Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

UNIT I - INTRODUCTION

Definition - Historical Views: Ancient Times – Humanitarian Views –Twentieth Century Views – Prevalence and Incidence of Mental Disorders - Classifying Abnormal Behavior: DSM 5 and ICD 11- Scientific Research Approaches in Abnormal Psychology.

Definition: The scientific study of abnormal behavior undertaken to describe, predict, explain, and change abnormal patterns of functioning.

- Most of the definitions have certain features in common, often called "the four Ds": deviance, distress, dysfunction, and danger.
- That is, patterns of psychological abnormality are typically *deviant* (different, extreme, unusual, perhaps even bizarre), *distressing* (unpleasant and upsetting to the person), *dysfunctional* (interfering with the person's ability to conduct daily activities in a constructive way), and possibly dangerous.

ANCIENT TIMES

- Prehistoric cultures often held a supernatural view of abnormal behavior and saw it as the work of evil spirits, demons, gods, or witches who took control of the person
- Treatment by cave dwellers included a technique called **trephination**, in which a stone instrument known as a *trephine* was used to remove part of the skull, creating an opening. They believed that evil spirits could escape through the hole in the skull, thereby ending the person's mental affliction and returning them to normal behavior.
- **Exorcism** in which evil spirits were cast out through prayer, magic, flogging, starvation, noise-making, or having the person ingest horrible tasting drinks.

Greek Roman Views

- Rejecting the idea of demonic possession, Greek physician, Hippocrates (460-377 B.C.), said that mental disorders were akin to physical disorders and had natural causes.
- Specifically, he suggested that they arose from *brain pathology*, or head trauma/brain dysfunction or disease, and were also affected by heredity.
- He also described four main fluids or **humors** that directed normal functioning and personality – *blood* which arose in the heart, *black bile* arising in the spleen, *yellow bile* or *choler* from the liver, and *phlegm* from the brain.

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
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- Greek philosopher, Plato (429-347 B.C.), who said that the mentally ill were not responsible for their own actions and so should not be punished
- In Rome, physician Asclepiades (124-40 BC) and philosopher Cicero (106-43 BC) rejected Hippocrates' idea of the four humors and instead stated that melancholy arises from grief, fear, and rage; not excess black bile.

The Middle Ages 500 AD to 1500 AD

- Middle Ages with the increase in power of the Church and the fall of the Roman Empire.
- Mental illness was yet again explained as possession by the Devil and methods such as exorcism, flogging, and prayer, the touching of relics, chanting, visiting holy sites, and holy water were used to rid the person of the Devil's influence.
- Group hysteria, or **mass madness**, was also seen in which large numbers of people displayed similar symptoms and false beliefs.
- This included the belief that one was possessed by wolves or other animals and imitated their behavior, called **lycanthropy**, and a mania in which large numbers of people had an uncontrollable desire to dance and jump, called **tarantism**.
- Science and medicine were once again called upon to explain mental disorders.

The Renaissance and the rise of Asylums

- This helped continue the decline of supernatural views of mental illness.
- In the mid to late 1500s, Johann Weyer (1515-1588), a German physician, published his book, *On the Deceits of the Demons,* that rebutted the Church's witch-hunting handbook, and argued that many accused of being witches and subsequently imprisoned, tortured, hung, and/or burned at the stake, were mentally disturbed and not possessed by demons or the Devil himself.
- He believed that like the body, the mind was susceptible to illness.
- The number of **asylums**, or places of refuge for the mentally ill where they could receive care
- Rise during the 16th century as the government realized there were far too many people afflicted with mental illness to be left in private homes.

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Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

- Hospitals and monasteries were converted into asylums. Though the intent was benign in the beginning, as they began to overflow patients came to be treated more like animals than people.
- In 1547, the Bethlem Hospital opened in London with the sole purpose of confining those with mental disorders. Patients were chained up, placed on public display, and often heard crying out in pain. The asylum became a tourist attraction, with sightseers paying a penny to view the more violent patients.

Humanitarian view

- Phillipe Pineal (1745-1826) who was assigned as the superintendent of la Bicester, a hospital for mentally ill men in Paris.
- He emphasized the importance of affording the mentally ill respect, moral guidance, and humane treatment
- Arguing that the mentally ill were sick people, Pineal ordered that chains be removed, outside exercise be allowed, sunny and well-ventilated rooms replace dungeons, and patients be extended kindness and support.
- William Tuke (1732-1822), a Quaker tea merchant, established a pleasant rural estate called the York Retreat. The Quakers believed that all people should be accepted for who they were and treated kindly. At the retreat, patients could work, rest, talk out their problems, and pray
- Benjamin Rush (1745-1813). Rush advocated for the humane treatment of the mentally ill, showing them respect, and even giving them small gifts from time to time.
- Dorothea Dix (1802-1887), a New Englander who observed the deplorable conditions suffered by the mentally ill while teaching Sunday school to female prisoners. She instigated the **mental hygiene movement**, which focused on the physical well-being of patients.

TWENTIETH CENTURY VIEWS

- By the end of World War II most psychologist specialized in particular sub disciplines with abnormal psychology being chosen field of study.
- Carl rogers created client centered therapy to treat the ill patients

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Assistant Professor and Head
Department of Psychology
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- The first DSM were published
- Abnormal behavior were viewed according to two perspectives psychogenic and somatogenic
- Psychogenic: The belief that the mental disorder has a psychological origin rather than a physical origin
- Somatogenic: one or more physiological origin rather than a psychogenic origin.
- Existential philosophers created the existential view belief that everyone has the freedom to find meaning in life
- 1963 community mental health center act was created to strengthen the future of quality patient care.

TWENTY FIRST CENTURY VIEWS:

- Researchers seek to cure incurable mental health disorders.
- Research today the study of brain matters and neurotransmitters. Scientists and physicians look closely at hormones and genetics to determine their impact on human brain.

CLASSIFYING ABNORMAL BEHAVIOR: DSM 5 AND ICD 11

Classification is important in any science whether we are studying plants, planet or people. Classification helps to communicate clearly and confidently. In abnormal psychology classification involves grouping varies sub variety of maladaptive behavior in a meaning full way.

Classification helps to discussing the nature, causes and treatment of abnormal behavior

DSM CLASSIFICATION

- The Diagnostic and Statistical Manual of Mental Disorders (DSM) is the handbook widely used by **clinicians and psychiatrists** in the **United States** to diagnose **psychiatric illnesses**. Published by the **American Psychiatric Association (APA),** the DSM covers all categories of mental health disorders for both adults and children.
- It contains **descriptions, symptoms, a**nd other criteria necessary for diagnosing mental health disorders.

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Assistant Professor and Head
Department of Psychology
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- DSM-I, there were **102 categories** of diagnoses, increasing to **182 in the DSM-II**, **265** in the DSM-III, and **297** in the DSM-IV.
- DSM-I®: 1952.
- DSM-II®: 1968.
- DSM-III®: 1980. The APA published a revised version, the DSM-III-R®, in 1987.
- DSM-IV®: 1994. The APA published a text revision version, the DSM-IV-TR®, in 2000.
- DSM-5: 2013. The APA published a text revision version, the DSM-5-TR, in 2022.

These criteria consist of symptom and sign

Symptom: Patients subjective description

Sign: Objective observation by Psychologist

DSM V EVALUATES AN INDIVIDUAL ACCORDING TO FIVE DIMENSION OR AXES

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Assistant Professor and Head
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Axis I – Clinical Syndromes

Axis I consisted of mental health and substance use disorders that cause significant impairment. Disorders were grouped into different categories such as mood disorders, anxiety disorders, and eating disorders.

Axis II – Personality Disorders and Mental Retardation

Axis II was reserved for what we now call intellectual development disorders (intellectual disability) and personality disorders, such as antisocial personality disorder and histrionic personality disorder.

Axis III – General Medical Conditions

Axis III was used for medical conditions that influence or worsen Axis I and Axis II disorders. Some examples include HIV/AIDS and brain injuries.

Axis IV – Psychosocial and Environmental Problems

Any social or environmental problems that may impact Axis I or Axis II disorders were accounted for in this axis. These include such things as unemployment, relocation, divorce, or the death of a loved one.

Axis V – Global Assessment of Functioning

Axis V is where the clinician gives their impression of the client's overall level of functioning. Based on this **assessment, clinicians** could better understand how the other four axes interacted and the effect on the individual's life.

ICD INTERNATIONAL CLASSIFICATION OF DISEASE The ICD is created by the World Health Organisation (WHO), an agency of the United Nations that is concerned with worldwide public health. Translated into 43 languages, the ICD is used in over 100 countries. ICD 10 published in 1992

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Assistant Professor and Head
Department of Psychology
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S.No	DSM	ICD
1	Diagnostic statistical manual of mental disorder	International classification of disease
2	Deals with mental disorder	General classification of all disease
3	Published by American Psychiatry Association (APA)	Published by World health organizations(WHO)
4	Numeric organization (313.2)	Alpha Numeric organization (F30,F38)
5	Dsm is produced by a single national professional association	ICD is produced by the global health agency with public health
6	English version only	Available in all widely spoken language
7	Mutiaxial	Single axis

Some terms in Abnormal Psychology

- Acute stage
- Chronic
- Mild or moderate
- Episodic

- **PREVALENCE AND INCIDENCE OF MENTAL DISORDERS**

Epidemiology is the study of the distribution of diseases, disorders, or health-related behaviors in a given population.

- Mental health epidemiology is the study of the distribution of mental disorders. A key component of an epidemiological survey is determining the frequencies of mental disorders
  - E.g. they make the survey to find out many of them have disease, disorder under each classification.

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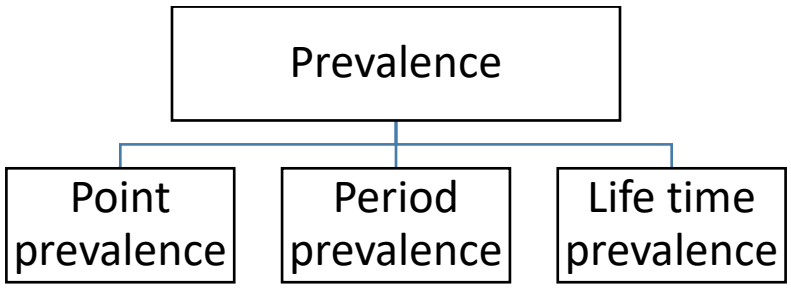
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

- Epidemiology is the study and analysis of the patterns
- Causes, effects of health and disease or condition in a particular population
- Epidemiology helps in finding the cause of disease and also help in identifying risk factors for disease
- It also helps to make preventive measures.

PREVALENCE:

- The term **prevalence** refers to the number of active cases in a population during any given period of time. Prevalence figures are typically expressed as percentages (i.e., the percentage of the population that has the disorder).
- How many people have this disease right now? Prevalence refers to the number of cases of a disease that are present in a particular population at a given time.
- E.g. How many of them are affected by depression in India till now
- Types of prevalence



Point prevalence refers to the estimated proportion of actual, active cases of the disorder in a given population at a given point in time.

For example, if we were to conduct a study and count the number of people who are suffering from major depressive disorder

Period Prevalence: It is proportion of a population has the condition at some time during given period of time

E.g. 12 months

Life time prevalence:

We may also wish to obtain an estimate of the number of people who have suffered from a particular disorder at any time in their lives (even if they are now recovered). This would provide us with a **lifetime prevalence (for table refer class notes)**

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Assistant Professor and Head
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Incidence: This refers to the number of *new* cases that occur over a given period of time. How many people per year newly acquire their disease? It is the number of new cases within a specified time period.

E.g. If a population initially contains 1,000 non diseased person and 28 develop a condition over two years of observation, the incidence proportion is 28 cases per 1000 person per two years

$$I = \frac{\text{No. of new case during a given time period}}{\text{Population at risk during that period}} X100$$

$$I = \frac{28 \text{ X } 100}{1000}$$

I = 2.8% of people have affected by depression in India in 2 years. This is called as incidence.

Scientific Research Approaches in Abnormal Psychology.

- Abnormal psychology research can take place in clinics, hospitals, schools, prisons, and even highly unstructured contexts such naturalistic observations of the homeless on the street.

- **Scientific method** – A systematic method of conducting scientific research in which theories or assumptions are examined in the light of evidence

Ethics in Research

Informed consent – The principle that subjects should receive enough information about an experiment beforehand to decide freely whether to participate.

Confidentiality – Protection of the identity of participants by keeping records secure and not disclosing their identities.

The Scientific Method

- Formulating a research question
- Framing the research question in the form of hypothesis
- Testing the hypothesis
- Drawing conclusion about the hypothesis

Sources of Information:

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

Case study: the information presented is subject to bias because the writer of the case study selects what information to include and what information to omit. Generalizability—that is, they cannot be used
to draw conclusions about other cases even when those cases involve people with a seemingly similar abnormality

- Self report Data
- Observational approach
- Direct observation
- Technology observation

Research Design:

1.Epidemiological Studies

Epidemiological studies – Research studies that track rates of occurrence of particular disorders among different population groups.

Survey method – A research method in which large samples of people are questioned by means of a survey instrument.

Incidence – The number of new cases of a disorder that occurs within a specific period of time.

Prevalence – The overall number of cases of a disorder in a population within a specific period of time. Researchers must take steps when constructing a sample to ensure that it represents the target population.

Random sample – A sample that is drawn in such a way that every member of a population has an equal chance of being included.

2.The Experimental Method

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

Experimental method – A scientific method that aims to discover cause-and-effect relationships by manipulating independent variables and observing the effects on the dependent variables.

