# Psychology Exam 2 Review

## Anxiety Disorders

* Definitions
  + Fear
    - Immediate, present-oriented.
    - Fight or flight mode
    - Response to the environment
    - Good from an evolutionary standpoint
    - Tense muscles, alert, and elevated HR
  + Anxiety
    - Apprehension, future-oriented
    - Tension (Somatic Symptom)
  + Panic
    - Abrupt experiences of intense fear at inappropriate times
    - Symptoms
      * Palpitations, chest pain, dizziness, nausea, and sweating
* Causes of Anxiety
  + Biological
    - Genetic
    - Neurotransmitters
      * GABA
        + Inhibitory, helps calm those prone to anxiety.
      * Serotonin
      * Norepinephrine
    - Limbic System
      * Emotion Processing. Those with anxiety have an over reactive limbic system
    - Behavioral Inhibition System (BIS)
      * Fight or flight system
  + Psychological
    - Classical Conditioning – The lack of sense of control
  + Social
    - Stressful life events
  + Triple Vulnerabilities
    - Generalized Biological Vulnerability
      * Genes and Neurotransmitters
    - Generalized Psychological Vulnerability
      * The world is dangerous and out of control
    - Specific Psychological Vulnerability
      * Something specific is dangerous and out of control

## Generalized Anxiety Disorder

* **Diagnosis Criteria under DSM-IV**
  + Excessive anxiety and worry occurring more days than not for at least **six months** about everyday routine events.
  + The person finds it difficult to control the worry
  + The person feels **at least three** of the following
    - Restlessness, easy fatigue, irritability, muscle tension, and sleep disturbances
  + The worry causes significant impairment or distress
* **Changes under DSM-V**
  + You need to have excessive anxiety or worry about two or more events (ie not just finances)
  + Excessive anxiety or worry more days than not for **3 months**
  + One psychical symptom instead of three
  + One behavioral response
    - The person avoids potential situations, excessive time and effort spent preparing for a possible negative outcome, procrastination due to worry, and repeatedly seeking reassurance
* **Characteristics**
  + Prevalence
    - 3.1% in one year
    - 5.7% in lifetime
  + Similar rates worldwide
  + Female:Male 2:1
  + Insidious Onset (Slow Developing)
    - Early adulthood, late 20s to early 30s
  + Chronic course but fluctuates
* **Causes**
  + Biological
    - Genetic
    - Autonomic Restrictors
      * Show a lower HR, BP, and respiration rate than other anxiety disorders
    - Heightened threat sensitivity
    - Reduced levels of GABA
  + Cognitive
    - Intense cognitive processing without accompanying imagery
    - They never expose themselves to the end outcome
* **Treatment**
  + Biological – Effective but only treat the symptoms
    - Benzodiazepines
      * Work on GABA (agnostic)
      * Provides a calming effect
    - Relaxation Training
      * Causes a physical relaxation causing mental relaxation
    - Biofeedback
      * Hooked up to sensors, giving an audible beep when HR is elevated
  + Psychological
    - Cognitive Therapy
      * Is the outcome you think will happen legitimate?
    - Worry Exposure
      * Expose them to the rational ends of the situation. How will you deal with the situation?
    - Coping Skills
      * Self-supportive statements that you’re trained to use when stressed. “I can do this”

## Phobias

* What is a panic attack?
  + Intense fear or discomfort in which **4 (or more)** of the following symptoms develop abruptly and **peak within 10 minutes**.
    - Heart pounding, sweating, trembling, shortness of breath, sensation of choking, chest pain, nausea, dizziness, derealization (feelings of unreality), depersonalization (feeling detached from self), fear of losing control, fear of dying, numbness, and chills.
  + High comorbidity with alcoholism
* **Diagnosis Criteria under DSM-IV**
  + Recurrent **unexpected** panic attacks
  + At least a month of
    - Persistent concern about having additional attacks
    - Worry about the implications of the attacks (losing control)
    - Significant change in behavior due to the attacks
* **Changes in DSM-V**
  + At least a month of
    - One or both of the following: Persistent worrying about another attack or it’s consequences
    - A maladaptive change in behavior
      * If they stop exercising because they feel that when they get sweaty they might get chest paints and might have a panic attack

