association:* a loose connection between thoughts that are often unrelated **"Umuwi ako ng probinsya. Favorite ko ang Speak Now TV. Ay! Malamig pala sa North Pole. Eto nga pala anak ko. Ang sakit mo naman sa puso,"** - *Neologism:* creating a new word meaning only to that person **Lathyzoid. Oh, hindi mo alam meaning diba? that's the point.** - *Word Salad:* combination of words that have no meaning **"Mine enchanted why sparks fly grow superman,"**
Inappropriate Affect – laughing or crying at improper times
Grossly Disorganized or abnormal motor behavior – childlike silliness to unpredictable agitation

- **Neologisms –** construction of new words in order to communicate with schizophrenics thoughts
- More severe symptoms of schizophrenia first occur in late adolescence or early adulthood
- **Prodromal Stage –** 1-2 year period before the serious symptoms occur but when less severe yet unusual behaviors start to show themselves
- Schizophrenia is partially the result of excessive stimulation of striatal dopamine d2 receptors
- It appears that several brain sites are implicated in the cognitive dysfunction observed among people with schizophrenia, especially prefrontal cortex, various related cortical regions and subcortical circuits, including thalamus and the striatum
- **Schizophrenogenic Mother –** used for a time to describe a mother whose cold, dominant, and rejecting nature was thought to cause schizophrenia in her children
- **Double bind communication –** used to portray communication style that produced conflicting messages, which caused schizophrenia to develop
- Families with high expressed emotion view the symptoms of schizophrenia as controllable and that the hostility arises when family members think that patients just do not want help themselves

Source: Barlow, Durand & Hofmann (2018), Comer & Comer (2017), Hooley, Butcher, Nock & Mineka (2017), DSM-V, DSM-V-TR, Psych Pearls

Delusional Disorder (≥ 1 month)

- one or more delusions for at least 1 month
- persistent belief that is contrary to the reality in the absence of other characteristics of schizophrenia
- tend not to have flat affect, anhedonia, or other negative symptoms
- socially isolated due to being suspicious
- *Shared Psychotic Disorder (Folie a Deux):* condition in which an individual develops delusions simply as a result of a close relationship with a delusional individual
- *Erotomanic, Grandiose, Jealous, Persecutory, Somatic, Mixed, Unspecified*
- functioning is better than what is observed in Schizophrenia
- eventually develop schizophrenia
- absence of active phase of schizophrenia (Attenuated Psychosis Syndrome)

Brief Psychotic Disorder (1 day ≤ ∞ ≤ 1 month)

- presence of one of the ff: delusions, hallucinations, disorganized speech, catatonic behavior for at least 1 day but less than 1 month, with eventual full return to premorbid level of functioning
- typically experience emotional turmoil or overwhelming confusion
- can experience relapse
- if psychotic symptoms persist for at least 1 day in PD, an additional diagnosis of Brief Psychotic Disorder may be appropriate

Schizophreniform Disorder (1 month ≤ ∞ ≤ 6 months)

- two or more of the following, present during a 1-month period: delusions, hallucinations, disorganized speech, catatonic behavior, negative symptoms
- at least 1 month BUT less than 6 months
- development similar to schizophrenia

Schizophrenia (≥ 6 months)

- two or more of the following, present during 1-month period: delusions, hallucinations, disorganized speech, catatonic behavior, negative symptoms
- disturbance in one or more major areas
- at least 6 months
- abrupt or insidious
- prognosis is influenced both by duration and by severity of illness and gender
- possible reduced psychotic experience during late life
- too much use of regression

Schizoaffective Disorder (≥ 2 weeks)

- major mood ep + delusions or hallucinations for 2 or more weeks
- some individuals tend to change diagnosis into mood disorder or to schizophrenia over time
- Anosognosia (poor insight) common in schizoaffective but less severe than in schizophrenia

Neurodevelopmental Disorders

Intellectual Developmental Disorder

- includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains
- difficulties with day-to-day activities to an extent that reflects both severity of their cognitive deficits and the type and amount of assistance their receive
- difficulties in conceptual, social, and judgement
- causes: deprivation, abuse, neglect, exposure to disease or drugs during pre-natal, difficulties during labor and delivery, infections, and head injury
- Phenylketonuria, Lesch-Nyhan Syndrome, Down Syndrome, Fragile X Syndrome
- generally nonprogressive, there are period of worsening, then stabilization, and in others progressive of intellectual function in varying degrees
- 2 SD below the mean
- lifelong
- most common co-occurring neurodevelopmental and other mental disorders are ADHD, Depressive and Bipolar disorder, anxiety disorders, ASD, stereotypic movement disorder, impulse-control disorders, and major neurocog. disorders

Components of Intellectual Functioning

1. Verbal Comprehension
2. Working Memory
3. Perceptual Reasoning
4. Quantitative Reasoning
5. Abstract Thought
6. Cognitive Efficacy

DSM-IV Criteria Intellectual Disability Severity

1. IQ 50-69 Mild – can live independently; intermittent support needed
2. IQ 36-64 Moderate – moderate levels of support; limited support needed in daily situations

IQ 20-35 Severe – requires daily assistance; extensive support needed

IQ <20 Profound – requires 24-hour care; pervasive support needed for every aspect

- often have congenital syndrome

Global Developmental Delay

Source: Barlow, Durand & Hofmann (2018), Comer & Comer (2017), Hooley, Butcher, Nock & Mineka (2017), DSM-V, DSM-V-TR, Psych Pearls

- for children under 5 years old when they fail to meet expected developmental milestone in several areas of functioning

Language Disorder

- difficulties in acquisition and use of language modalities due to DEFICITS in comprehension and production
- reduced vocab, limited sentence structure, impairments in discourse
- can be adept at accommodating to their limited language
- shy or reticent to talk
- regional, social, or cultural/ethnic variations must be considered when an individual is being assessed
- declines in critical social communication behavior during the first two years of life are evident in most children with ASD, thus, it must be not confused with LD
- associated with SLD, IDD, ADHD, ASD, and DCD

Speech Sound Disorder

- difficulty in speech sound production
- children's progression in mastering speech sound production should result in most intelligible speech by 3 years old
- continuous use of immature phonological simplification processes when the child has already passed the age wherein most of them can now produce words clearly
- when LD is present, Speech Sound Disorder has poorer prognosis
- selective mutism may develop
- co-occur with language disorder

Childhood-Onset Fluency Disorder (stuttering)