Independent variables – Factors that are manipulated in experiments.

Dependent variables – Factors that are observed in order to determine the effects of manipulating the independent variable.

Experimental group – In an experiment, a group that receives the experimental treatment.

Control group – In an experiment, a group that does not receive the experimental treatment.

Random assignment – A method of assigning research subjects at random to experimental or control groups to balance these groups on the characteristics of people that comprise them.

Selection factor – A type of bias in which differences between experimental and control groups result from differences in the type of participants in the groups, not from the independent variable.

Blind – A state of being unaware of whether one has received an experimental treatment

3.Correlation method: Examine the relationship between two or more factors

Eg. Negative thinking and depression symptom

Longitudinal study: Which individual are periodically tested or evaluated over lengthy period of time.

Case Studies: Case study – A carefully drawn biography based on clinical interviews, observations, and psychological tests.

Single-case experimental design – A type of case study in which the subject is as his or her control.

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

Reversal design – An experimental design that consists of repeated measurement of a subject's behavior through a sequence of alternating baseline and treatment phases.

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

UNIT II VIEWPOINTS AND CAUSAL FACTORS

Biological Viewpoint, Psychodynamic Viewpoint, Behavioral Viewpoint, Cognitive Behavior Viewpoint, Humanistic Viewpoint, Interpersonal Viewpoint, Existential Viewpoint.

Causal Factors: Biological Causal Factor: Neurotransmitter and Hormonal Imbalance, Genetic Defects, Constitutional Liabilities, Brain Dysfunction, Physical Deprivation, Sociocultural Causal Factors.

PSYCHOANALYSIS/ SIGMUND FREUD'S PSYCHODYNAMIC APPROACH

History

- Developed by Sigmund Freud in 1896
- Inspired by Jean- Martin Charcot and Josef Breuer
- 1873 – Freud joined to study M.D in Vienna, Austria
- He was introduced to Breuer while he was doing his MD. Breuer was treating a patient with nick name 'Anna O'. Anna O was suffering from Conversion Disorder/Somatoform Disorder. He used a method called 'Talking Cure/Therapy' and helped her to heal herself.
- 1881 – Freud Completed his MD
- 1882- Joined as Physician in Vienna General Hospital and did researches in Neurology
- 1885- went to Paris, France and got trained under Charcot. He was using Hypnosis to treat
- 1896- He started using the term Psycho-analysis

IMPORTANT CONCEPTS

Levels of consciousness

- There are 3 levels of consciousness - the conscious, the preconscious, and the unconscious.
- The **conscious includes** *sensations and experiences that* the person is aware of at any point in time.
- The **preconscious/subconscious** *includes* memories of events and experiences that can easily be retrieved with little effort.

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

- *The* **unconscious which is the** container for memories and emotions that are threatening to the conscious mind and must be pushed away.
- Slips of the tongue and forgetting are other examples of unconscious expression.

Structure of personality

Freud hypothesized three basic systems that are contained within the structure of personality: the **id, the ego, and the superego.**

- Briefly, the **id represents** unchecked biological forces, the superego is the voice of social conscience, and the
- Ego is the rational thinking that mediates between the two and deals with reality.
- When the **superego is too** strong, individuals may set unrealistically high moral or perfectionistic standards (superego) for themselves and thus develop a sense of incompetence or failure.
- Anxiety develops out of this conflict among id, ego, and superego. When the ego senses anxiety, it is a sign that danger is imminent and something must be done.

Ego Defense Mechanisms

- To cope with anxiety, the ego must have a means of dealing with situations.
- Ego defense mechanisms deny or distort reality while operating on an unconscious level.

Ego Defense Mechanisms

- **Repression:** Repression serves to **remove painful thoughts, memories**, or feelings from conscious awareness by excluding painful experiences or unacceptable impulses.
- **Denial.** Somewhat similar to repression, denial is a way of distorting or not acknowledging what an individual thinks, feels, or sees.
- **Reaction formation.** A way of **avoiding an unacceptable impulse is to act in the opposite extreme.** By acting in a way that is opposite to disturbing desires, individuals do not have to deal with the resulting anxiety.
- **Projection.** Attributing one's own unacceptable feelings or thoughts to others is the basis of projection
- **Displacement.** When anxious, individuals can place their feelings not on an object or person who may be dangerous but on those who may be safe.

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

- **Sublimation.** Somewhat similar to displacement, sublimation is the modification of a drive (usually sexual or aggressive) into acceptable social behavior.
- **Regression.** To revert to a previous stage of development is to regress. Faced with stress, individuals may use previously appropriate but now immature behaviors

Psycho Sexual Stages of Development

- Freud believed that the development of personality and the formation of the id, ego, and superego, as well as ego defense mechanisms, depend on the course of psychosexual development in the first 5 years of life.

• **STAGES**	• **YEAR**	• **EROGENOUS ZONE**	• **FIXATION**
• **ORAL STAGE**	• Infancy- 1 year	• Mouth	• Smoking
• **ANAL STAGE**	• 1-3 years	• Bowel and bladder control	• Oderliness, messiness
• **PHALLIC STAGE**	• 3-6 years	• Genital	• Deviancy, sexual dysfunction
• **LATENT STAGE**	• 6-Puberty	• Sexual feeling inactive	• None
• **GENITAL STAGE**	• Puberty-Death	• Maturing sexual interest	• All stages completed successfully the person should be sexually matured and healthy

- Freud's theory is based on biological drives and the importance of the pleasure principle; thus, certain parts of the body are thought to be a significant focus of pleasure during different periods of development (Freud, 1923).
- Freud believed that infants receive a general sexual gratification in various parts of the body that gradually becomes more localized to the genital area.

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

- The oral, anal, and phallic stages show the narrowing of the sexual instinct in the development of the child.

Behavioral Viewpoint

CLASSICAL CONDITIONING

- The first experimental study is on the learning with the classical conditioning proposed by Ivan Pavlov the Russian physiologist in 1905 who was doing the research in physiology of digestion by using hungry dogs.
- The theory got the name classical because it is 1st experiment study of learning and before Pavlov's work. We had philosophical explanation like "tabula rasa" (blank slate) for learning.
- Conditioning refers to the process of connecting or joining the response to the unrealistic or artificial or natural stimulus.

Experiment: Pavlov used the hungry dog for his experiment through the operation a tube was inserted into the salivary gland. So that saliva would be collected in measuring jar. The dog was made to stand on a table in a box .Pavlov presented the food to the dog and the dog salivated Pavlov called it has unconditioned stimulus [UGS]. The salivation to the food called as unconditional

- response[UR]. Then Pavlov presented the food alongwith the bell sound and after some trial the dog salivated to the bell sound. The Pavlov called the bell sound as the conditional stimulus [CS]. Salivation to bell sound conditional response[CR]. ***This theory is also known as S***-R theory.

- ***Principles of classical conditioning:***

- Laws of classical conditioning

- Law of acquisition
- Law of extinction and spontaneous recovery
- Law of generalisation

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Assistant Professor and Head
Department of Psychology
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- Law of discrimination
- Law of higher order conditioning.

- **Law of acquisition:** It explains how the learning takes place through practice or trail. A trial is a combination of food and the bells sound are “UCS AND CS”. We have the variations of the combinations and based upon the variation, we have the following conditioning,

- Simultaneous conditioning
- Delayed conditioning
- Trace conditioning

Backward conditioning

Law of acquisition: It explains how the learning takes place through practice or trail. A trial is a combination of food and the bells sound are “UCS AND CS”. We have the variations of the combinations and based upon the variation, we have the following conditioning,

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Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

Simultaneous conditioning:

Law of extinction:

- In classical condititioning food plays a dual role

- Stimulus
- Reinforcement

- If we don't give the food for many trails the learned response or CR or salivation gradually reducesand at one point it disappears. This gradual disappearance of learned response or CR is known asextinction.
- One related event to the extinction is the spontaneous recovery. It refers to sudden reappearance of learned response or CR. It is also known as reconditioning. The reconditioning recovers is madepossible by manipulating the food or UCS or reinforcement.

Law of generalization:

- It is the law of stimulus generalization. The stimulus can also produce the response and both the responses must be given the reinforcement.
- For eg: we have conditioned do to salivate to the bell sound and not salivated to the buzzer sound.After some trial the do will salivate both to the bell and buzzer sound. After some trials the dog will salivate both to the bell and buzzer sound because it received food for both sound.

Law of discrimination:

- The law of discrimination is the law of differentiation.

- For eg: we have conditioned the do to salivate to the bell and buzzer sound. Now the do is presentedonly the bell sound and not the buzzer sound. After some trails

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

the dog salivates only to the bell sound.

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

- First we condition that the do to salivate to the bell sound and its known as first order conditioning.Add one more stimulus green light can be added and the do is presented with red light +bell+ sound +food. After some trial the do salivates to red light. It is higher order conditioning.

- Green light+ red light +bell sound +food = salivationRed light = salivation

OPERANT CONDITIONING (or) INSTRUMENTAL CONDITIONING

- It was proposed by American psychologist B.F. Skinner in 1930.
- Before skinner another American psychologist E.L.Thornkide proposed the instrumental conditioning. He proposed law of effect. Thorndike experimented with cat in puzzle box 1898-1911
- ***Experiment***: consists of wooden box with a grillwork at the bottom. It also have a tray and bar, skinner placed the hungry rat into the Skinner
- box and it ran randomly and accidently it pressed the bar food pellet was delivered in the tray. Here rat has leaned to press the bar.
- In Skinner experiment bar pressing is the response and food is the reinforcement .we connect the response to reinforcement this *theory called response – reinforcement theory.*In second part of the experiment a change was introduced when the rat pressed bar it not received the food but got electric shock but the rat learned to avoid the electric shock by not touching the bar. So, ***it is avoidance learning***

- REINFORCEMENT:

- Both classical and operant conditioning makes use of the reinforcement. However operantconditioning is more important to the reinforcement.

Classification of reinforcement:

- Primary reinforcement

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

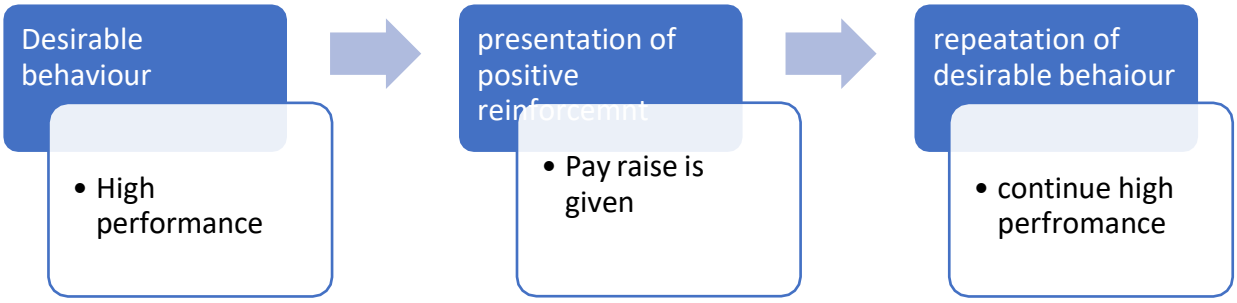
Secondary reinforcement

Classification I:

- **Primary reinforcement:**
- It is the one which as the survival value. Eg:Food, Water, Shelter ,air
- **Secondary reinforcement:**
- These are the reinforcement which has the acquired value.Eg: Money, old.

Classification II:

- Positive reinforcement
- Negative reinforcement
- *Positive Reinforcement* is used to promote the desirable behavior and provides Favourableconsequences. It encourages the Repetition of the behavior.
- *F*or eg. Compliment, bonus.
- A compliment from boss after completing the difficult job is salary.



- *Negative reinforcement* :Like positive reinforcement ,it also focuses on increasin desirable behaiour in a different way.Rather than receivin a reward followin a desirable ebhaviour the personis given an opportunity to avoid an unpleasant result.

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Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

- Eg: The boss may criticize the individual to dress casually.
- To avoid criticism the worker may dress well . the worker is engaging in desirable behaviour to avoid an unpleasant result So its also known as avoidance

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Assistant Professor and Head
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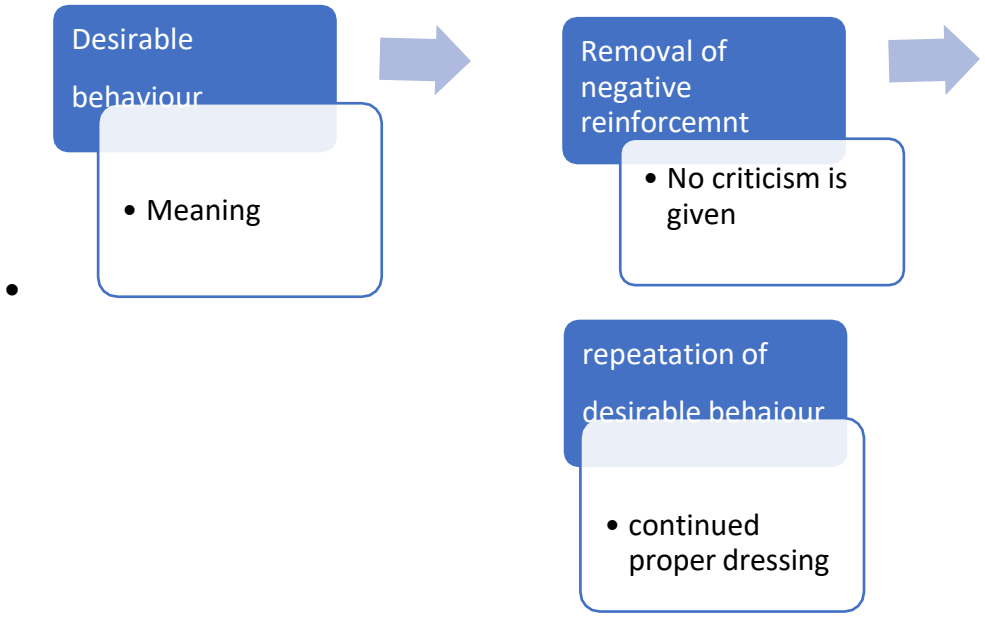

PUNISHMENT

- Many people confused between negative reinforcement and punishment.
- Punishment is used to decrease the undesirable behaviour.
- In work place the unreserved behaviour like stealing, smoking, absenteeism. Eg for punishment: Pay cut, dismiss.