## Agoraphobia

* **Diagnosis Criteria under DSM-IV**
  + Anxiety about being in places or situations from which escape may be difficult or embarrassing or in which help may not be available in the event of having a panic attack. Such as:
    - Being outside the home alone
    - Being in a crowd or standing in line
    - Being on a bridge
    - Traveling in a bus, train, or automobile
  + The situations are avoided
    - Or else endured with marked distress
    - Or with anxiety about having a panic attack
    - Or require the presence of a companion
  + You cannot have a diagnosis of agoraphobia without a diagnosis of panic disorder
  + No duration requirement
* **Diagnosis Criteria under DSM-V**
  + Fear or anxiety of **at least two agoraphobic situations**
    - Example: Being outside of the house *and* public transportation
  + Fears or avoids these situations because escape may be difficult or help may not be available
  + Agoraphobic situation must **consistently** provoke anxiety
  + The situations are avoided
    - Or else are endured with marked distress
    - Or with anxiety about panic attack
    - Or require the presence of a companion
  + Behavior **must persist for six months**
* **Characteristics**
  + Prevalence
    - 2.7% 1 Year
    - 4.7% Lifetime
  + Similar rates worldwide
  + Panic Disorder without Agoraphobia
    - Female:Male 2:1
  + Panic Disorder with Agoraphobia
    - Much higher female:male however males may mask it with self medication
  + Acute onset, ages 20-24
* **Causes (PD/A)**
  + Biological
    - Generalized vulnerability towards alarm responses
  + Psychological – Cognitive
    - Conditioning
      * If you have a panic attack in one situation you may fear that situation
      * If you feel the same symptoms before you may induce a panic attack
    - Misperception / Inaccurate Assumptions
      * If your heart is pounding and you feel flushed, most attribute it towards a workout but those with PD/A or PD attribute it towards a panic attack
    - Increased Sensitivity of Bodily Sensations
      * Interoceptive Awareness
        + Some people may be more in tune towards their bodily sensations
        + If you’re more sensitive towards that you’re more likely to inaccurately interpret those sensations
* **Treatment (PD/A)**
  + Biological
    - Selective Serotonin Reuptake Inhibitors (SSRIs)
      * Prozac and Paxil
    - Serotonin responds better than GABA
    - Only works so long as they stay on the medication
  + Psychological
    - Cognitive Restructuring
      * Relates to challenging the persons beliefs
      * Teach them their bodily sensations are not dangerous
    - Exposure
      * External
        + Take them into a situation where they’re likely to have an attack and show them a panic attack is not going to happen
        + Particularly important for agoraphobics
      * Introreceptive Exposure
        + Introceptive = Of the body
        + Teaching them to be aware of their bodily sensations but not to fear them
  + Combined
    - Psychological treatments are better than biological
    - Using SSRI’s gets them to stop worrying which stops the cycles of attacks