- disturbances in normal fluency and time patterning of speech that are inappropriate for the individual's age and language skills
- can be insidious or more sudden

Social (Pragmatic) Communication Disorder

- difficulties in the social use of verbal and nonverbal communication
- deficits in using communication for social purposes in a manner that is appropriate for the social context
- difficulties in following the rules of conversating and do not understand metaphors, etc.
- current symptoms or developmental history fails to reveal evidence that could meet the restrictive/repetitive patterns of behavior, interests, or activities of ASD

Autism Spectrum Disorder

- deficient Communication, Restrictive/Repetitive Actions/Behaviors, Impaired Social Interaction
- evident in early childhood
- failure to develop age-appropriate social relationships, social reciprocity, nonverbal comms, and initiating and maintaining social relationships
- inability to engage in joint attention
- maintenance of sameness
- The developmental course and absence of restrictive, repetitive behaviors and unusual interests in ADHD help in differentiating ASD and ADHD
- A concurrent diagnosis of ADHD should be considered when attentional difficulties or hyperactivity exceeds that typically seen in individuals of comparable mental age
- ADHD is one of the most common comorbidities in ASD
- A diagnosis of ASD in individual with IDD is appropriate when social communication and interaction are significantly impaired relative to the developmental level of the individual's nonverbal skills
- IDD is appropriate diagnosis when there is no apparent discrepancy between the level of social communicative skills and other intellectual skills
- The diagnosis of ASD supersedes that of social communication disorder whenever the criteria for ASD are met, and care should be taken to enquire carefully regarding past or current restricted/repetitive behavior
- **Rett Disorder** – genetic condition that affects mostly females and is characterized by hand wringing and poor coordination
- Clear genetic component
- Evidence of brain damage combined with psychosocial influences

Attention-Deficit/Hyperactivity Disorder (≥ 6 months)

- pattern of inattention and/or hyperactivity-impulsivity that interferes functioning for at least 6 months
- dislikes organization, focused work
- often losses things, forgets daily activities, and easily distracted
- fidgets a lot, stands up when seating is expected, always "on the go"
- present in two or more settings
- difficulty sustaining their attention on task or activity
- in pre-school, main manifestation is hyperactivity

Source: Barlow, Durand & Hofmann (2018), Comer & Comer (2017), Hooley, Butcher, Nock & Mineka (2017), DSM-V, DSM-V-TR, Psych Pearls

- Fidgetiness and restlessness in ADHD are typically generalized and not characterized by repetitive stereotypic movements
- A diagnosis of ADHD in IDD requires that inattention or hyperactivity be excessive for mental age

Specific Learning Disorder (≥ 6 months)

- difficulties learning and using academic skills for at least 6 months, despite interventions
- academic skills are substantially and quantifiably below those expected for the individual's chronological age, IQ, and education

Developmental Coordination Disorder

- acquisition and execution of coordinated motor skills are below expected given the chronological age
- clumsiness, slowness, and inaccuracy of performance of motor skills

Stereotypic Movement Disorder

- repetitive, seemingly driven, and apparently purposeless motor behavior
- may result in self-injury

Tic Disorders

- *Tourette's:* both motor and one or more vocal tics for more than 1 year
- *Persistent:* single or multiple motor or vocal tics, but NOT BOTH for more than 1 year
- *Provisional:* single or multiple more and/or vocal tics for less than 1 year since the first onset
- Motor Stereotypies are defined as involuntary rhythmic, repetitive, predictable movements that appear purposeful but serve no obvious adaptive function; often self-soothing or pleasurable and stop with distraction

Neurocognitive Disorders

- **Diffuse –** widespread damage
- **Focal –** involve circumscribed areas of abnormal change in brain structure

Delirium

- characterized by impaired consciousness and cognition during the course of several hours or days
- appear confused, disoriented, and out of touch with their surroundings
- often associated with disturbance in sleep-wake cycle (daytime sleepiness, nighttime agitation, difficulty falling asleep, excessive sleepiness, or wakefulness at night)
- effects may more lasting
- can be experienced by children who have high fevers or taking certain medication
- reversible
- occurs during the course of dementia
- full recovery with or without treatment

Major Neurocognitive Disorder

- gradual deterioration of brain functioning that affects memory, judgement, language, and other advanced cognitive process

Mild Neurocognitive Disorder

- early stages of cognitive declines
- most impairments in cognitive abilities but can, with some accommodations

- **Dementia –** describe a group of symptoms affecting memory, thinking, and social abilities severely enough to interfere daily life

Alzheimer's

– most common type of neurocognitive disorder, usually occurring after the age 65, marked most prominently by memory impairment
- Usually begins with mild memory problems, lapses of attention, and difficulties in language and communication
- Excessive senile plaques (sphere-shaped deposits of beta-amyloid protein that form in the spaces between certain neurons and in certain blood vessels of the brain as people age) and neurofibrillary tangles (twisted protein fibers that form within certain neurons)
- includes multiple cognitive deficits that develop gradually and steadily
- inability to integrate new information results to failure to learn new association
- Anomia, Apraxia, Agnosia, Amnesia, Aphasia
- cognitive deterioration is slow during the early and later stages but more rapid during middle stages

Vascular Injury

- when the blood vessels in the brain are blocked or damaged and no longer carry oxygen and other nutrients to certain areas of brain tissues, damage results
- declines in speed of information processing and executive functioning

Frontotemporal Degeneration

- categorize a variety of brain disorders that damage the frontal or temporal regions of the brain – areas that affect personality, language, and behavior
- declines in appropriate behavior or language
- *Pick's Disease*: rare neurological condition that produces symptoms similar to Alzheimer's, usually occurring in relatively early in life (40s or 50s)

Source: Barlow, Durand & Hofmann (2018), Comer & Comer (2017), Hooley, Butcher, Nock & Mineka (2017), DSM-V, DSM-V-TR, Psych Pearls

Traumatic Brain Injury

- symptoms must persist for at least a week following the trauma, including executive dysfunction and problems with learning and memory

Lewy Body Disease

- involves the buildup of clumps of protein deposits called Lewy Bodies, within many neurons
- Features significant movement difficulties, visual hallucinations, and sleep disturbances
- Second most common neurocognitive disorder
- gradual and include impairment in alertness and attention, vivid visual hallucinations, and motor impairment

Parkinson's Disease

- slowly progressive neurological disorder marked by tremors, rigidity, and unsteadiness
- motor problems, tend to have stooped posture, slow body movements (bradykinesia), tremors, and jerkiness
- can also involve depression, anxiety, apathy, cognitive problems, and even positive symptoms
- damage in dopamine pathways, loss of dopamine neurons in substantia nigra
- second most common neurodegenerative disorder