Effective Reinforcement:

- It is not the question of positive or negative reinforcement. Both are important . It works partial. In partial reinforcement is more effective and to give partial reinforcement skinner as developed reinforcement schedule

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
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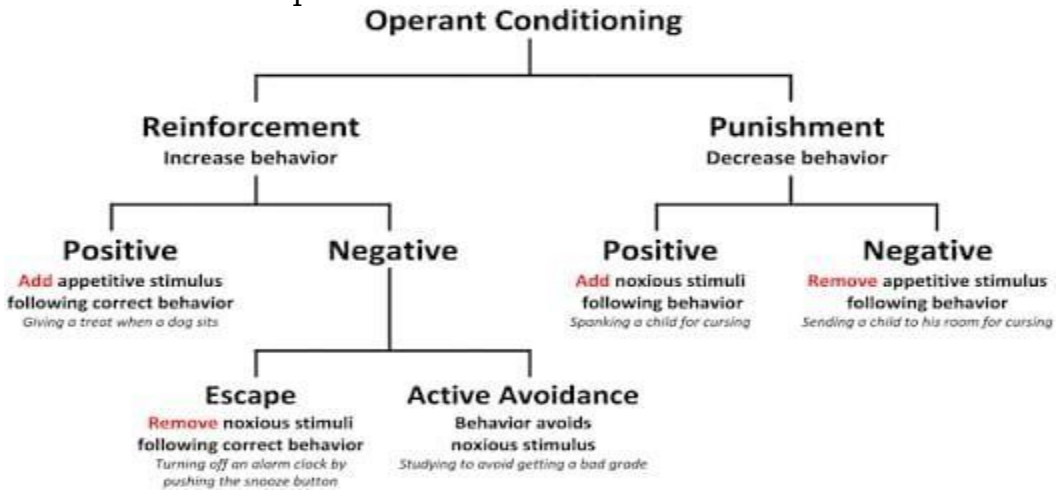
- ***REINFORCEMENT SCHEDULE***

- It can be given based on amount of response or work.
- It is also based on amount of time interval
- *Fixed interval-* Reinforcement follows the 1st response emitted after a fixed time period eg: Every one minute reinforcement given.
- *Fixed ratio-* on this schedule it occurs after a fixed number of reinforcement.
- *Eg*: It occurs after every 20 responses
- *Variable interval-* in this schedule the amount of time varies to get the reinforcement.
- *Eg*: Reinforcement varies between 0-2 minutes.
- *Variable ratio-* in occurs after a fixed number of non reinforcement.. Eg: It occurs between0-40 responses



THE LAW OF EFFECT

- It basically states that responses that produce a satisfying effect in a particular situation become more likely to occur again in that same kind of situation.
- Law of effect is the belief that a pleasing after effect strengthen the action that

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Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

produced it. This law of effect was published by Edward thronalite in 1905

Humanistic view point :Abraham Maslow Hierarchy, Carl Rogers Viewpoint

Carl Roger's Person-centred approach

History

- **Key Concepts of PCT**
- Core Conditions of Counselling
- Immediacy
- Advanced Empathy

Core Conditions of Counselling

To encourage disclosure, Rogers described 4 trust promoting conditions

- Empathy
- Unconditional Positive Regard
- Congruence or Genuineness
- Concreteness

Empathy

- Defn of Empathy.: Understanding another's experience as if it were your own without ever losing the "as if" quality.

Unconditional Positive Regard

- Defn of UPR: Caring for your client without setting conditions for your caring. (avoiding the message "I will care about you if you do what I want")

Genuineness

- Patterson defined genuineness as being you seem to be, consistent over time and dependable in the relationship.
- Rogers defined genuineness as the characteristic of transparency, realness, honesty, or authenticity

Concreteness

Defn.: Using clear language to describe the client's life situation.

A concrete counselor promptly seeks specifics rather than vague generalities.

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

Counselors should be interested in specific feelings, specific thoughts and specific behaviours Counselor should identify the important themes to be pursued.

2. Advanced Empathy

- Egan poses 4 questions to get the content to communicate advanced empathy
- What is this person only half saying?
- What is this person hinting at?
- What is this person saying in a confused way?
- What messages do I hear behind the explicit message?

Immediacy

- Defn.: Immediacy refers to the current interaction of the therapist and the client in the relationship.
- Immediacy is when a counsellor talks openly about something that is occurring in the present moment of the session.
- Immediacy is direct, mutual, here-and-now, you-and-me talk. It means greater self involvement—you want to move deeper.
- Immediacy is not dumping your feelings/thoughts/opinions on your client.

Maslow Hierarchy Viewpoint

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Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

Maslow's hierarchy of needs is a theory of psychology explaining human motivation based on the pursuit of different levels of needs. The theory states that humans are motivated to fulfill their needs in a hierarchical order. This order begins with the most basic needs before moving on to more advanced needs. The ultimate goal, according to this theory, is to reach the fifth level of the hierarchy: self-actualization.

History

- Maslow's hierarchy of needs was first introduced in Abraham Maslow's 1943 paper, "A Theory of Human Motivation". Maslow later refined this theory in 1954 with his book, "Motivation and Personality".
- **PHYSIOLOGICAL NEEDS**
- Physiological needs are the lowest level of Maslow's hierarchy of needs. They are the most essential things a person needs to survive. They include the need for shelter, water, food, warmth, rest, and health. A person's motivation at this level derives from their instinct to survive.
- **SAFETY NEEDS**
- The second level of Maslow's hierarchy of needs consists of safety needs. Safety, or security needs, relate to a person's need to feel safe and secure in their life and surroundings. Motivation comes from the need for law, order, and protection from unpredictable and dangerous conditions.
- **LOVE AND BELONGING NEEDS**
- The third level of Maslow's hierarchy of needs is love and belonging needs. Humans are social creatures that crave interaction with others. This level of the hierarchy outlines the need for friendship, intimacy, family, and love. Humans have the need to give and receive love; to feel like they belong in a group. When deprived of these needs, individuals may experience loneliness or depression.
- **ESTEEM NEEDS**

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

- The fourth level of Maslow's hierarchy of needs is esteem needs. Esteem needs are related to a person's need to gain recognition, status, and feel respected. Once someone has fulfilled their love and belonging needs, they seek to fulfill their esteem needs.
- **SELF-ACTUALIZATION NEEDS**
- The fifth and final level of Maslow's hierarchy of needs is self-actualization needs. Self-actualization relates to the realization of an individual's full potential. At this level, people strive to become the best that they possibly can be.
- The need for self-actualization can manifest in different ways, such as:
- Obtaining skills (e.g., financial modeling skills)
- Continued education (e.g., online training courses)
- Utilizing skills, knowledge, and talents
- Pursuing life dreams
- Seeking happiness

Viktor Frankl's Existential Approach/Logo Therapy

Logotherapy is a term derived from "logos," a Greek word that translates as **"meaning," and therapy**, which is defined as treatment of a condition, illness, or maladjustment. Founded by **Viktor Frankl.**

- Logotherapy is based on the premise that the human person is motivated by a "will to meaning," an inner pull to find a meaning in life.
- The following list of tenets represents basic principles of logotherapy:
  Life has meaning under all circumstances, even the most miserable ones.
  Our main motivation for living is our will to find meaning in life.
  We have freedom to find meaning in what we do, and what we experience, or at least in the stand we take when faced with a situation of unchangeable suffering.

History

- Victor Frankl was born in Vienna in 1905. He trained as a psychiatrist and neurologist.

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

- During World War II, Frankl spent about three years in various Nazi concentration camps, an
- experience that greatly influenced his work and the development of logotherapy.
- Frankl observed that those who were able to survive the experience typically found some meaning in it, such as a task that they needed to fulfill.
- In 1946, he published *Man's Search for Meaning*, outlining his experiences in the concentration camps as well as the basic tenets and techniques of logotherapy.

Man's Search for Meaning

- Frankl identifies three psychological reactions experienced by all inmates to one degree or another:
- shock during the initial admission phase to the camp,
- apathy after becoming accustomed to camp existence, in which the inmate values only that which helps himself and his friends survive, and
- reactions of depersonalization, moral deformity, bitterness, and disillusionment if he survives and is liberated.

Key Concepts

Finding Meaning with Logotherapy

- According to Frankl, life's meaning can be discovered in three different ways:

By creating a work or accomplishing some task

By experiencing something fully or loving somebody

By the attitude that one adopts toward unavoidable suffering

Suffering is part of life

- Frankl believed that suffering is a part of life, and that man's ultimate freedom is his ability to choose how to respond to any set of given circumstances, even the most painful ones.
- Additionally, people can find meaning in their lives by identifying the unique roles that only they can fulfill.

Techniques

Dereflection:

- Dereflection is used when a person is overly self-absorbed on an issue or attainment of a goal. By redirecting the attention, or dereflecting the attention away from the self, the person can become whole by thinking about others rather than themselves.
- Logotherapy is meaning-centered. Rather than asking what I want from life the question is what life wants from me. The person in crisis is very self-absorbed.

Paradoxical intention:

- Paradoxical intention involves asking for the thing we fear the most.
- In the application of paradoxical intention we use our capacity for self-distancing or self detachment through humor, heroism and the defiant power. We can poke fun at a tragic situation.
- For people who experience anxiety or phobias, fear can paralyze them. But by using humor and ridicule, they can wish for the thing they fear the most, thus removing the fear from their intention and relieving the anxious symptoms associated with it.

Socratic dialogue:

- Socratic dialogue is a technique in which the logotherapist uses the own person's words as a method of self-discovery. By listening intently to what the person says, the therapist can point out specific patterns of words, or word solutions to the client, and let the client see new meaning in them.

INTERPERSONAL VIEWPOINT: Herbert “Harry” Stack Sullivan (1892– 1949) was an American Neo-Freudian psychiatrist and psychoanalyst who held that the personality lives in a complex of interpersonal relations. Harry was the oldest existing son of poor Irish Catholic parents, lonely childhood existence, and a poor relationship with his father. Academically gifted, Sullivan graduated from high school as valedictorian at age 16. He then entered Cornell University intending to become a physicist, although he also had an interest in psychiatry.

Assumptions and Key Concepts

- **Basic Anxiety:** fear of rejection by significant persons

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

- **Interpersonal Security:** feelings associated with relief of anxiety, the point when all needs are met, or a sense of total well-being
- **Parataxic Distortion:** a person's fantasy perception of another person's attributes without consideration important personality differences
- **Selective Inattention:** how people cope with the anxiety caused by the undesired traits

Stages of Development

Stage	Age	Significant Other	Interpersonal Process	Learnings
Infancy	0-2	Mother	Tenderness	Good / Bad
Childhood	2-6	Parents	Imaginary Playmates	Syntaxic Language
Juvenile Era	6-8.5	Playmates	Living with Peers	Competition, Compromise, Cooperation
Preadolescence	8.5 – 13	Single Chum	Intimacy	Affection & Respect
Early Adolescence	13 – 15	Several Chums	Intimacy and Lust	Balance, Security Operations
Late Adolescence	15 -	Lover	Fusion of Intimacy and Lust	Discovery of self & world

- **Infancy** – Sullivan acknowledged that the developmental process begins early in life, though he gave this phase less importance than Freud did.
- **Childhood**, ages 1-5 – During this stage of development, speech forms the framework upon which subsequent learning is built.
- **Juvenile, ages 6-**8 – During this period, a wide variety of playmates and access to healthy socialization and social skills become increasingly important.

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

- **Preadolescence, ages 9-12** – In preadolescence, the ability to form close friendships assists the child in developing self-esteem and serves as practice for later relationships.
- **Early adolescence, ages 13-17** – Friendship takes on a sexual dimension, and the focus on relationship with peers shifts toward romantic interests. An adolescent's sense of self-worth is based in large part upon his or her perceived sexual attractiveness.
- **Late adolescence, ages 18–early 20s** – The young adult struggles with conflicts between parental control and the desire to form an independent identity, while beginning to focus on both romance and friendship.
- **Adulthood** – The primary struggles of adulthood include family, financial security, and a rewarding career. Socialization continues to play a role in adult development

Sullivan explained about three types of self:

- The 'good me' versus the 'bad me' based on social appraisal and the anxiety that results from negative feedback
- The 'not me' refers to the unknown, repressed component of the self

Personifications

Sullivan suggests that infants develop three basic personifications—the bad-mother, the good-mother, and the me. In addition, some children acquire an eidetic personification during childhood.

(**a) Bad-Mother, Good-Mother:**

These develop from an infant's experiences. When a nipple that does not satisfy an infant's hunger needs, the **bad-mother personification** develops.