## Specific Phobia

* **Diagnosis Criteria under DSM-IV**
  + Marked and **persistent** fear that is **excessive** *or* **unreasonable**, cued by the presence or anticipation of a specific object or situation
  + Exposure provokes an immediate anxiety response, sometimes to the point of panic
  + Recognizes that the fear is unreasonable or excessive
  + Phobic stimulus is avoided or endured with intense anxiety or distress
  + Impairs functioning
  + No duration requirement
* **Types of Specific Phobia (Higher rate of fainting)**
  + Blood-injury-injection
    - Seeing blood
  + Situational
    - Being on subways, planes, or busses, etc
  + Natural Environment
    - Thunderstorms, lightning, heights, water, etc
  + Animal Type
    - Snakes, spiders, dogs, etc
  + “Other”
    - Seperation Anxiety
      * Common in children.
    - Clowns, choking, etc
  + How to differentiate from agoraphobia
    - They only have the fear response when they’re IN that place
* **Changes in DSM-V**
  + Duration of six months
  + When writing it up “Axis 1 – Specific Phobia, Animal Type”
* **Characteristics**
  + 8.7% 1 Year
  + 12.5% Lifetime
  + Female:Male 4:1
  + Chronic Course
  + Onset = 7 (Starts early)
* **Causes**
  + Biological
    - Inherited vulnerability
      * Specific types may be inheritable genetically
      * There could be an impact of modeling / conditioning
    - Evolutionary
      * Snakes can still be a threat to humans but back in the day it was much worse
      * Higher threat superiority effect
  + Psychological – Cognitive/Behavioral
    - Traumatic Exposure
      * If you’re attacked by a dog when you’re young you’re likely to stay afraid of dogs
    - Conditioning
      * If you have a panic attack at the top of a roller coaster you may fear heights
    - Modeling
      * Parenting can cause the phobia
      * Dentist example
        + In a dentist office and hearing the screams after the drill slipped and went through a patients mouth
    - Information Transmission
      * Just by telling someone you can give them a phobia
    - Social and Gender Roles
      * Because of the gender disparity we see
      * Females are more prone to express a phobia or seek treatment
      * It is more acceptable for females to be afraid or something than males
      * Could contribute to etiology
* **Treatment**
  + No biological treatment
  + Cognitive-behavior Therapies
    - Relaxation
      * Expose them to the stimulus and relax
    - Exposure
      * Systematic Desensitization
        + Learning to relax in the presence of the feared stimulus
        + Your body can only stay tense for so long, you’ll naturally relax

Habituation

Process of beginning to relax naturally

* + - * + Fear Hierarchy
* **Blood-injury-injection**
  + Tensing
    - They have a reflex that causes the fainting response
    - It causes them to not be able to see the blood
    - If people tense their muscles it’ll keep their blood pressure up and cause them not to faint

## Social Phobia

* **Diagnosis Criteria under DSM-IV**
  + Marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or scrutiny by others
  + Fears he or she will be embarrassed or humiliated
  + Exposure provokes an immediate anxiety response, sometimes to the point of panic
  + Recognizes that the fear is unreasonable or excessive
  + Phobic stimulus is avoided or endured with intense anxiety or distress
  + Impairs functioning
* **Generalization Specification**
  + Applied if the person has an anxiety response to multiple social situations (public speaking, using the restroom, being around a group of people you don’t know, etc)
  + Axis 1 – Social Phobia – Generalized **or** just Social Phobia
* **Changes in DSM-V**
  + Duration of six months
  + Addition of specifiers
    - Selective Mutism
      * Failure to speak in one situation but do in others
    - Performance Only
      * Restricted to public speaking or performing in public
        + Axis 1 – Social Phobia – Performance nly
* **Characteristics**
  + 6.8% 1 Year
  + 12.1% Lifetime
  + Female:Male 1.4:1
  + Gender roles aren’t firmly established yet since the onset is young. You cannot really hide it when you’re told to present at work.
  + Adolescence onset
    - Peaks at age of 13
* **Causes**
  + Biological
    - Inherited vulnerability
      * If your parents are very shy and introverted you’re more likely to be diagnosed with social phobia
    - Evolutionary
      * Face in a crowd task. You’re more likely to notice an angry face.
  + Psychological – Cognitive/Behavioral
    - Traumatic Exposure
      * If you’re bullied as a kid you’re more likely to develop social phobia
      * If someone has a negative experience in public one time it could cause you to be afraid
    - Conditioning
      * Anxiety response
    - Social
      * If your parents are highly concerned of what other people think, you will then start to learn that social evaluation is very critical and that it can be negatively evaluated.
* **Treatment**
  + Biological – Only works as long as the person uses them
    - MAOI’s
      * Metabolizes Norepinephrine, serotonin, and dopamine
      * The patient has more of the above in their system so it makes their levels more normal
      * Negative side effects
        + There is a chemical that reacts in a negative way with MAOI’s that’s found in cheese and beans
        + If you have this reaction your blood pressure will rise dramatically and you could have a stroke
        + MAOI’s are thus used conservatively
    - SSRI’s
      * Preferred over MAOI’s
  + Psychological
    - Group Cognitive Behavioral Therapy (Group CBT)
      * Exposure
      * Since everyone is concerned with their own fears of being judged, they end up not judging others
      * Instructed to engage in the feared situations
    - Social Skills Training
      * Since its onset is early they don’t know how to engage in social situations