HIV Infection

- HIV infection seems to be responsible for the neurological impairment
- early symptoms: cognitive slowness, impaired attention, and forgetfulness
- clumsy, repetitive movements, and become apathetic and socially withdrawn
- sometimes referred as *Subcortical Dementia*
- more likely to experience depression and anxiety
- involves various changes in the brain such as generalized atrophy, edema, inflammation, and patches of demyelination

Substance-Use

- use of different psychoactive substances + poor diet
- include memory impairment, aphasia, apraxia, agnosia, or disturbance in executive functioning

Huntington's

- inherited progressive disease in which memory problems, along with personality changes and mood difficulties, worsen over time
- characterized by chronic, progressive chorea with subtle cognitive problems
- Have movement problems too, such as severe twitching and spasms
- rare degenerative disorder of CNS
- caused by single dominant gene (Huntingtin Gene) on Chromosome 4
- loss of cells in the basal ganglia and cortex

Prion Disease

- caused by prions (proteins that can reproduce and cause damage to brain cells leading to neurocognitive decline
- no treatment but not contagious
- *Creutzfeldt-Jakob Disease:* symptoms include spasms of the body caused by slow acting virus that may live in the body for years before the disease develops

Therapeutic Interventions of Psychological Disorders (10)

Different Psychological Interventions

Treatment: Definition of Terms

- **Idiographic Data** – specific details and background information
  - Specific or unique information
- **Nomothetic** – broad information, nature, and treatment
  - Generalization or commonalities with other context
- **Treatment** – also known as *therapy*, procedure designed to change abnormal behavior to a more normal behavior
  - Consists of client, therapies, and series of contact between them

Psychological Interventions

Psychodynamic

1. Free Association – therapist tells the patient to describe any thought, feeling, or image that comes to mind even if it seems unimportant

2. Transference – they act and feel toward the therapist as they did toward important person in their lives

3. Resistance – unconscious refusal to participate fully in the therapy

4. Dreams interpretation – can reveal unconscious instincts, needs, and wishes
- *Manifest:* consciously remembered dream
- *Latent:* meaning

5. Catharsis – reliving past repressed feelings
- powerful emotional release that, when successful, is accompanied by cognitive insight and positive change

6. Working Through – patient and therapist must examine the same issues over and over in the course of many sessions

Source: Barlow, Durand & Hofmann (2018), Comer & Comer (2017), Hooley, Butcher, Nock & Mineka (2017), DSM-V, DSM-V-TR, Psych Pearls

7. Short-Term Psychodynamic Therapies – patient choose a single problem, a dynamic focus to work on and work only on the psychodynamic issues that relate to it

8. Relational Psychoanalytic Therapy – therapist disclosing things about themselves, particularly their own reactions to patients, and try to establish more equal relationships with patients

8. Hypnotherapy – patient undergoes hypnosis and is then guided to recall forgotten events or perform other therapeutic activities

9. Play Therapy – an approach to treating childhood disorders that helps children express their conflicts and feelings indirectly by drawing, playing, and making stories

Humanistic

1. Client-Centered Therapy – clinicians try to help clients by accepting, empathizing accurately, and conveying genuineness (Carl Rogers)

2. Support Group

3. Home-Based Self-Help Programs

4. Social Skills Training

5. Family Therapy – therapist meets with the all the members of a family and helps them to change in therapeutic ways
- *Maudsley Model:* blames neither the parents nor the child for the disease

6. Group Therapy – group of people with similar problems meet together with a therapist to work on those problems

7. Psychological Debriefing – form of crisis intervention in which victims are helped to talk their feelings and reactions to traumatic experiences
- *critical incident stress debriefing*

8. Interpersonal Psychotherapy (IPT) – treatment for depression that based on belief that clarifying and changing one's interpersonal problems will help lead to recovery
- improving interpersonal functioning, addresses current problems and relationships rather than childhood or developmental issues

9. Motivational Interviewing – use mixture of empathy and inquiring review to motivate clients to recognize they have serious psychological problem and to commit to making constructive choices and behavior changes

10. Milieu Therapy – institutions can help patients recover by creating a climate that promotes self-respect, individual responsible behavior, and meaningful activity

11. Parent Management Training – combine family and cognitive-behavioral interventions to improve family functioning and help parents deal with their children more effectively

12. Gestalt Therapy – clinicians actively move clients toward self-recognition and self-acceptance by using techniques such as role playing and self-discovery exercises

13. Interpersonal Social Rhythm Therapy – derived from interpersonal psychotherapy for depression and behavioral intervention for social rhythm and sleep-wake regulation
- focus on the difficulties that children and adolescents with BD have with the rhythmicity of their behaviors

Cognitive

1. Cognitive-Behavioral Therapy – seek to help clients change both counterproductive behaviors and dysfunctional ways of thinking
- *Rational-Emotive Behavioral Therapy:* change and identify irrational assumptions
- *Mindfulness-Based CBT (Acceptance and Commitment Therapy):* "thoughts are mere events of mind"
- *Behavioral Activation:* therapy for depression in which the client is guided systematically increase the number of constructive and pleasurable activities and events in his or her life
- *Cognitive Remediation:* focuses on the cognitive impairments that often characterize people with schizophrenia, particularly their difficulties in attention, planning, and memory
- *Panic Control Treatment:* clients are educated about the nature of anxiety and panic and involves teaching people with panic disorder to control their breathing, then people are taught about the logical errors that people who have panic disorders are prone to making and learn to subject their own automatic thoughts to logical re-analysis
- *Enhanced CBT (CBT-E):* focuses on addressing, disrupting, and modifying the factors that maintain the eating disorders
- *Hallucination Reinterpretation and Acceptance:* designed to help how people view and react to their hallucinations, so they will not suffer the fear and confusion produced by their delusional misinterpretations

Source: Barlow, Durand & Hofmann (2018), Comer & Comer (2017), Hooley, Butcher, Nock & Mineka (2017), DSM-V, DSM-V-TR, Psych Pearls

- *Dialectical Behavior Therapy:* can help people who have difficulty with emotional regulation or are exhibiting self-destructive behaviors; accept the reality of their lives and their behaviors

2. Neutralizing – attempting to eliminate thoughts that one finds unacceptable by thinking or behaving in ways that make up for those thoughts and so put right internally