The infant develops **three types of personifications of himself.**

(1) The bad-me, when a person's behaviour is disapproved of and considered unworthy.

(2) The good-me, when his behavior is accepted and praised.

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

(3) The not-me, when a person disengages or selectively ignores the experiences that induce anxiety.

(c) **Eidetic Personifications:**

He observed that people create and project imaginary traits on to others. These eidetic personifications include the imaginary friends that preschool-aged children often have. Even though these playmates are imaginary, children learn to develop a secure relationship with another person.

Cognitive Therapy

History

Cognitive Therapy (CT) was pioneered by Dr. Aaron T. Beck in the 1960s, while he was a psychiatrist at the University of Pennsylvania. Having studied and practiced psychoanalysis, Dr. Beck designed and carried out several experiments to test psychoanalytic concepts of depression. Fully expecting the research would validate these fundamental concepts, he was surprised to find the opposite.

Three categories: The patients had negative ideas about themselves, the world and/or the future.

Dr. Beck began helping patients identify and evaluate these automatic thoughts. He found that by doing so, patients were able to think more realistically. As a result, they felt better emotionally and were able to behave more functionally. When patients changed their underlying beliefs about themselves, their
world and other people, therapy resulted in long-lasting change. Dr. Beck called this approach “cognitive therapy.” It has also become known as “cognitive behavior therapy.”

Philosophical Assumptions:

• Cognitions affect and cause behaviour and emotions.
• Cognitions can be measured, monitored, and altered.

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

• Pathology occurs when people have negative core beliefs. They can be categorized into 2.

Interpersonal category ("I'm unlovable", "I am a burden to others") and achievement category

("I'm incompetent", "I am not good enough", "I am a failure")

Key Concepts:

• **Automatic thought:** is a brief stream of thought about ourselves and others. Automatic thoughts largely apply to specific situations and/or events and occur quickly throughout the day as we appraise ourselves, our environment, and our future. We are often unaware of these thoughts, but are very familiar with the emotions that they create within us.

• **Intermediate Belief/ Assumption:** These are attitudes or rules that a person follows in his/her life. Intermediate beliefs can often be stated as conditional rules: "If x , then y." They may be about oneself, Others and Life/World If… then, I need to…. (will be with conjunctions)

• **Core belief**: Core beliefs are often formed in childhood and solidified over time as a result of one's perceptions of experiences. Generally core beliefs tend to be rigid and pervasive. It can also be about oneself, others.

Negative Self-Schemas

Beck believed that depression prone individuals develop a negative self-schema. They possess a set of beliefs and expectations about themselves that are essentially negative and pessimistic.

Beck claimed that negative schemas may be acquired in childhood as a result of a traumatic event.

- Parental rejection, criticism, overprotection, neglect or abuse.
- Bullying at school or exclusion from peer group.

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

People with negative self schemas become prone to making logical errors in their thinking and they tend to focus selectively on certain aspects of a situation while ignoring equally relevant information.

Cognitive Distortions

Beck (1967) identifies a number of illogical thinking processes (i.e. distortions of thought processes). These illogical thought patterns are self-defeating, and can cause great anxiety or depression for the individual.

• **Arbitrary interference**: Drawing conclusions on the basis of sufficient or irrelevant evidence: for example, thinking you are worthless because an open air concert you were going to see has been rained off.

• **Selective abstraction**: Focusing on a single aspect of a situation and ignoring others: E.g., you feel responsible for your team losing a football match even though you are just one of the players on the field.

• **Magnification**: exaggerating the importance of undesirable events. E.g., if you scrape a bit of paint work on your car and, therefore, see yourself as a totally awful driver.

• **Minimisation**: underplaying the significance of an event. E.g., you get praised by your teachers for an excellent term's work, but you see this as trivial.

• **Overgeneralization**: drawing broad negative conclusions on the basis of a single insignificant event. E.g., you get a D for an exam when you normally get straight As and you, therefore, think you are stupid.

BIOLOGICAL VIEWPOINT

Biological viewpoint focuses on mental disorders as diseases whose primary symptoms are behavioural or cognitive although their causes are biological or physiological as against the physical illnesses where the cause and symptoms

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

are purely physical. According to this view, mental disorders are seen as disorders of the central nervous system and thus are sometimes inherited or caused by some medical factors like injuries or physical diseases. Psychological or environmental factors are not considered to cause these disorders

- `central nervous system
- Autonomic nervous system
- Endocrine system

Central Nervous System:

- Central nervous system with the back of the head, where the spinal cord meets the brain, and work forward
- The lower part of the brain, or hindbrain, consists of the medulla,

pons, and cerebellum.

- The medulla plays roles in such vital life-support functions as

heart rate, respiration, and blood pressure.

- The pons transmits information about body movement and is involved in functions related to attention, sleep, and respiration.
- The cerebellum regulates balance and motor (muscle) behavior.
- Injury to the cerebellum can impair your ability to coordinate your movements, causing stumbling and loss of muscle tone.
- The midbrain lies above the hindbrain and contains nerve pathways linking the hindbrain to the upper region of the brain, called the forebrain.

Autonomic Nervous System:

- The autonomic nervous system is a component of the peripheral nervous system that regulates involuntary physiologic processes including heart rate, blood pressure, respiration, digestion, and sexual arousal.

- It contains three anatomically distinct divisions: sympathetic, parasympathetic, and enteric.

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

- The sympathetic nervous system (SNS) and the parasympathetic nervous system (PNS) contain both afferent and efferent fibers that provide sensory input and motor output, respectively, to the central nervous system (CNS).

Endocrine System:

- The endocrine system is a complex network of glands and organs.
- It uses hormones to control and coordinate your body's metabolism, energy level, reproduction, growth and development, and response to injury, stress, and mood.
- **Hypothalamus:** The hypothalamus secretes hormones that stimulate or suppress the release of hormones in the pituitary gland, in addition to controlling water balance, sleep, temperature, appetite, and blood pressure.
- **Pineal body.** The pineal body is located below the corpus callosum, in the middle of the brain.
- **Pituitary**. The pituitary gland is located below the brain. Usually no larger than a pea, the gland controls many functions of the other endocrine glands.
- **Thymus.** The thymus is located in the upper part of the chest and produces white blood cells that fight infections and destroy abnormal cells.
- **Ovary.** A woman's ovaries are located on both sides of the uterus, below the opening of the fallopian tubes (tubes that extend from the uterus to the ovaries).
- **Testis.** A man's testes are located in a pouch that hangs suspended outside the male body. The testes produce testosterone and sperm.

BIOLOGICAL CAUSAL FACTORS

. We will discuss 'five' of the most important categories of biological factors that seem to be responsible for maladaptive behavior. These are given below:

- Neurotransmitter and Hormonal imbalances in the brain

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

- Genetic defects
- Constitutional liabilities
- Brain Dysfunction
- Physical deprivation or disruption.

Neurotransmitter and Hormonal Imbalances in the Brain

Neurotransmitter Imbalances

The 100 billion neurons in the central nervous system (CNS) communicate by Chemical messengers called neurotransmitters. When these neurotransmitters Become imbalanced they give rise to many psychological problems.

Neurotransmitters (e.g., serotonin, dopamine, nor epinephrine, GABA) are released into the synaptic cleft*. They regulate level of mood, anxiety, and cognitive functioning.

Factors affecting neurotransmitter imbalance include:

1) Excessive production and release of the neurotransmitter substance into the synapses, causing an excess in levels of that neurotransmitter.

2) Dysfunctions in the normal processes by which neurotransmitters are deactivated after they are released into the synapse.

3) Problems in the receptors in the postsynaptic neuron, which may either be Abnormally sensitive or insensitive.

Hormonal Imbalance

- Hormones are chemicals messengers secreted by the endocrine glands (e.g., pituitary).
- They play a role in the functioning of the nervous system and in the Regulation of behavior (e.g., during adolescence, changes in the hypothalamic pituitary-adrenal axis are involved in the increase in cortisol, a stress-related Hormone).
- Malfunction of this system has been said to be responsible for various forms of psychopathology.

- Hormonal influences are also responsible for the differences in behaviour between men and women.

Genetics

There are some evidence show that some mental disorder have a hereditary component. Some inherited defects interfere directly with the normal development of brain. Some affected by variation in biochemical and genetic code.

Chromosomal Anomalies:

Chromosomal anomalies is irregularities in the chromosomal structure. Normal human cells have 46 chromosome containing the genetic material in which the hereditary plan is encoded

Inheritance consist of 23 paris of chromosomes. 22 chromosome pairs are called autosome that determine by their bio chemical action. General anatomical and physiological character. If there is abnormalities in the structure and number of chromosome it cause sever malformation and disorder

Faulty Gene

A change in gene is called a fault or mutation. These faults can make a cell stop working properly. Gene expression is not only by DNA, but also through the influence of internal and external environment.

Genotype

A person total genetic endowment is referred to his or her genotype.

Phenotype

The observed structural and functional characteristics that result from an interaction of the genotype and the environment are referred to as a persons phenotype. The genotype may shape the environmental experience a child has affecting the phenotype.

Constitutional Liabilities

The term ‘constitutional’ is used to describe any characteristic that is either innate or acquired early in life often at prenatal stage and in such strength that it is functionally similar to a genetic characteristic. Physical handicaps and

temperament are some of the traits included in this category.

Physical Handicap

- Embryonic abnormalities or environmental conditions operating before or after birth may result in physical defects.
- The most common birth difficulty associated with learning disabilities and behavioural and emotional disorders is **low birth weight**.
- low birth weights include nutritional deficiencies, disease, and exposure to radiation, drugs, severe emotional stress or mother's excessive use of alcohol or tobacco.
- Socio-economic status is also related to fetal and birth difficulties.

PRIMARY REACTIVE TENDENCIES AND TEMPERAMENT

- New born react to certain stimuli. Each child differ in reacting to various stimuli. Babies differ in their emotional and arousal responses to various stimuli and their tendency to approach withdraw or attend to various stimuli. Early temperament leads to our personality sharing about 2-3 months of their age.

2-3 MONTH OF AGE	**ADULTHOOD (PERSONALITY)**
Fearful, irritability and frustration	Neuroticism
Positive affect, activity level	Extraversion
Attentional persistence	Conscientiousness

BRAIN DYSFUNCTION:

Damage in brain tissue by neurosyphilis. Knowledge about brain structure has increased with the advances in computed tomography (CT) scanning and magnetic resonance imaging (MRI).

- This evidence indicates that schizophrenia may be neurodevelopmental in origin. Exposure to adverse conditions which can affect brain development (in utero or in early life) may lead to changes in the frontal lobes that increase the risk of schizophrenia.

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

- Neuroimaging also helps us to distinguish between different types of dementia. Also, some older people experiencing severe depression for the first time might have underlying cerebro-vascular disease.

Causes of Brain Dysfunction

Localized brain dysfunction is caused by disorders that occur in a specific area of the brain, including the following:

- Brain tumors
- Brain abscesses
- Disorders that reduce blood flow (and thus the oxygen supply) to a specific area, such as a stroke
- Head injuries

PHYSICAL DEPRIVATION OR DISRUPTION

- The most basic human requirements are those of food, water, oxygen, sleep and elimination of wastes.
- Insufficient rest, inadequate diet or working too hard when ill, can all interfere with a person's ability to cope and might predispose him or her to a variety of problems.
- Experimental studies of volunteers who have gone without sleep for 72 to 98 hours show psychological problems like disorientation for time and place and feelings of depersonalisation.
- Prolonged food deprivation also affects psychological health.
- Severe malnutrition in children not only impairs physical development and lowers resistance to disease but it also stunts brain growth, results in lowered intelligence and increases risk for disorders like attention-deficit disorder.

Socio-Cultural Factors

- Social-Economic Status
- Gender
- Age

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

- Urban Environment
- Social Networks

Social-Economic Status

- Social class is one of the most important causal factors in mental illness. It was found that those from the lower economic classes are more likely than those from other classes to be mentally ill.
- lower economic class people are more prone to mental disorder because they are more likely to experience social stress (e.g. unemployment, separation), to suffer from psychic frailty, infectious diseases, neurological impairments, and to lack good medical treatment, coping ability and social support.

Gender

- The next social factor associated with mental illness is gender.
- In most studies women are found to have a higher rate of mental disorder, but some others find men to be more predominant or no difference between the sexes.
- These usually show that women predominate in depression and anxiety disorders, while men more commonly have antisocial personalities, paranoia, drug and alcohol

Age

- Another social factor that has been associated with mental disorder is age. Studies conducted before the 1980's suggested that older persons were more likely to suffer from mental disorders.
- Yet, more recent studies in the 1980's and 1990s show that the elderly are the least likely among all age groups to become mentally ill.

Urban Environment

- It is argued that the urban environment produces a lot of mental problems because it generates an abundance of physical and social stresses (e.g. traffic congestion, noise, population density, tenuous social relations, loneliness and lack of social support).

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

- Some community studies also reveal a link between urban living and specific psychological problems (e.g. neurotic and personality disorders).
- More serious psychotic conditions are more prevalent among rural

and small town residents.

Social Networks

- Having caring and close relationships strongly protects against most non psychotic forms of mental illness.
- Supportive social networks, particularly family, are crucial in times of crisis. Such networks extend beyond family and close friends, and in many communities include religious groups.
- People with psychological illness tend to have more impaired social networks than their peers.