3. Exposure and Response (Ritual) Prevention – treatment of OCD that exposes client to anxiety-arousing thoughts or situations and then prevents the client from performing his or her compulsive acts

4. Beck's Cognitive Therapy – people identify and change the maladaptive assumptions and ways of thinking that help cause their psychological disorders

5. Aversion Therapy – client is repeatedly presented with unpleasant stimuli while performing undesirable behavior such as taking drug

6. Relapse-Prevention Training – treatment for alcohol use disorder in which clients are taught to keep track of their drinking behavior, apply coping strategies in situation that typically trigger excessive drinking, and plan for risky situations and reactions

7. Cognitive Processing Therapy – intervention for people with PTSD in which therapist guide individuals to examine and change the dysfunctional attitudes and styles of interpretation they have developed as a result of their traumatic experiences, thus, enabling them to deal with difficult memories and feelings

8. Mentalization – uses therapeutic relationship to help patients develop the skills they need to accurately understand their own feelings and emotions, as well as the feelings and emotions of others

9. Affectual Awareness – help identify and counter negative attitudes that one holds toward sex

10. Positive Family Interaction Therapy – involves both individual CBT with the client as well as additional family sessions

Biological

1. Sedative-Hypnotic Drugs – also called as *anxiolytic*, produce feelings of relaxation and drowsiness
- *Benzodiazepines:* sedative that slow down body and brain's function (depressant)
- *Barbiturates:* medication that causes relaxation and drowsiness (depressant)

2. Antidepressant – improve the mood of people with depression
- increase the activity of serotonin and norepinephrine

3. Antipsychotic – correct grossly confused or distorted thinking
- relieve anxiety by altering the activity of dopamine

4. Vagus Nerve Stimulation – treatment for depression in which implanted pulse generator sends regular electrical signals to a person's vagus nerve, then stimulates the brain

5. Electroconvulsive Therapy – electrodes attached to patient's head and send an electrical current through the brain, causing seizure

6. Transcranial Magnetic Stimulation – electromagnetic coil, which placed on or above a person's head sends a current into the person's brain

7. Mood Stabilizers – stabilize the moods of people suffering from bipolar disorder
- also known as *antibipolar drugs*
- *Lithium:* metallic element that occurs in nature as mineral salt and is an effective treatment for bipolar disorders

8. Detoxification – systematic and medically supervised withdrawal from a drug
- *Disulfiram:* causes violent vomiting when followed by ingestion of alcohol

9. Antagonist Drug – block or change the effects of an addictive drug

10. Antianxiety – also called as *minor tranquilizers*, help in reducing tension and anxiety

11. SSRIs – treat depression by increasing the levels of serotonin in the brain
- block reabsorption of serotonin into neurons

Behavioral

1. Exposure Treatment – behavior-focused intervention in which fearful people are repeatedly exposed to the objects they dread
- *Virtual Therapy/Virtual Reality Treatment:* cognitive-behavioral intervention that uses VR as an exposure tool
- *Prolonged Exposure:* clients confront not only trauma-related objects and situations, but also their painful memories of traumatic experiences
- *Eye Movement Desensitization and Reprocessing (EMDR):* clients move their eyes in a rhythmic manner from side to side while flooding their minds with images of objects and situations they ordinarily avoid
- *Participant Modeling:* therapist calmly models ways of interacting with the phobic stimulus or situation

Source: Barlow, Durand & Hofmann (2018), Comer & Comer (2017), Hooley, Butcher, Nock & Mineka (2017), DSM-V, DSM-V-TR, Psych Pearls

- *Interoceptive Exposure:* deliberate exposure to feared internal sensations
2. Systematic Desensitization – exposure therapy that uses relaxation training and a fear hierarchy to help clients with phobias react calmly to the objects or situations they dread
3. Flooding (Implosive Therapy) – exposure therapy in which clients are exposed repeatedly and intensively to a feared object and made to see that it is actually harmless
4. Token Economy Programs – behavior-focused program in which a person's desirable behaviors are reinforced systematically throughout the day by the awarding of tokens that can be exchanged for goods or privileges
5. Contingency Management – an operant conditioning training program wherein clients are offered incentives that are contingent on the submission of drug-free urine specimens

Illustrate the Application of Psychological Interventions for treatment

Disorder	Treatment
Generalized Anxiety Disorder	- Free Association - Dream Interpretation - Transference - Resistance - Client-Centered Therapy - CBT (Rational-Emotive Therapy, Mindfulness-Based CBT) - Benzodiazepines - Antidepressant - Antipsychotic - Play Therapy
Specific Phobia	- Exposure Treatments - Participant Modeling - Systematic Desensitization - Flooding
Agoraphobia, Separation Anxiety Disorder	- Exposure Therapy (Prolonged Exposure) - Support Group - Home-Based Self-Help – Programs - Benzodiazepines, SSRIs
Social Anxiety	- Benzodiazepines - Antidepressants - CBT - Exposure Therapy - Social Skills Training - D-Cycloserine
Panic Attacks	- Antidepressant - CBT (Panic Control Treatments) - Anxiolytics
Obsessive-Compulsive Disorder	- Free Association - Short-Term Psychodynamic Therapy - Neutralizing - Exposure and Response Prevention - Antidepressant - Positive Family Interaction Therapy
Body Dysmorphic Disorder	- Antidepressants - Exposure and Response Prevention
PTSD and Acute Stress Disorder	- Antidepressant - CBT (Mindfulness-Based) - Exposure Therapy (Virtual Reality Therapy, Prolonged Exposure) - Group and Family Therapy - Psychological Debriefing
Dissociative Amnesia	- Psychodynamic Therapy - Hypnotic Therapy - Drug Therapy (Amytal, Pentothal)
Dissociative Identity Disorder	- Psychodynamic - Supportive - Cognitive - Drug Therapy
Depression	- Free Association - CBT (Behavioral Activation, Acceptance and Commitment Therapy) - Beck's Cognitive Therapy - Antidepressant - Vagus Nerve Stimulation

Source: Barlow, Durand & Hofmann (2018), Comer & Comer (2017), Hooley, Butcher, Nock & Mineka (2017), DSM-V, DSM-V-TR, Psych Pearls