UNIT III ANXIETY DISORDERS

Definition of Anxiety Disorder: The Fear and Anxiety Response Patterns –DSM 5 Classification: Phobic Disorders – Panic Disorders – Generalized Anxiety Disorder – Obsessive Compulsive Disorder – PTSD –Clinical Features, Causal Factors, Treatments and Outcomes

Anxiety involves a general feeling of apprehension about

possible future danger, and fear is an alarm reaction that occur in response to immediate danger Anxiety disorders all have unrealistic, irrational fears or anxieties .

The Fear and Anxiety Response

- There has never been complete agreement about how distinct the two emotions of **fear and anxiety** are from each other.
- When the **source of danger is obvious**, the experienced emotion has been called fear (e.g., "I'm afraid of snakes").
- With anxiety, however, we frequently **cannot specify clearly what the danger** is (e.g., "I'm anxious about my parents' health").Fear In recent years, however, many prominent researchers have proposed a more fundamental distinction between the fear and anxiety response patsystem

Fear

- According to these theorists, **fear is a basic emotion** (shared by many animals) that involves **activation of the "fight-or-flight"** response of the **autonomic nervous system.**
- When the fear response occurs in the **absence of any obvious external danger**, we say the person has had a spontaneous or **uncued panic attack.** The symptoms of a panic attack are nearly identical to those experienced during a state of fear except that panic attacks are often accompanied by a subjective sense of impending doom, including fears of dying, going crazy, or losing control.

Fear and panic have three components:

1. cognitive/subjective components ("I feel afraid/terrified";

“I’m going to die”)

2. physiological components (such as increased heart rate and

heavy breathing)

3. behavioral components (a strong urge to escape or flee; Lang,

Anxiety

- In contrast to fear and panic, the anxiety response pattern is a complex blend of unpleasant **emotions and cognitions that is both more oriented to the future** and much more diffuse than fear (Barlow, 1988, 2002).
- But like fear, i**t has not only cognitive/subjective components but also physiological and behavioral components.**
- At the cognitive/subjective level, anxiety involves negative mood, worry about possible future threats or danger, self-preoccupation, and a **sense of being unable to predict the future threat or to control** it if it occurs.
- At a and readiness for dealing with danger should it occur (“Something awful may happen, and I had better be ready for it if it does”).

Generalized Anxiety Disorder: Generalized anxiety disorder (or GAD) is marked by excessive, exaggerated anxiety and worry about everyday life events for no obvious reason. People with symptoms of generalized anxiety disorder tend to always expect disaster and can't stop worrying about health, money, family, work, or school.

Symptoms:

- Edginess or restlessness
- Tiring easily; more fatigued than usual
- Impaired concentration or feeling as though the mind goes blank
- Irritability (which may or may not be observable to others)
- Increased muscle aches or soreness
- Difficulty sleeping (due to trouble falling asleep or staying asleep, restlessness at night, or unsatisfying sleep)

Causes for GAD

Biological Perspective

Genetic Factors:

- One of the largest and most recent twin studies has reported a variance of 15 to 20 percent in liability to GAD due to genetic component.
- There is higher concordance rate for GAD in MZ than DZ twins. Further, strong evidence has been found for a common underlying genetic predisposition for GAD and major depressive
- A basic personality trait called neuroticism has been conceptualize disorder . Nevertheless, whether a person with a genetic risk for GAD or MDD will develop the disorder/s is determined by the environmental factors

Neurochemical and Neurohormonal Factors:

- Researchers discovered a to the inhibitory neurotransmitter, Gamma Amino Butyric Acid or GABA.
- In normal fear reactions, neurons throughout the brain fire and create the experience of anxiety. This neural firing also stimulates GABA system, which inhibits this and reduces anxiety.
- GAD may result from some defect in the GABA system so that anxiety is not brought under control. The benzodiazepines may reduce anxiety by enhancing the release of GABA
- The Corticotropin Releasing Hormone (CRH): The CRH plays a role in GAD as it is an anxiety producing hormone.

Psychoanalytic Perspective

- Generalized anxiety is the result of a constant **unconscious struggle between id impulses and ego**
- **Id impulses are aggressive and** sexual in nature, and struggle for expression whereas the ego because of its unconscious fear of being punished, does not let id express its desires.

- Since the source of **anxiety is unconscious, person does** not know the reason for anxiety and as a result is always anxious and apprehensive.
- The person cannot evade anxiety as he/she can not escape from id, for escape from id means that the person is no longer alive.

Behavioural Perspective

- A person who spends most hours of his/her day with other people may be anxious because of the p**eople or the social situations and not because of any internal factors, i.e.,** the person learns to associate their anxiety with the presence of other people.

Cognitive-Behavioral Perspective

- The main underlying idea is that GAD results from distorted cognitive processes.
- People with GAD often misperceive benign events, such as crossing the street as involving threats, and their cognitions focus on anticipated future disasters
- Their attention is easily drawn to threatening stimuli

Treatment:

Medication:

Medications can't cure an anxiety disorder. But they can improve symptoms and help you function better. Medications for anxiety disorders often include:

- **Anti-anxiety medications,** such as benzodiazepines, may decrease your anxiety, panic and worry. They work quickly, but you can build up a tolerance to them. That makes them less effective over time.
- **Antidepressants** can also help with anxiety disorders. They tweak how your brain uses certain chemicals to improve mood and reduce stress.

- **Beta-blockers,** usually used for high blood pressure, can help reduce some of the physical symptoms of anxiety disorders.

Psychotherapy, or counseling, helps you deal with your emotional response to the illness.

- **Cognitive behavioral therapy (CBT)** is the most common type of psychotherapy used with anxiety disorders. CBT for anxiety teaches you to recognize thought patterns and behaviors that lead to troublesome feelings. You then work on changing them.
- **Exposure therapy** focuses on dealing with the fears behind the anxiety disorder. It helps you engage with activities or situations you may have been avoiding. Your provider may also use relaxation exercises and imagery with exposure therapy.

Obsessive-compulsive disorder (OCD)

Obsessive-compulsive disorder (OCD) is a mental illness, with a chronic (long-lasting) state of anxiety. It traps people in a constant cycle of repeated obsessions and compulsions:

- **OCD obsessions:** People with OCD have repetitive and distressing fears or urges they can't control. These obsessive thoughts cause intense anxiety.

- **OCD compulsions**: To control obsessions and anxiety, people with OCD turn to certain behaviors, rituals or routines. They do so repeatedly. They don't want to perform these compulsive behaviors and don't get pleasure from them. But they feel like they have to follow along or their anxiety will get worse.

Obsessions Symptoms:

While everyone worries, in people with OCD, worries and anxiety can take over, making it hard to carry out everyday tasks.

- **Contamination**, by bodily fluids, germs, dirt, and other substances
- **Losing control**, such as the fear of acting on an urge to self-harm or hurt others
- **Perfectionism**, which may involve the fear of losing things or an intense focus on exactness or remembering things
- **Harm**, including a fear of being responsible for a catastrophic event
- **Unwanted sexual thoughts**, including thoughts about inappropriate activities
- **Religious or superstitious beliefs**, such as a concern about offending God or stepping on cracks in the sidewalk

Compulsions: Not every repetitious behavior is a compulsion. Most people use repetitive behaviors, such as bedtime routines, to help them manage everyday life. For a person with OCD, however, the need to perform repetitious behavior is intense, it occurs frequently, and it is time-consuming. The behavior may take on a ritualistic aspect.

OCD in children

Complications among young people, including children, with OCD include:

- low self-esteem
- disrupted routines
- difficulty completing schoolwork

- physical illness, due to stress, for example
- trouble forming or maintaining friendships and other relationship

Causes

Genetic causes

OCD appears to run in families, suggesting a possible genetic link, which experts are investigating. Genes that affect how the brain responds to the neurotransmitters dopamine and serotonin, for example, may play a role in causing the disorder.

Behavioral causes

One theory suggests that a person with OCD learns to avoid fear associated with certain situations or objects by performing rituals to reduce the perceived risk.

The initial fear may begin around a period of intense stress, such as a traumatic event or significant loss.

Cognitive causes

Another theory is that OCD starts when people misinterpret their own thoughts.

Most people have unwelcome or intrusive thoughts at times, but for people with OCD, the importance of these thoughts becomes more intense or extreme.

Environmental causes

Stressful life events may trigger OCD in people with a predisposition, genetic or otherwise.

Many people have reported that the symptoms appeared within 6 months of events such as:

- childbirth
- complications during pregnancy or delivery
- a severe conflict
- a serious illness
- a traumatic brain injury

Also, OCD may occur alongside post-traumatic stress disorder, or PTSD

TREATMENT

If you have symptoms of OCD that interfere with your daily life, you should talk to a healthcare provider. A professional who is specially trained in mental illness can offer several strategies:

- **Cognitive-behavioral therapy (CBT)**: Cognitive-behavioral therapy is a type of psychotherapy. You will talk to a therapist, who will help you examine and understand your thoughts and emotions. Over several sessions, CBT can help you stop negative habits, perhaps replacing them with healthier ways to cope.
- **Medications**: Drugs called serotonin reuptake inhibitors (SRIs), selective SRIs (SSRIs) and tricyclic antidepressants may help. They increase levels of serotonin. Examples
  include clomipramine, fluoxetine, fluvoxamine, paroxetine and sertraline.
- **Exposure and response prevention (EX/RP):** With this therapy, you do the thing that causes anxiety. The healthcare provider then prevents you from responding with a compulsion. For example, the provider may ask you to touch dirty objects but then stop you from washing your hands.

What happens if CBT and medications don't work for OCD. If OCD doesn't respond to CBT and medication, a healthcare provider may try to improve mood, specifically depression, with these therapies:

- **Electroconvulsive therapy (ECT):** Electroconvulsive therapy uses electrodes that get attached to the head. These wires deliver electric shocks to the brain. The shocks cause small seizures, which help the brain release helpful chemicals.
- **Transcranial magnetic stimulation (TMS):** Transcranial magnetic stimulation uses a magnetic device placed on the head. It delivers electrical impulses to the brain. The impulses cause the brain to release chemicals known to improve mood.

Your provider might suggest using mindfulness to treat OCD and to improve the usefulness of other OCD treatments.

PTSD : PTSD is an anxiety disorder which occurs after a person experiences a severe trauma. It is a set of symptoms including hyper vigilance, re-experiencing of the trauma, emotional numbing experienced by trauma survivors.People who experience severe and long lasting traumas, who have lower levels of social support, who experience socially stigmatizing traumas, who were already depressed or anxious

The **three main categories of symptoms of PTSD are –**

1**. Re – experiencing of the traumatic event –**

Frequent nightmares, flashbacks of the event, other stimulus

remind the event, etc.

2. **Emotional numbing and detachment -**

Avoidance of anything which reminds of the event, restricted

emotional responses, no reaction to any kind of emotional

provocation, sometimes unable to remember certain aspects of

the event, etc.

3. **Hyper vigilance and chronic arousal -**

Constantly alertness for the traumatic event, panic and flight,

chronically over aroused, easily startled, quick to anger, etc.

Four types of events are seen to result in PTSD –

1. Natural disasters – Floods, earthquakes, fires, tornadoes, etc.

2. Abuse – Physical abuse like beating, sexual abuse like rape,

emotional abuse like critical parents, etc.

3. Combat and War related traumas - War prisoners witnessing

deaths, war zone stress etc.

4. Common traumatic events - Accidents, sudden death of loved

ones, drowning, heart break, etc.

CAUSES OF PTSD

1. **Psychological Causes** – Human beings live with many assumptions about

themselves and others, this keeps the person‘s faith and trust intact. But if these assumptions, one shattered because of the trauma, may result in PTSD.

b) People already suffering from depression and anxiety are more vulnerable to develop PTSD

The onset of PTSD also depends on the person‘s coping styles and adjustments. People using self-destructive styles such as taking alcohol, drugs, isolation are more vulnerable to PTSD.

2. Biological Causes -

a) Lower level of the hormone cortisol can result in PTSD, as it prolongs the activity of the sympathetic nervous system. PTSD people show increased blood flow in the amygdala area of the brain.

b) Twin and family studies shows that PTSD can be inherited, it runs in the family.

3. **Social and Cultural Causes -**

People with strong social and supportive social group are less likely to develop PTSD after a trauma.

TREATMENT OF PTSD

1. **Cognitive Treatment**

a) **Behavioural therapy** –Systematic desensitisation helps the patient to identify the stimulus and rank the fear ascendingly. Positive imagery training helps the victims of rape to recover from PTSD.

b) **Stress management** methods helps to develop skills to overcome stressful issues.

2. **Biological therapy –**Selective Serotonin Reuptake Inhibitors (SSRI) and

Benzodiazepines are helpful in treating PTSD symptoms.

3. **Social – Cultural Help –**Community level interventions helps the people with PTSD caused by natural disasters, etc.

Unit IV

SOMATOFORM AND DISSOCIATIVE DISORDER

Somatoform Disorder: Hypochondriasis, Somatization Disorder, Pain Disorder, Conversion Disorder – Clinical Features, Causal Factors, Treatment and outcomes.

Dissociative disorder: Depersonalization Disorder, Dissociation Amnesia and fugue Dissociative Identity Disorder-Clinical Features-Causal Factors, Treatment and outcome

SOMATOFORM DISORDER

The somatoform disorders are conditions involving physical complaints or disabilities occurring in the absence of any physical pathology that could account for them. (Soma means from the Greek word for Body)

Though no sufficient organic bases exist these people sincerely believe their symptoms are real and serious.