	- Electroconvulsive Therapy - Transcranial Magnetic Stimulation - Interpersonal Psychotherapy - Couple Therapy
Bipolar Disorder	- Psychotropic Drugs - Mood Stabilizers - Antipsychotics - Antidepressant - Lithium - Interpersonal Social Rhythm Therapy - Family Intervention
Suicide Attempts	- CBT (Mindfulness-Based) - Dialectal Behavior Therapy (DBT)
Conversion and Somatic Symptom Disorders	- Education - Reinforcement - Cognitive Restructuring - CBT
Physical Disorders	- Relaxation Training - Biofeedback - Meditation - Hypnosis - Self-Instruction Training - Support Groups
Anorexia	- Nutritional Rehabilitation (tube and intravenous feedings) - Motivational Interviewing - CBT - Family Therapy - Antidepressants - Antipsychotic
Bulimia	- Nutritional Rehabilitation - Antidepressant - CBT (Exposure and Response Prevention, CBT-E) - Interpersonal Psychotherapy - Psychodynamic Therapy
Binge-Eating	- CBT - Antidepressant
Substance-Use Disorders	- Aversion Therapy - Contingency Management - Relapse Prevention Training - CBT (Acceptance and Commitment Therapy) - Detoxification - Antagonist Drugs - Drug Maintenance Therapy - Self-Help Programs - Community-Based Prevention Programs - Disulfiram
Sexual Dysfunctions	- Affectual Awareness - Self-Instruction Training - Hormone Treatments
Gender Dysphoria	- hormone administration - gender-confirmation surgery/gender-reassignment surgery
Schizophrenia	- Milieu Therapy - Token Economy program - Antipsychotic Drugs - CBT (Cognitive Remediation, Hallucination Reinterpretation and Acceptance) - Family Therapy - Social Therapy
Paranoid PD	- CBT - Anxiety-Reduction Techniques - Antipsychotic drugs
Schizoid PD	- Social Skills Program - Group Therapy - CBT
Schizotypal PD	- CBT - Speech Lessons - Social Skills training - Antipsychotic Drugs (low doses)
Antisocial PD	- Antipsychotic Drugs

Source: Barlow, Durand & Hofmann (2018), Comer & Comer (2017), Hooley, Butcher, Nock & Mineka (2017), DSM-V, DSM-V-TR, Psych Pearls

	- CBT
Borderline PD	- Relational Psychoanalytic Therapy - DBT - Mentalization - antidepressant - antibipolar - antianxiety - antipsychotic
Histrionic PD	- CBT - Psychodynamic Therapy - Group Therapy
Avoidant PD and Dependent PD	- CBT - Psychodynamic Therapy - Exposure treatments - Antianxiety - Antidepressant - Short-term psychotherapy
Obsessive-Compulsive PD	- SSRIs
Conduct Disorder	- Parent Management Training
Encopresis, Enuresis	- dry-bed training (reinforcement) - biofeedback training - family therapy
ADHD	- Methylphenidate (Stimulant) - CBT - Parent Management Training
Autism Spectrum Disorder	- CBT - Communication Training - Parent training - Community Integration - Psychotropic Drugs
Intellectual Disability	- special education

Evaluate the Efficacy of Psychological Interventions

- Psychodynamic therapy seems to help most in cases of depression that are modest or moderate in severity and that involve clear history of childhood loss or trauma
- Short-term psychodynamic therapies have performed better than long-term approaches, especially when they are combined with psychotropic medications
- Most patients have fewer new episodes of manic episodes by taking lithium and other mood stabilizers
- Antipsychotic drugs reduced positive symptoms in around 70% of patients diagnosed with schizophrenia
- Exposure therapies are effective with phobias
- Benzodiazepines can be effective in many cases of panic disorder, although they are used less often than depressants
- CBT are equally effective as antidepressant drugs in the treatment of panic disorders
- Antidepressant drugs bring improvement to between 50 and 60 percent of those with obsessive-compulsive disorder
- Structures in the circuit do indeed seem to interconnect more appropriately after individuals with OCD respond successfully to antidepressant treatment
- Long-term psychodynamic therapy is only occasionally helpful in cases of unipolar depression (short-term >>>>)
- Culture-Sensitive approaches increasingly are being combined with traditional forms of psychotherapy to help minority clients overcome their disorders
- ECT has apparent effectiveness with severe depression, especially when patients follow up the initial cluster of sessions with continuation or maintenance therapy, either ongoing antidepressant medications or periodic ECT sessions
- CBT, Interpersonal, and Biological Therapies are all effective treatment for unipolar depression
- However, drug therapy reduced depressive symptoms more quickly than CB and Interpersonal therapies, but these psychotherapies had matched the drugs in effectiveness by the final 4 weeks of treatment
- CBT and Interpersonal Therapies lower the likelihood of relapse
- Token Economies help reduce psychotic and related behaviors, however, its uncontrolled
- Drugs appear more effective treatment for schizophrenia than any other approaches used alone, such as psychotherapy, milieu therapy, or electroconvulsive therapy

Source: Barlow, Durand & Hofmann (2018), Comer & Comer (2017), Hooley, Butcher, Nock & Mineka (2017), DSM-V, DSM-V-TR, Psych Pearls

- Psychotherapy is successful in many more cases of schizophrenia these days (CBT, Family Therapy, Social Therapy)
- For people with schizophrenia, cognitive remediation brings about moderate improvements in attention, planning, memory, and problem-solving
- CBTs often help people with schizophrenia feel more control over their hallucinations and reduce their delusional ideas
- For certain phobia, such as small-animal phobia, flying phobia, claustrophobia, BI phobia, exposure therapy is often highly effective when administered in a single long session
- Medication treatments are ineffective by themselves, and there is even some evidence that anti-anxiety medications may interfere with beneficial effects of exposure therapy
- D-Cycloserine can enhance the effectiveness of exposure therapy for fear of heights in a virtual reality environment
- In the long-term, after medication for panic disorder has been tapered, clients who have been on medication with or without cognitive or behavioral treatment seem to show a greater likelihood of relapse
- CBT has been found to be useful in helping people who have used benzodiazepines for over a year to successfully taper their medications
- A major disadvantage of medication treatment for OCD is that when the medication is discontinued relapse rates are generally very high
- Family therapy is more helpful for some patients with Anorexia Nervosa then for others
- DBT, the most effective treatment for Borderline Personality Disorder
- Positive Family Interaction Therapy demonstrated 70% response rate compared to more traditional model of individual CBT with psychoeducation

Socio-Cultural Factors and Ethics (5)