There are four pattern of Somatoform disorders:

- Somatization disorder
- Factitious disorder
- Hypochondriasis (Illness Anxiety disorder)
- Pain Disorder
- Conversion Disorders

FACTITIOUS DISORDER A disorder in which a **person feigns or induces physical symptoms,** typically for the purpose of assuming the role of a sick person. False creation of physical or psychological symptoms, or deceptive production of injury or disease, even without external rewards for such ailments.

Factitious disorder seems to be particularly **common among people** who

(1) received extensive treatment for a medical problem as children,

(2) carry anger of the medical profession, or

(3) have worked as a nurse, laboratory technician, or medical aide.

A number have poor social support, few enduring social relationships, and little family life

Types of factitious disorder

- **Factitious disorder imposed on self:** This type includes the falsifying of psychological or physical signs or symptoms. The person may appear confused, make absurd statements, and report hallucinations (the experience of sensing things that are not there; for example, hearing voices).
- **Factitious disorder imposed on another:** People with this disorder produce or fabricate symptoms of illness in others under their care: children, elderly adults, disabled persons or pets. It most often occurs in mothers (although it can occur in fathers) who intentionally harm their children in order to receive attention. The diagnosis is not given to the victim, but rather to the perpetrator.

CAUSES FACTITIOUS DISORDER

The exact cause of **factitious disorder is not known,** but researchers believe **both biological and psychological factors** play a role. Some theories suggest that a history **of abuse or neglect as a child**, or a history of **frequent illnesses** in themselves or family members that required hospitalization, may be factors in the development of the disorder.

FACTITIOUS DISORDER TREATED

The primary treatment for factitious disorder **is psychotherapy** (a type of counseling). Treatment likely will focus on changing the thinking and behavior of the individual with the disorder (**cognitive-behavioral therapy).** Family therapy also may help in teaching family members not to reward or reinforce the behavior of the person with the disorder. **No medications to actually** treat factitious disorder.

SOMATIZATION DIOSRDER

Somatization disorder is characterized by multiple complaints of physical ailments over a long period of time. A long term condition in which a person has physical symptoms that involve more than one part of the body but no physical cause can be found
Age: Beginning before age 30

FOUR TYPES OF SYMPTOMS

- Four pain symptom

- Two gastrointestinal symptom
- One sexual symptom
- One pseudo neurological symptom

Four Pain symptom:

The patient must report history of pain respect to at least four different sites or function
The symptoms are: Head ache, back pain, joints pain, rectum pain, menstruation pain, sexual intercourse pain, urination pain

Two Gastrointestinal symptom:

The patient must report a history of at least 2 symptoms other than pain symptom
The symptom are: Nausea, bloating, diarrhea, multiple food intolerance, vomiting when not pregnant

One sexual symptom:

The patient must report a history of at least one reproductive system other than pain
The symptoms are: Sexual indifference or dysfunction, menstrual irregularities and vomiting throughout pregnancy

One Pseudo neurological symptom:

The patient must report a history of at least one symptom of neurological condition
The symptoms are: Mimic sensory or motor impairment, anomalies of consciousness or memory.

ILLNESS ANXIETY DISORDER:

A disorder in which people are chronically anxious about and preoccupied with the notion that they have or are developing a serious medical illness, despite the absence of somatic symptoms. Previously known as hypochondriasis.

- People with hypochondriasis always think that they have health problem and have unrealistic fears of disease. They go for repeated medical advice and get disappointed when no physical problem is found.

- They have complain of uncomfortable and peculiar sensation in areas like stomach, chest, head, genital and anywhere else in the body
- Although illness anxiety disorder can begin at any age, it starts most often in early adulthood, among men and women in equal numbers. Between 1 and 5 percent of all people experience the disorder

Symptoms of Illness anxiety disorder:

- Person is preoccupied with thoughts about having or getting a significant illness. In reality, person has no or, at most, mild somatic symptoms.
- Person has easily triggered, high anxiety about health.
- Person displays unduly high number of health related behaviors (e.g., keeps focusing on body) or dysfunctional health-avoidance behaviors (e.g., avoids doctors).
- Person's concerns continue to some degree for at least 6 months.

Types: There are two types of illness anxiety disorder: care-seeking and care-avoidant.

Care-Seeking Type: Some people with illness anxiety disorder react with a need for constant reassurance. They may visit the doctor regularly despite tests showing that everything is normal. They may also frequently complain of their symptoms to friends and family members.

Care-Avoidant Type: Others with IAD react in the opposite extreme. They may avoid visiting the doctor for fear of learning bad news. They may be reluctant to share their fears with loved ones, either because they are afraid of having their fears confirmed or because they believe that they will not be taken seriously.

Treatment: Psychotherapy:

Cognitive behavioral therapy (CBT) has become a popular option for treating IAD. This type of therapy helps people learn to manage the anxiety that they feel towards their physical symptoms. In turn, this can help the symptoms themselves diminish.

Medication: Selective serotonin reuptake inhibitors (SSRIs) are a type of medication that can help to treat illness anxiety disorder. These drugs are generally known as antidepressants and work by affecting the levels of serotonin in the brain.

PAIN DISORDER: Pain disorder is characterized by the report of pain of sufficient duration and severity to cause significant life disruption in the absence of objective finding of medical pathology.

Diagnosis:

- Pain disorder associated with psychological Factors
- Pain disorder associated with both psychological factors and a general medical condition

Treatment:

Pain disorder is easier to treat. Indeed cognitive behavioral techniques have been widely used in the treatment of physical and more psychological pain disorder. Treatment program generally include relaxation training, support and validation, scheduling daily activities, reinforcement.

CONVERSION DISORDER A disorder in which a person's bodily symptoms affect his or her voluntary motor and sensory functions, but the symptoms are inconsistent with known medical diseases.

The person has blindness, paralysis and neurological symptoms that cannot be explained by medical evaluation formerly known as hysteria. The term conversion has it's origin in freud's doctrine that anxiety is converted into physical symptoms.

Symptoms of conversion Disorder:

- Blindness
- Partial paralysis
- Inability to speak
- Deafness
- Numbness
- Balance problem
- Seizure
- Difficult in walking

Conversion disorder is categorized of three symptoms:

- Sensory Symptoms
- Motor Symptoms
- Visceral Symptoms

Sensory Symptoms: This refers to the inability to receive sensory stimuli. Anyone of the senses like visual, or tactual may be involved.

Anaesthesia — loss of sensitivity

Hyposthenia — partial loss of sensitivity

Hyperesthesia — excessive sensitivity

Analgesic — loss of pain sensitivity

Paraesthesia — exceptional sensation such as tinglings.

Motor Symptoms:

- Impaired balance of body
- Paralysis of limb or entire body
- Loss of speech
- Urinary retention
- Fainiting, loss of touch

Visceral Symptoms

- Headache, lung in the throat, choking sensation, coughing, difficult in breathing, nausea and vomiting

Causes

The exact cause of functional **neurologic disorder is unknown.** Theories regarding what happens in the brain to result in symptoms are complex and involve multiple mechanisms that may differ, depending on the type of functional neurological symptoms.

Basically, **parts of the brain that control the functioning of your muscles and senses may be involved, even though no disease or abnormality exists**. Other

triggers may include changes or disruptions in how the brain functions at the structural, cellular or metabolic level. But the trigger for symptoms can't always be identified.

Risk factors: Factors that may increase your risk of functional neurologic disorder include:

- Having a neurological disease or disorder, such as epilepsy, migraines or a movement disorder
- Recent significant stress or emotional or physical trauma
- Having a mental health condition, such as a mood or anxiety disorder, dissociative disorder or certain personality disorders
- Having a family member with a neurological condition or symptoms
- Having a history of physical or sexual abuse or neglect in childhood

Treatment:

- **Behavior therapy** that focuses on stress reduction and relaxation techniques can also help reduce symptoms.
- **Cognitive behavioral therapy** (CBT) can help people identify negative or irrational thought patterns and respond to challenges more effectively. CBT can also help people build better-coping skills for life stressors
- **Hypnosis and self-hypnosis** have also proven beneficial for symptom reduction in conversion disorder.
- **Pharmacotherapy** for conversion disorder usually involves medication that treats the symptoms of co-occurring conditions.

SOMATIC SYMPTOM DISORDER A disorder in which people become excessively distressed, concerned, and anxious about bodily symptoms that they are experiencing, and their lives are greatly and disproportionately disrupted by the symptoms.

DEPERSONALIZATION DISORDER

- Depersonalization disorder is characterized by feeling detached from one’s life, thoughts and feelings.

- People with this type of disorder say they feel distant and emotionally unconnected to themselves, as if they are watching a character in a boring movie.
- Other typical symptoms include problems with concentration and memory. The person may report feeling ‘spacey’ or out of control.
- Time may slow down. They may perceive their body to be a different shape or size than usual; in severe cases, they cannot recognize themselves in a mirror

Two Condition:

- **Depersonalization** – experiences of unreality or detachment from one’s mind, self or body. People may feel as if they are outside their bodies and watching events happening to them.
- **Derealization** – experiences of unreality or detachment from one’s surroundings. People may feel as if things and people in the world around them are not real.

Risk factors

Factors that may increase the risk of depersonalization-derealization disorder include:

- **Certain personality traits** that make you want to avoid or deny difficult situations or make it hard to adapt to difficult situations
- **Severe trauma,** during childhood or as an adult, such as experiencing or witnessing a traumatic event or abuse
- **Severe stress,** such as major relationship, financial or work-related issues
- **Depression or anxiety,** especially severe or prolonged depression, or anxiety with panic attacks
- **Using recreational drugs,** which can trigger episodes of depersonalization or derealization

Depersonalization symptoms

Symptoms of depersonalization include:

- Feelings that you're an outside observer of your thoughts, feelings, your body or parts of your body — for example, as if you were floating in air above yourself
- Feeling like a robot or that you're not in control of your speech or movements
- The sense that your body, legs or arms appear distorted, enlarged or shrunken, or that your head is wrapped in cotton
- Emotional or physical numbness of your senses or responses to the world around you
- A sense that your memories lack emotion, and that they may or may not be your own memories

Derealization symptoms

Symptoms of derealization include:

- Feelings of being alienated from or unfamiliar with your surroundings — for example, like you're living in a movie or a dream
- Feeling emotionally disconnected from people you care about, as if you were separated by a glass wall
- Surroundings that appear distorted, blurry, colorless, two-dimensional or artificial, or a heightened awareness and clarity of your surroundings
- Distortions in perception of time, such as recent events feeling like distant past
- Distortions of distance and the size and shape of objects

Psychotherapy: Talk therapy is the main treatment for dissociative disorders. Your provider may opt for one or more of these methods:

- **Cognitive-behavioral therapy:** CBT focuses on changing thinking patterns, feelings and behaviors that aren’t serving you.

- **Dialectic-behavior therapy:** DBT may help with severe personality disturbances. It may help you tolerate difficult emotions, including dissociative symptoms. DBT is useful if you've experienced abuse or trauma.
- **Eye movement desensitization and reprocessing:** EMDR can help you cope with post-traumatic stress disorder (PTSD). It can reduce persistent nightmares, flashbacks and other symptoms.
- **Family therapy:** Working together, your family learns about the disorder. The group learns how to recognize signs of a recurrence.
- **Creative therapies:** Art or music therapy can help you explore and express your thoughts and feelings in a safe, creative environment.
- **Grounding techniques** use the 5 senses (eg, by playing loud music or placing a piece of ice in the hand) to help patients feel more connected to themselves and the world and feel more real in the moment.
- **Psychodynamic therapy** helps patients deal with negative feelings, underlying conflicts, or experiences that make certain affects intolerable to the self and thus dissociated.

Other treatments:

- **Meditation and relaxation techniques:** Mindfulness may help you tolerate symptoms. You can learn to tune in to your thoughts and feelings. It also can help settle your body's responses.
- **Clinical hypnosis (hypnotherapy):** This treatment uses intense relaxation, concentration and focused attention. The goal is to achieve an intense state of awareness. A provider can help you explore deep thoughts, feelings and memories. It can help find the root of a problem.
- **Medication:** There isn't a medicine for depersonalization disorder. But treating depression or anxiety can help. Your provider may prescribe antidepressant or anti-anxiety medications such as desipramine (Norpramin®).

DISSOCIATIVE IDENTITY DISORDER

- Dissociative identity disorder (DID), formerly called multiple personality disorder, is a condition that is characterized by the presence of at least two clear personality/self-states, called alters, which may have different reactions, emotions, and body functioning.
- Each system has distinct well developed emotional and thought processes and represent a separate, unique and relatively stable personality
- The individual may change from one personality to another at period of varying from a few minutes to several years though shorter time frames are most common
- One personality is commonly **"Host"** other personalities are usually strikingly different from the host personality and from one another. One may be carefree, fun loving and another quiet, studious, and serious.
- Dissociative identity disorder, previously called multiple personality disorder, is usually a reaction to trauma as a way to help a person avoid bad memories.

People may experience:

Behavioral: impulsivity, self-destructive behavior, or self-harm

Mood: anxiety, feeling detached from self, or mood swings

Psychological: altered consciousness, depression, or flashback

Also common: amnesia or blackout

Including symptoms of:

- Depression
- Mood swings
- Suicidal tendencies
- Sleep disorders (insomnia, night terrors, and sleepwalking)
- Anxiety, panic attacks, and phobias (flashbacks, reactions to stimuli or "triggers")
- Alcohol and drug abuse
- Compulsions and rituals
- Psychotic-like symptoms (including auditory and visual hallucinations)
- Eating disorders

Psychotherapy itself includes a number of possible courses, though it is always a long process to recovery.