Identifying Socio-Cultural factors

- **Stigma** – a strong lack of respect for a person or a group or a bad opinion of them because they have doen something society does not approve off
- **Ataque de Nervous** – syndrome among individuals of Latino Descent, characterized by symptoms of intense emotional upset, including acute anxiety, anger, or grief; screaming; attacks of crying; trembling; heat in the chest rising into the head; and becoming verbally and physically aggressive
- **Dhat Syndrome** – coined in South Asia (India) characterized by young male patients who attributed their symptoms to semen loss
- **Koro** - acute anxiety and a deep-seated fear of shrinkage of the penis and its ultimate retraction into the abdomen, which will cause death
- **Khyal Cap** – syndrome found among Cambodians characterized by panic attacks
- **Kufungisisa** – overthinking; idiom of distress and cultural explanation among the Shona of Zimbabwe
- **Maladi Moun** – Haiti; sent sickness; interpersonal envy and malice cause people to harm their enemies by "sending illness"
- **Nervios** – among Latinos; general state of vulnerability to stressful life experiences and to difficult life circumstances
- **Shenjing Shuairuo** – syndrome composed of weakness, emotions, excitement, nervous pain, and sleep
- **Susto** – distress and misfortune prevalent among some Latinos in US, attributed to a frightening event that causes the soul to leave the body and results to unhappiness and sickness, as well as functioning in key social roles
  - Cause: induvial believes that he or she has become the subject of black magic
  - Similar to Maladi Moun
- **Taijin Kyufusho** - an intense fear that one's body parts or functions displease, embarrass or are offensive to others
- **Amok** - syndrome or pattern of behavior acknowledged in Southeast Asia (Malaysia, Philippines, Indonesia) characterized by sudden outbursts and frenzied violent behaviors after a period of brooding and quiet
- The likelihood of having a particular phobia is powerfully influenced by gender
- Males are more likely than females to self-medicate their fear and panic with alcohol and in so doing start down the slippery slope to addiction
- BN, AN, and BDD is common to females
- Well-established ability of women to recall emotional memories somewhat better than men may facilitate emotional processing and long-term treatment gains
- **Dissociative Trance** – counterpart of DID in eastern countries; *sapi*

- Experiences during different periods of development may influence our vulnerability to other types of stress or to differing psychological disorders

Ethics

- If mistakes was made, they should do something to correct or minimize the mistakes
- If an ethical violation made by another psychologist was witnessed, they should resolve the issue with informal resolution, as long as it does not violate any confidentiality rights that may be involved
- When they are tasked to provide services to clients who are deprived with mental health services (e.g., communities far from the urban cities), however, they were still not able to obtain the needed competence for the job, they could still provide services AS LONG AS they make reasonable effort to obtain the competence required, just to ensure that the services were not denied to those communities
- During emergencies, psychologists provide services to individuals, even though they are yet to complete the competency/training needed just to ensure that services were not denied. However, the services are discontinued once the appropriate services are available
- Informed Consent:
  - ✓ When conducting research, providing assessment, therapy, counseling, or consultation
  - ✓ For legally INCAPABLE, they must provide appropriate explanation, assent, consider the client's preferences and best interests, and obtain permission from a legally authorized person
  - ✓ If COURT ORDERED, they must inform the nature of the services, whether it is court order or mandated, as well as, its limits of confidentiality before proceeding
  - ✓ Must document written or oral consent, permission, and assent
- In case of interruption of services (such as death, relocation, illness, retirement), psychologists must make reasonable efforts to plan for continuing services
  - Unless stated in the contract
- Psychologists should discuss the limits of confidentiality, uses of the information that would be generated from the services to the persons and organizations with whom they establish a scientific or professional relationships
- Before recording voices or images, they must obtain permission first from all persons involved or their legal rep
- Only discuss confidential information with persons clearly concerned/involved with the matters
- Disclosure is allowed with appropriate consent
  - No consent is not allowed UNLESS mandated by the law
- No disclosure of confidential information that could lead to the identification of a client unless they have obtained prior consent or the disclosure cannot be avoided
  - Only disclose necessary information
- Exemptions to disclosure:
  - ✓ If the client is disguised/identity is protected
  - ✓ Has consent
  - ✓ Legally mandated
- Opinions written on recommendations, reports, and diagnostic or evaluative statements must be based and sufficient to their findings
- Only provide statements after conducting examinations to support their statements
- Informed Consent, except:
  - ✓ Mandated by law
  - ✓ Routine
  - ✓ Evaluating decisional capacity
  - If the person has a questionable capacity to consent, it must be obtained using the language that is reasonably understandable to the person being assessed
- In the absence of client/patient release, psychologists must provide test data only as required by law
- Psychological assessment techniques done by unqualified persons, except during training purposes, given it is supervised
- When conducting or providing services to several persons who have a relationship, they should clarify which of them is the clients and the relationship he/she will have with each person
  - If conflicting roles would arise, he/she must clarify, modify, or withdraw from roles appropriately
- Psychologists do not engage in sexual intimacies with former clients/patients for AT LEAST TWO YEARS after termination of therapy
- Terminate therapy when the client no longer needs the service, is not likely to benefit, or is being harmed by continued service
  - Also, when threatened or endangered by the client
  - Must provide pretermination counseling and suggest alternative service providers as appropriate

Source: Barlow, Durand & Hofmann (2018), Comer & Comer (2017), Hooley, Butcher, Nock & Mineka (2017), DSM-V, DSM-V-TR, Psych Pearls

- **Telepsychology** – provision of psychological services using telecommunication technologies
  - Must ensure competence with both the technologies used and the potential impact of technologies on clients/patients, supervisees or other professionals
  - Ensure ethical and professional standards of care and practice
  - Informed consent must still be obtained, which specifically addresses the unique concerns related to the telepsychology services they provide
  - Should include the manner of telecommunication, the boundaries they will establish, and the procedures for responding to electronic communications
  - When necessary, psychologists obtain the appropriate consultation with technology experts to augment their knowledge of telecommunication technologies in order to apply security measures in their practices that will protect and maintain the confidentiality of data and information related to their clients/patients.
  - Some of the potential risks to confidentiality include considerations related to uses of search engines and participation in social networking sites.
  - Psychologists are encouraged to weigh the risks and benefits of dual relationships that may develop with their clients/patients, due to the use of telecommunication technologies, before engaging in such relationships
  - Psychologists who use social networking sites for both professional and personal purposes are encouraged to review and educate themselves about the potential risks to privacy and confidentiality and consider utilizing all available privacy settings to reduce these risks
  - Psychologists are encouraged to create policies and procedures for the secure destruction of data and information and the technologies used to create, store and transmit the data and information.
  - Psychologists are thus encouraged to be knowledgeable about, and account for, the unique impacts, suitability for diverse populations, and limitations on test administration and on test and other data interpretations when these psychological tests and other assessment procedures are considered for and conducted via telepsychology

Global Health Crisis and Mental Health Law (10)

Different Issues and Concerns on the Impact of COVID-19 on the Mental Health of people

- After acquiring COVID-19 (or even prior), a person may experience cognitive and attention deficits (brain fog), anxiety and depression, psychosis, seizures, and even suicidal behavior
- Data suggests that people are more likely to develop mental illness or disorders in the months following infection, including symptoms of PTSD
- People who are more likely to experience the symptoms of mental illnesses or disorders during the pandemic:
  a) People from racial and ethnic minority
  b) Mothers and pregnant people
  c) People experiencing poverty
  d) Children
  e) PWDs
  f) People with pre-existing mental illnesses
  g) Health Care Workers

Online Classes

- Online learning in nursing education is not significantly different from blended or face-to-face learning in terms of its impact on knowledge acquisition and attitudes toward learning (Kim & Kim, 2022)
- Online Learning caused by the COVID-19 Pandemic brought negative learning attitudes and poorer learning performance compared to classroom learning, especially during the early days of the pandemic (Chen et.al., 2022)
- Learning in the new normal has been a challenge to institutions, more particularly to students and educators (Ignacio, 2021)
  - Not all institutions have the capability to deliver online classes due lack of equipment, technical know-how
- In the Philippines, children in vulnerable groups have no access to quality education. They also struggle to find distance learning opportunities. According to UNESCO, about 28 million learners are affected by school closures. Unfortunately, the COVID-19 pandemic will severely affect their learning quality without the help of government and nongovernment organizations.

Source: Barlow, Durand & Hofmann (2018), Comer & Comer (2017), Hooley, Butcher, Nock & Mineka (2017), DSM-V, DSM-V-TR, Psych Pearls

- The findings revealed that the online learning challenges of college students varied in terms of type and extent. Their greatest challenge was linked to their learning environment at home, while their least challenge was technological literacy and competency. The findings further revealed that the COVID-19 pandemic had the greatest impact on the quality of the learning experience and students' mental health (Barrot, Llenares, & del Rosario, 2021)

Frontliners

- Insomnia was found to be the most common mental health problem, followed by anxiety, PTSD, depression and stress in healthcare workers in the face of the COVID-19 pandemic (Hayati et.al., 2023)
- Post-traumatic stress disorder was the most common mental health disorder reported by healthcare workers during the COVID-19 pandemic, followed by anxiety, depression, and distress (Advani et.al., 2021)
- Besides the lack of personal protective equipment, our frontliners are underpaid and do not get the respect they deserve. They answer "to the call of duty while battling fear and anxiety".7 Aside from this, they also experience pressure, stress, insomnia, denial, anger, and fear (Biana & Joaquin, 2020)
  - According to WHO, Exposure to excessive stress, for prolonged periods can have many harmful consequences on the emotional and mental well-being of frontline workers. It can:
  - ✓ lead to burnout.
  - ✓ trigger the onset of common mental disorders such as depression and anxiety or post-traumatic stress disorder (PTSD).
  - ✓ result in unhealthy behaviours like using tobacco, alcohol or other substances, which may lead to substance use disorders.
  - ✓ result in frequent absence from work or reduced productivity while at work.
  - ✓ increase the risk of suicide among frontline workers, particularly health care workers

Vaccination

- COVID-19 vaccination is associated with larger reductions in anxiety or depression symptoms among individuals with lower education levels, who rent their housing, who are not able to telework, and who have children in their household (Agrawal et.al., 2021)
- The results of the present study showed that the mental health of young people did not significantly improve in the time period after vaccinations became widely available and promoted in Austria and Turkey (Chen et. Al., 2023)
  - The impact of age may be related to more pronounced uncertainty and anxiety among younger groups, as unpredictable pandemic circumstances make it even more difficult for them to plan their future, as they cross the threshold to adulthood and independence.
  - a number of recent studies have confirmed that younger adults and females in particular suffered from the adverse outcomes associated with the COVID-19 pandemic
- An overwhelming majority of Filipinos surveyed (over 15,600 participants) currently distrust available vaccines, their efficacy against the original and emerging strains, the cost of being vaccinated, and the authenticity of vaccine samples available in the country (CNN Philippines, 2021; Sabillo 2021).

Lockdown

- Anxiety, depression, irritability, boredom, inattention and fear of COVID-19 are predominant new-onset psychological problems in children during the COVID-19 pandemic. Children with pre-existing behavioral problems like autism and attention deficit hyperactivity disorder have a high probability of worsening of their behavioral symptoms (Gupta et. Al., 2020)
- The review highlights the need for mental health services to address the increased mental health symptoms in people with pre-existing mental illnesses during a pandemic (Duddu et. Al., 2020)
- Students and unemployed respondents are highly vulnerable to COVID stress and its mental health implications. Men and women did not significantly differ in distress (Acebes & Montano, 2020)
- Cluster analysis revealed two age clusters—those between 16 and 35 years and those 36 years and above. The younger group reported greater depression, anxiety, and stress symptoms and poorer psychological well-being compared to the older group. The younger group also reported less

resilience, nonreactivity, and use of spiritual coping compared to the older group. The results suggest that the young are most vulnerable during the pandemic, and findings suggest what might be done to provide them mental health psychosocial support. (Alampay, Hechanova & Valentin, 2022)

Teleconsultation

- Telephone-delivered psychotherapy has increased utility as a method of service delivery in the current world, where several barriers, including economic hardships and limited access to care, may prevent people from receiving the treatment they need (Arafat, Hawlader & Zaman, 2021)
  - telemedicine is perfectly suitable to treat the mental health problems of the people in this pandemic situation without increasing the risk of infection, promoting health and prolonging life as well.