- The most common psychotherapies to treat DID are creative art therapy and cognitive therapy.
- In creative art therapy, the analysis focuses on what is being expressed as well as the cultivation of self-awareness and coping mechanisms.
- Cognitive therapy focuses on the identification of unhealthy and negative behaviors and then replacing them with positive ones.
- In both cases, the therapist will work on understanding the underlying causes of DID, as well as, help them develop better coping mechanisms.

Hypnosis and medication are usually used in addition to therapy.

- Through hypnosis, the patient is taught to relax and try to bring back their memories.
- The medication used is not specifically for DID since no such medication exists. However, the medication typically prescribed is antidepressants or anti-anxiety

medications to help make it less likely that a dissociative episode will be triggered due to stress.

TREATMENT:

STABILIZATION:

Understanding about the problem are shared trust issues are explored and preliminary stopgaps are put in place of halt further untoward reaction to impinging stressors

WORKING THROUGH OF TRAUMA AND RESOLUTION OF DISSOCIATIVE DEFENSES:

Which if successful leads to in dissociative defenses which if successful leads to integration of the separate personality system. This phase the critical therapeutic one is said

- Dealing effectively with amnesia and propensity to switch often in the obvious service of defense among differing identity states
- Dealing effectively with dissociative memories which must be reconnected to real life events
- Reestablishing connections between distinct seemingly separate identity states.

Post Integration therapy:

Which is basically a stage of repair and compensation for the multiple deficiencies left in the wake of years of pseudo adjustment accomplished by means of dissociative strategies.

Huge gaps may appear in the patient skills, knowledge, and general functioning and there is often a sense of profound loneliness and detachment.

Dissociative amnesia

Dissociative amnesia is when a person can’t remember the details of a traumatic or stressful event, although they do realize they are experiencing memory loss. This is also known as psychogenic amnesia. This type of amnesia can last from a few days to one or more years. Dissociative amnesia may be linked to other disorders such as an anxiety disorder.

It is usually limited to a failure to recall. The forgotten material is there in under the level of consciousness and can bring out through hypnosis or narcosis.

The four categories of dissociative amnesia include:

- **Localized amnesia** – for a time, the person has no memory of the traumatic event at all. For example, following an assault, a person with localized amnesia may not recall any details for a few days.
- **Selective amnesia –** the person has patchy or incomplete memories of the traumatic event.
- **Generalized amnesia** – the person has trouble remembering the details of their entire life.
- **Systematized amnesia –** the person may have a very particular and specific memory loss; for example, they may have no recollection of one relative.

DISSOCIATIVE FUGUE

- Dissociative fugue is also known as psychogenic fugue.
- The person suddenly, and without any warning, can't remember who they are and has no memory of their past.
- They don't realize they are experiencing memory loss and may invent a new identity.
- Typically, the person travels from home – sometimes over thousands of kilometers – while in the fugue, which may last between hours and months.
- When the person comes out of their dissociative fugue, they are usually confused with no recollection of the 'new life' they have made for themselves.

Causes

Dissociative fugue is caused by a situation that gives the person extreme emotional stress. The dissociative fugue is believed to occur as the person's means of escape from the stress that they can't otherwise cope with.

- extreme feelings of shame or embarrassment
- trauma caused by war
- trauma caused by an accident
- trauma caused by a natural disaster
- kidnapping
- torture
- long-term emotional or physical abuse in childhood

These traumas may have actually happened to the person, or they may have witnessed it happening to others and been severely traumatized by what they saw. There is also a possibility that a genetic link may predispose someone to dissociative fugue.

Treatment

The first step in treatment of dissociative fugue involves ruling out any medical conditions that might cause memory loss. There isn't a specific test that can diagnose dissociative fugue. The treatment may include the following:

- creating a safe environment
- help recovering lost memories
- help reconnecting to life prior to the trauma
- gradually discovering, dealing with, and then managing the trauma that originally caused dissociative fugue
- strengthening and improving relationships

These goals are accomplished through several types of therapies, which may include:

- family therapy
- psychotherapy
- cognitive behavioral therapy

- meditation and relaxation techniques
- music or art therapy
- clinical hypnosis
- dialectical behavior therapy

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

UNIT V : MOOD DISORDERS AND SUICIDE

Unipolar Mood Disorders: Normal Depression - Mild to Moderate Depressive – Major Depressive Disorder - Bipolar Disorders: Cyclothymiacs Disorder – Bipolar Disorder I and II -Causal Factors, Treatment and Outcomes

Introduction: mood disorder was called as Affective disorder. Affect meant emotion which is also known as deep depression. The two key states of mood disorders are mania & depression

Mania:

Intense unrealistic feelings of excitement and euphoria

Depression:

Extraordinary sadness & dejection. In rare, cases people may have the

symptoms of both mania & depression at the same time. In this time

sadness, euphoria & irritability at Same time

Mood disorder are distinguished into two forms namely:

• unipolar

• Bipolar

This distinction is prominent in mood disorders can be differentiate by

its

- Severity
- Duration

Severity:

The number of dysfunction experienced in various area of living

The relative degree of impairment evidenced in those area.

Duration:

whether the disorder is acute, chronic or intermittent (normal functioning in

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

between)

MOOD DISORDER

- Mood disorders involve disabling disturbances in emotion—from the extreme sadness and disengagement of depression to the extreme elation and irritability of mania.
- The proposed DSM-5 recognizes two broad types of mood disorders: Unipolar disorder and Bipolar Disorder.

UNIPOLAR MOOD DISORDER

UNIPOLAR mood Disorders: sadness discouragement pessimism and

hopelessness are familiar feelings to most people Depression is unpleasant

when we are in it. But it usually does not last long.

The three levels of depression

- Normal depression
- Mild to moderate depressive disorder
- Major depressive disorder

Normal depression:

Normal depression are almost always the result of recent Stress

Grief & Grieving process:

we usually think of grief as the psychological Process one goes through the

- Death of loved one
- loss of status or position
- Separation or divorce
- Financial loss
- Breakup of a romantic affair retirement
- Seperation from friend
- Absence from home for the first time

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

Grief has certain characteristics qualities there are four phase of response

to the loss of spouse

Phase I - Disbelief of death for few hours to a week.

Phase II -> Yearning & searching for the dead person for months for a year

Phase III - Disorganized and despair

Phase IV - Reorganization and return to normal lives.

Other normal mood variation: many situations other than obvious

loss can develop depressive feelings, such

•After completing their final doctoral exam

After success in election

•After giving birth for child (Post Partum depression)

MILD TO MODERATE DEPRESSIVE DISORDERS:

The point as which mood disturbance becomes mood disorder is a matter of

Clinical Judgement. It is difficult to point out the clinical & non clinical depression Dsm iv includes two main categories for mild to moderate: Dysthymia & Adjustment disorder with mood disorder.

Dysthymia: Persistent depressive disorder, also called dysthymia

- People with dysthymia are chronically depressed— more than half of the time for at least 2 years, they feel blue or derive little pleasure from usual activities and pastimes.
- In addition, they have at least two of the other symptoms of depression.

Proposed DSM-5 Criteria for Chronic Depressive Disorder (Dysthymia)

A. Depressed mood for most of the day more than half of the time for 2 years (or 1 year for children and adolescents).

B. At least two of the following during that time:

- Poor appetite or overeating
- Sleeping too much or too little
- Poor self-esteem
- Low energy
- Trouble concentrating or making decisions
- Feelings of hopelessness

C. The symptoms do not clear for more than 2 months at a time.

Causes

The exact cause of persistent depressive disorder isn't known. As with major depression, it may involve more than one cause, such as:

- **Biological differences.** People with persistent depressive disorder may have physical changes in their brains. The significance of these changes is still uncertain, but they may eventually help pinpoint causes.
- **Brain chemistry.** Neurotransmitters are naturally occurring brain chemicals that likely play a role in depression.
- **Inherited traits.** Persistent depressive disorder appears to be more common in people whose blood relatives also have the condition.
- **Life events.** As with major depression, traumatic events such as the loss of a loved one, financial problems or a high level of stress can trigger persistent depressive disorder in some people

Adjustment Disorder with depressed mood:

- Adjustment disorder does not exceed Six months in duration & Should have identifiable psychosocial stressor in the client's life with in three months before the onset of depression.
- The client may experience impaired Social or occupational functioning moderate.
- Serious depression occur in reaction to Stressful circumstances.

MAJOR DEPRESSIVE DISORDER

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

- The proposed DSM-5 diagnosis of major depressive disorder (MDD) requires five depressive symptoms to be present for at least 2 weeks.
- These symptoms must include either depressed mood or loss of interest and pleasure.
- As shown in the proposed DSM-5 criteria, additional symptoms must be present, such as changes in sleep, appetite, concentration or decision making, feelings of worthlessness, suicidality, or psychomotor agitation or retardation.

MDD is an episodic disorder, because symptoms tend to be present for a period of time and then clear.

Proposed DSM-5 Criteria for Major Depressive Disorder

A. Sad mood or loss of pleasure in usual activities.

B. At least five symptoms (counting sad mood and loss of pleasure):

- Sleeping too much or too little
- Psychomotor retardation or agitation
- Weight loss or change in appetite
- Loss of energy
- Feelings of worthlessness or excessive guilt
- Difficulty concentrating, thinking, or making decisions
- Recurrent thoughts of death or suicide

C. Symptoms are present nearly every day, most of the day, for at least 2 weeks. Major depressive episodes tend to recur—once a given episode clears, a person is likely to experience another episode. About two-thirds of people with an episode of major depression will experience at least one more episode during their lifetime.

Psychotic symptoms

- ·loss of contact with reality
- Delusions (false beliefs)
- Hallucination (false sensory perception.

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

severe major depressive episode psychotic features are present

There are another concepts called

Mood Congruent: Presence of Delusion on or hallucination

Mood- incongruent: Disordered thinking

when a diagnosis of major depressive disorder is made it usually specified whether it is a single episode or a recurrent episode.

Single: First time

recurrent episode: One or more previously occurred.

Relapse: When the pharmacotherapy is terminated after the symptoms have reduced person may get the symptom again.

Seasonal affective disorder (SAD) is a type of depression that's related to changes in seasons — SAD begins and ends at about the same times every year. If you're like most people with SAD, your symptoms start in the fall and continue into the winter months, sapping your energy and making you feel moody. These symptoms often resolve during the spring and summer months. Less often, SAD causes depression in the spring or early summer and resolves during the fall or winter months.

Signs and symptoms of SAD may include:

- Feeling listless, sad or down most of the day, nearly every day
- Losing interest in activities you once enjoyed
- Having low energy and feeling sluggish
- Having problems with sleeping too much
- Experiencing carbohydrate cravings, overeating and weight gain
- Having difficulty concentrating
- Feeling hopeless, worthless or guilty
- Having thoughts of not wanting to live

CAUSAL FACTORS OF UNIPOLAR MOOD DISORDER

Biological Factors

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

Researchers have found the possible role of genetics, neurochemistry, hormones, neuroanatomy, neurophysiology, sleep and circadian rhythms.

Genetics: Family studies report that **first-degree relatives of a person** has depression have an **increased risk (about 2-3 times higher)** to develop depression than relatives of control group.

- **Twin studies** have also found higher concordance rate for depression in identical twins relative with non-identical twins.
- Higher Mood Disorders for females than males.
- **Adoption studies** also provide support for genetic basis of unipolar mood disorders; chances of unipolar depression were higher in biological relatives of adopted children than in biological relatives of control-adopted children.

Neurotransmitters:

(1) Reduced production

(2) Increased degradation of the neurotransmitters at the synapse, or

(3) Altered functioning of the postsynaptic receptors.

- Some studies have found that there may actually be in increase in norepinephrine
- Medicines immediately increase the availability of neurotransmitters, but they take about 2-4 weeks to show effect.
- Finally, it was found that people with depression did not have disturbance in the 'absolute' level of neurotransmitters.

Endocrine System/Hormones:

Hypothalamus-Corticotropin(CRH)-Pituitary gland-Adrenocorticotrophic hormone-Adrenal gland-Cortisol-Blood steam-Autonomic nervous system

- Focus on **neurotransmitters** to the endocrine system, in particular the Hypothalamic-Pituitary-Adrenal (HPA) axis.
- According to the stress hypothesis, people with depression have dysfunction in the HPA axis leading to the increased blood plasma levels of **cortisol (stress hormone).**

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

Sleep and Circadian Rhythms:

- The **common sleep problems** in depressed outpatients show a variety of patterns like, early morning awakenings, periodic awakening during night, and difficulty falling asleep.
- Studies have found that, people with depression **enter REM sleep more quickly (usually after an hour when typical people take about 1.5 hours) and have** lower-than-normal amount of deep sleep than normal.

Psychosocial Factors

Stressful Life Events:

- Many studies have shown that severely stressful life events such as **loss of loved one, serious threats to important relationships, or to one's occupation, severe economic or health problems** often serve as a precipitating factor (trigger) for unipolar depression.
- one's interpersonal skills, problem solving and coping skills, such as constant reassurance seeking, poor management of time or self-medication
- Research suggests that dependent life events play a stronger role in the **onset of major depression than do independent life events.**

Interpersonal Factors: Early childhood adversity**, lack of social support, marital and familial discord,** and parental depression have been identified as possible triggers for the development of depression in someone with biological and psychological diatheses for development of depression.

Beck's Cognitive Theory:

One of the most prominent theories of depression was given by Aaron Beck who proposed that the cognitive symptoms of depression

Cognitive distortion is maintained by cognitive distortions that are errors in one's thinking and leads to biased processing of information. Some examples of cognitive errors are, all or none thinking.