Work From Home

- The top factors that contribute to people's stress, anxiety, and depression are financial considerations, health concerns, and inconsistencies in the workplace setup (Del Mundo, 2022)
  - When experienced with frequency, these result in burnout, loss of drive and focus, and struggles with work-life balance
- The switch to a work from home status has contributed to the higher critical levels in our workforce's mental health. Those who are working from home are 3.7 times more likely to have critical anxiety levels and 6 times more likely to have critical depression levels.
- Another survey by Lenovo Philippines as early as April reported that up to 87% employees were ready to shift to WFH when required. "Our survey suggests that the employee experience was already changing before the pandemic hit," said Michael Ngan, president and general manager of Lenovo Philippines, reported Business Mirror.
- On top of the mental health issues that WFH employees are now facing are logistical concerns surrounding the adjustment to the telecommuting scheme. A BPO Industry Employees Network survey revealed common issues faced by WFH employees, including: "lack of logistical assistance (such as delivery of equipment)," "longer working hours," "unpaid wages due to poor or no Internet connection," "unjust sanctions due to technical problems," and "shouldering of Internet and utility expenses by employees." Up to 77% of respondents say that they've been shouldering their own Internet costs while 54% did not receive Internet allowance and 20% did not receive work laptops.
- Dr. Agnes Casiño of the National Center for Mental Health (NCMH) said maintaining work-life balance in a work from home setup is hard especially when one has to take on different roles at different times in the same place.
- Employees pointed out that with the new work arrangement, they still find satisfaction, enjoyment, and fulfilment given the necessary condition at home. However, detrimental factors like balancing work and family, difficulty focusing on work tasks and collaborating with colleagues, poor working environment, and slow internet connectivity lead to isolation, stress, and anxiety.
  - women experienced higher stress and exhaustion with working from home compared to men due to familial and domestic responsibilities.

Children

- Learning deficits are particularly large among children from low socio-economic backgrounds (Betthäuser, Bach-Mortensen & Engzell, 2022)
- "In 2020, schools globally were fully closed for an average of 79 teaching days, while the Philippines has been closed for more than a year, forcing students to enroll in distance learning modalities. The associated consequences of school closures – learning loss, mental distress, missed vaccinations, and heightened risk of drop out, child labour, and child marriage – will be felt by many children, especially the youngest learners in critical development stages," UNICEF Philippines Representative Oyunsaikhan Dendevnorov says.
- While children are more vulnerable to these detriments, there remains the absence of unified and comprehensive strategies in mitigating the deterioration of the mental health of Filipino children (Biag, 2021)

Source: Barlow, Durand & Hofmann (2018), Comer & Comer (2017), Hooley, Butcher, Nock & Mineka (2017), DSM-V, DSM-V-TR, Psych Pearls

Evaluating the Impact of Global Health Crisis and other mental health conditions on the implementation of RA 11036

- Dr. Razel Nikka Hao, DOH Disease Prevention and Control Bureau director, reported to the committee that since RA 11036 was passed, 62 of their personnel were trained on Basic Institutional Review Board (IRB); 51 as future trainers for IRB; 1,556 completed the World Health Organization Quality Rights e-training; 28 with Lived Experiences completed the course on mental health advocacy and leadership (pilot implementation); and over about 40 media practitioners were trained on responsible and ethical reporting and portrayal of suicide (pilot implementation).
- DepEd officials noted that after the pandemic lockdowns, the transition from blended learning to in-person classes also created new pressures on students. But there are no programs specifically designed to promote mental health for any age group. Bullying has been a serious problem in schools even before the pandemic, with social media facilitating the abuse, and DepEd officials believe bullying cases are also underreported.
- Despite passing the Philippine Mental Health Act (RA 11036), access to mental health care remains limited. Most pediatricians, adolescent medicine specialists, and psychiatrists practice in urban areas in the country. Moreover, payment for mental health consultation remains an out-of-pocket expense for Filipinos (Malaluan et. Al., 2022)
- Rep. Florida Robes said that aside from minimum health standards and protocols aimed at halting the spread of COVID-19 in communities, local government units (LGUs) should also establish mental help desks in every barangay to address those suffering from anxiety or depression as a result of the pandemic (Quismorio, 2020)
- In a statement on Monday, Deputy Speaker Loren Legarda said that the government must work to address the mental health issues of Filipinos, who have struggled to cope with the demands and the problems brought by the COVID-19 pandemic.
- Legarda, who was co-author of Republic Act No. 11036, was referring to a Philippine Statistics Authority (PSA) data that showed suicide incidents increasing by 57 percent for 2020, compared to 2019.
- She said she is seeking a policy measure dedicated to "enhancing the delivery of mental health services to the people," especially since recent studies showed that only around five percent of the whole health budget was allocated to mental health concerns.
- The DOH has launched a multi-sectoral approach for mental health with programs and interventions across a variety of settings (e.g. workplaces, schools, communities) aimed at high-risk groups. The commemoration of World Suicide Prevention Day also calls attention to the plight of those who are undergoing severe forms of depression.
- Another project is the development of a multi-sectoral National Suicide Prevention Strategy, which includes psychosocial services such as the NCMH's Crisis Hotline "Kamusta Ka? Tara Usap Tayo," launched on 2 May 2019. The hotline is available 24/7 for prompt psychological first aid. The UP Diliman Psychosocial Services (UPD PsychServ) has also provided free counseling via telephone for front liners. RA 11036 or the ("Mental Health Act") mandates the provision of comprehensive suicide prevention services encompassing crisis intervention, and a response strategy on a nationwide scale.

Additional Notes

- **Leta Hollingworth –** believed that many mentally defective children were actually suffering from emotional and behavioral problems primarily due to inept treatment by adults and a lack of appropriate intellectual challenge
- **Monomania –** partial delusion
- **Neurasthenia –** characterized by persistent and distressing complaint of increased fatigue after mental effort or persistent and distressing complaints of bodily weakness and exhaustion after minimal effect
- **Psychasthenia –** anxiety, excessive worrying and doubting
- **Phonasthenia –** weakness or hoarseness of voice
- **Jean Esquirol –** first to describe a medical disorder quite similar to contemporary OCD and classified it as monomania

Source: Barlow, Durand & Hofmann (2018), Comer & Comer (2017), Hooley, Butcher, Nock & Mineka (2017), DSM-V, DSM-V-TR, Psych Pearls

- Freud and Pierre Janet isolated OCD from neurasthenia
- **Pierre Janet –** proposed that obsessional patients possessed an abnormal personality (psychasthenia) with features such as anxiety, excessive worrying and doubting, and described the successful treatment of compulsions and rituals with techniques that are similar to the ones used currently in behavioral therapy

end

Congratulations *for reaching the end of this reviewer! <3*

Remember to ***take rest*** *if you need to and* ***be less harsh*** *to yourself.* ***Reward yourself****, you deserve it. You* ***can never learn everything*** *but at least* ***you still did learn something****.* ***Progress is progress.*** *The most important thing is* ***you will get there****!*

Claim that license*!*

Congratulations*, Future* ***RPm****!*