(I'm either best at something or I'm nothing), **overgeneralization, (**I failed

in my job, I'm an absolute loser), **arbitrary reference** (nothing good can ever happen to me and I can never get well), and p**ersonalization** (it's all my fault).

Automatic negative thoughts can cause depressed mood and depressed mood in turn can make negative thoughts salient, this has been labeled as the 'vicious cycle of depression.'

Hopeless/Helpness:

Motivational Deficit: The patient do not try to escape form the negative situation

Cognitive deficit: The people will not realize the way to escape from the negative situation even they have way to escape from there

Emotional Deficit: The people will always be in depression and they do not over come.

What Is Bipolar Disorder?

Bipolar disorder, also known as manic depression, is a mental illness that brings severe high and low moods and changes in sleep, energy, thinking, and behavior.

Bipolar I disorder: With this type, you have extreme erratic behavior, with manic "up" periods that last at least a week or are so severe that you need medical care. There are also usually extreme "down" periods that last at least 2 weeks.

Bipolar II disorder: With this type, you also have erratic highs and lows, but it isn't as extreme as bipolar I.

Cyclothymic disorder: This type involves periods of manic and depressive behavior that last at least 2 years in adults or 1 year in children and teens. The symptoms aren't as intense as bipolar disorder I or bipolar disorder I

Unspecified" or "other specified" bipolar disorder (formerly called "bipolar disorder not otherwise specified") is now used to describe conditions in which a person has only a few of the mood and energy symptoms that define a manic or hypomanic episode, or the symptoms may not last long enough to be considered as clear-cut "episodes."

Cyclothymic Disorder

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

- Also called cyclothymia, cyclothymic disorder is a second chronic mood disorder (the other is dysthymia).
- As with the diagnosis of dysthymia, the proposed DSM-5 criteria require that symptoms be present for at least 2 years among adults.
- In cyclothymic disorder, the person has frequent but mild symptoms of depression, alternating with mild symptoms of mania. Although the symptoms do not reach the severity of full-blown manic or depressive episodes, people with the disorder and those close to them typically notice the ups and downs.
- During the lows, a person may be sad, feel inadequate, withdraw from people, and sleep for 10 hours a night.
- During the highs, a person may be boisterous, overly confident, socially uninhibited and gregarious, and need little sleep.

Proposed DSM-5 Criteria for Cyclothymic Disorder

A. For at least 2 years (or 1 year in children or adolescents):

 Numerous periods with hypomanic symptoms that do not meet criteria for

a manic episode

 Numerous periods with depressive symptoms that do not meet criteria for

a major depressive episode.

B. The symptoms do not clear for more than 2 months at a time.

C. Symptoms cause significant Distress or functional impairment.

B. At least three of the following are noticeably changed from baseline (four if

mood is irritable):

Cyclothymia:

Proposed DSM-5 Criteria for Manic and Hypomanic Episodes

A. Distinctly elevated or irritable mood for most of the day nearly every day.

Abnormally increased activity and energy.

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

 Increase in goal-directed activity or psychomotor agitation

 Unusual talkativeness; rapid speech

 Flight of ideas or subjective impression that thoughts are racing

 Decreased need for sleep

 Increased self-esteem; belief that one has special talents, powers, or abilities

 Distractibility; attention easily diverted

 Excessive involvement in activities that are likely to have undesirable consequences, such as reckless spending, sexual behavior, or driving

For a manic episode:

 Symptoms last for 1 week or require hospitalization

 Symptoms cause significant distress or functional impairmen

For a hypomanic episode:

 Symptoms last at least 4 days

 Clear changes in functioning that are observable to others, but impairment is not marked

 No psychotic symptoms are present

CAUSAL FACTORS OF BIPOLAR MOOD DISORDERS

Bipolar disorders **biological causal factors** are clearly dominant, and the role of **psychological causal factors** has received significantly less attention.

Biological Causal Factors

A number of biological factors are thought to play a causal role in the onset of bipolar disorder including

- Genetic
- Neurochemical hormones
- Neurophysiological, Neuroanatomical, and
- Biological rhythm influences.

Genetic Factors:

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

- There is greater influence of **genes in etiology** of bipolar disorder than unipolar disorder.
- The **heritability estimates** are higher than for any other major adult psychiatric disorders including schizophrenia.
- **Family studies have** found that being related to a person with bipolar disorder
- (First degree relatives of person with bipolar are also at the risk for developing unipolar mood disorder, although reverse is not true.
- **Twin studies have** found concordance rate to be a high 60 percent for monozygotic twins and 12 percent for dizygotic twins

Neurohormonal Factors, Neurophysiological and Neuroanatomical: Mood Disorders Hypothalamic-Pituitary-Adrenal (HPA) axis is implicated in both unipolar and bipolar disorder. Cortisol levels are elevated in bipolar depression as well as manic episodes.

Hypothalamus-Corticotropin(CRH)-Pituitary gland-Adrenocorticotrophic hormone-Adrenal gland-Cortisol-Blood steam-Autonomic nervous system

Neurophysiological and neuroanatomical findings

Changes seen in unipolar disorder in brain structures (amygdala, hippocampus, cingulate cortex and anterior cingulate cortex) are also seen in bipolar disorder. Differences emerge during the manic phase; blood flow to the brain increases, blood flow to **left prefrontal cortex is reduced during depression,** during mania it is reduced in the **right frontal and temporal regions.** In normal moods, blood flow across two brain hemispheres is approximately equal. Brain region involved in reaction to reward is overly active.

Circadian Rhythms:

- Circadian rhythm disturbances have been found to be common in bipolar patients
- Insomnia is the most common **symptom before the onset of the manic phase.**
- Bipolar disorder or tends to show seasonal pattern. During manic phases patients tend to sleep very little, this is the most common symptom.

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

Psychosocial Factors

- psychosocial factors such as **stressful life events, poor social support,** and certain **personality traits and cognitive styles** have also been identified as important.
- Stressful life events are found to precipitate manic/depressive episodes in bipolar life events.
- Further, **stressors in life make** recovery more difficult and more difficult to recover from the episodes. It has been hypothesized that stress may disrupt the critical **circadian rhythms and trigger manic/depressive episode.**

Treatment

Treatment for mood disorders depends on the specific condition and symptoms.

Medications for mood disorders

Medications that healthcare providers may prescribe to help treat mood disorders include:

- **Antidepressants**: Some of the most widely used drugs to treat depression and depressive episodes of bipolar disorder are selective serotonin reuptake inhibitors (SSRIs).
- **Mood stabilizers**: These medications help regulate the mood swings that occur with bipolar disorder or other disorders.
- **Antipsychotics (neuroleptics)**: People with bipolar disorder who experience mania or mixed episodes may be treated with an atypical antipsychotic (neuroleptic) drug.

Psychotherapy for mood disorders

Psychotherapy, also called talk therapy, is a term for a variety of treatment techniques that aim to help a person identify and change unhealthy emotions, thoughts and behaviors.

Common types of psychotherapy include:

- **Cognitive behavioral therapy (CBT)**: This is a structured, goal-oriented type of psychotherapy. Mental health professionals use it to treat or manage mental health conditions and emotional concerns.
- **Dialectical behavior therapy (DBT)**: DBT is a type of talk therapy that's based on cognitive behavioral therapy (CBT), but it's specially adapted for people who experience emotions very intensely.

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

- **Psychodynamic therapy**: This type of therapy is based on the idea that behavior and mental well-being are influenced by childhood experiences and problematic repetitive thoughts or feelings that are outside of your awareness (they're unconscious).

Other treatments for mood disorders include:

- **Electroconvulsive therapy (ECT)**: ECT is a medical procedure that involves passing a mild electric current through your brain, causing a short seizure. This procedure is proven to have strong positive effects on severe, treatment-resistant mental health conditions, including depression and bipolar disorder.
- **Transcranial magnetic stimulation (TMS)**: TMS is a treatment for people with severe depression that hasn't been helped by at least one antidepressant medication. It's a type of brain stimulation therapy.
- **Light therapy**: This technique has long been used to treat seasonal affective disorder (SAD). It's based on the idea of supplementing natural sunlight with bright artificial light during the fall and winter.

Suicide: The Clinical Picture and the Causal Factors - Suicidal Ambivalence - Prevention of Suicide.

Suicide: A self-inflicted death in which the person acts intentionally, directly, and consciously.

Parasuicide : suicide attempt that does not result in death

Types of Suicide

Death seeker: A person who clearly intends to end his or her life at the time of a suicide attempt.

Death initiator: A person who attempts suicide believing that the process of death is already under way and that he or she is simply hastening the process.

Death ignore: A person who attempts suicide without recognizing the finality of death.

Death darer: A person who is ambivalent about the wish to die even as he or she attempts suicide.

Sub intentional death: A death in which the victim plays an indirect, hidden,

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

partial, or unconscious role.

Research Study: Retrospective analysis: A psychological autopsy in which clinicians piece together information about a person's suicide from the person's past.

Triggers a Suicide

Stressful Events and Situations: The stressors that help lead to suicide do not need to be as horrific as those tied to combat. Common forms of immediate stress seen in cases of suicide are the loss of a loved one through death, divorce, or rejection

Social Isolation: people from loving families or supportive social systems may commit suicide. However, those without such social supports are particularly vulnerable to suicidal thinking and actions.

Serious Illness: People whose illnesses cause them great pain or severe dis-
ability may try to commit suicide, believing that death is unavoidable and imminent

Abusive or Repressive Environment Victims of an abusive or repressive environment from which they have little or no hope of escape sometimes
commit suicide.

Occupational Stress Some jobs create feelings of tension or dissatisfaction
that may trigger suicide attempts. Research has found particularly high suicide rates among psychiatrists and psychologists, physicians, nurses, dentists, lawyers, police officers, farmers, and unskilled laborers

Depressive disorder and certain other mental disorders

- Alcoholism and other forms of substance abuse
- Suicidal ideation, talk, preparation; certain religious ideas
- Social withdrawal, isolation, living alone, loss of support
- Hopelessness, feeling trapped, cognitive rigidity
- Impulsivity and risk-taking behavior
- Being an older white American male
- Modeling, suicide in the family, genetics
- Economic or work problems; certain occupations
- Marital problems, family pathology
- Dramatic changes in mood

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

- Anxiety
- Stress and stressful events
- Anger, aggression, irritability
- Physical illness
- Sleep problems

Causes of Suicide

- The Psychodynamic View
- Durkheim's Sociocultural View
- The Biological View

Psychodynamic View

understands human behavior in terms of unconscious or out-of-awareness aims, motives, and intentions in conflict with each other. Much behavior reflects attempts to reconcile these conflicts and to deal with the unpleasant tensions—anxiety, guilt, and shame—associated with them.

- Psychodynamic theories view depression in terms of inwardly directed **anger, loss of self-esteem or self-worth, egotistic or excessive** narcissistic or personality demand, or deprivation in mother-child relationship .
- **Repressed anger at a loss (**symbolic or actual loss of a loved one during childhood, for example) is directed inwards, reduces self-esteem and increases **vulnerability to further experiences in the futu**re, causing the individual to 're-experience' (symbolic or actual) the loss when encountering similar triggering stimuli during adulthood.
- Those who may depend on others for their sense of self-esteem may therefore remain in a more vulnerable 'depression-prone' state.

Durkheim's Sociocultural View

Durkheim believed that various **sociologically** factors and influences were at work such as work pressure, financial, religious, marital to name just a few.

According to Durkheim, there are four types of suicide:

- Egoistic suicide.
- Altruistic suicide.

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

- Anomic suicide.
- Fatalistic suicide.

Egoistic suicide relates to the person being alone or an outsider and subsequently they see themselves alone within the world. This type of person has a low social interaction with others.

Altruistic suicide is when social group involvement is too high, expectation from a group is being met at a very high level such as a sacrifice for a cult or religion. Another example would be a Marta or a suicide bomber.

Anomic suicide relates to a low degree of regulation and this kind of suicide is carried out during periods of considerable stress and frustration. A good example would be great financial loss or when the financial market that person controls collapses with severe consequences for many involved.

Fatalistic suicide is when people are kept under tight regulation such as in Korea. Where there is extreme rule in order or high expectations set upon a person or peoples in which lead them to a sense of no self or individuality.

Biological view point

- **Twin studies** have also found higher concordance rate for depression in identical twins relative with non-identical twins.
- **Adoption studies** also provide support for genetic basis of suicide chances were higher in biological relatives of adopted children than in biological relatives of control-adopted children.

TREATMENTS FOR SUICIDE PREVENTION

Psychotherapy. In psychotherapy, also called psychological counseling or talk therapy, you explore the issues that make you feel suicidal and learn skills to help manage emotions more effectively. You and your therapist can work together to develop a treatment plan and goals.

Ms.Soniya.K.,M.Sc
Assistant Professor and Head
Department of Psychology
DKM College for Women (Autonomous)

Medications. Antidepressants, antipsychotic medications, anti-anxiety medications and other medications for mental illness can help reduce symptoms, which can help you feel less suicidal.

Addiction treatment. Treatment for drug or alcohol addiction can include detoxification, addiction treatment programs and self-help group meetings.

Family support and education. Your loved ones can be both a source of support and conflict. Involving them in treatment can help them understand what you're going through, give them better coping skills, and improve family communication and relationships.

Emergencies

If you've attempted suicide and you're injured:

- Call 911 or your local emergency number.
- Have someone else call if you're not alone.