## PTSD

* **Diagnosis under DSM-IV**
  + **Exposure to a traumatic event** that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others. During the event, the person felt intense fear, helplessness, or horror.
  + Traumatic event is **persistently re-experienced**, through recurrent or intrusive distressing recollections of the event, nightmares, flashbacks, or intense psychological distress when confronted with a “trigger”
  + Persistent symptoms of **increased arousal**, such as difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, hypervigilance, or an exaggerated startled response
  + Persist **avoidance** of stimuli associated with the trauma and **numbing** or general responsiveness
    - For example:
      * Avoiding thinking or talking about the trauma
      * Inability to recall an important aspect of the trauma
      * Diminished interest or participation in significant activities
      * Feeling detached from others
      * Restricted range of affect (outward showing of emotional state)
      * Sense of foreshortened future (Can’t view themselves as an elderly person)
  + The symptoms must persist for more than **one month**
    - Length of symptoms
      * 1-3 Months = Acute PTSD
      * 3+ Months = Chronic PTSD
    - If PTSD is not developed immediately it is classified as PTSD with Delayed Onset
  + Significant distress or impairment
* **Changes in DSM-V**
  + Negative alterations in cognition and mood shown by three of the following
    - Inability to recall an important aspect of the trauma
    - Persistent and distorted sense of self blame for the accident
    - In a pervasive (negative) emotional state
    - Diminished interest or participation in significant life activities
    - Feeling of detachment from others
    - Inability to experience positive emotions
* **Acute Stress Disorder**
  + If they do not meet the one month criteria, they will be found with acute stress disorder
* **Characteristics**
  + Rape, combat related, car accidents, etc
  + 20% of women who are exposed to a trauma get PTSD
  + 8% of men who are exposed to a trauma get PTSD
* **Causes**
  + Factors affecting the likelihood of developing PTSD
    - Features of the Trauma
      * Intensity of the exposure/proximity
      * Duration of the exposure
      * Extent of threat posed
    - Features of the Person
      * Pre-trauma Psychological Adjustment
      * Family History (Generalized Vulnerability)
      * Cognitive and coping styles
      * Feelings of guilt
    - Features of the Post-trauma Environment
      * Availability and quality of social support
      * Additional major stressors
* **Treatment**
  + Biological
    - SSRI’s
      * They do not do much for the primary system for PTSD, only effect arousal, alertness, and the exaggerated fear response
      * Doesn’t do anything for self blame, reliving the experience, or the avoiding aspect of the trauma
  + Psychological
    - Exposure Techniques
      * Lack of exposure maintains the heightened anxiety
      * Focuses on processing the trauma
    - Cognitive Techniques
      * Reduce self blame and guilt
    - Group Therapy
      * It’s always hard to believe that someone who has not gone through the same experience would understand where you’re coming from so they use support groups

## Obsessive-Compulsive Disorder

* **Diagnosis under DSM-IV**
  + Obsessions
    - Persistent, intrusive, and distressing thoughts, impulses, or images
    - Examples
      * Cleanliness or contamination - 55%
      * Symmetry - 37%
      * Sexual Urges – 32%
      * Symmatic Concerns (Concerns about the body, health, etc) – 35%
    - These are not simply excessive worries about real-life problems (else that would be generalized anxiety disorder)
    - The person attempts to ignore, suppress, or neutralize the obsessions with some other thoughts or action
    - The person recognizes that the obsessional thoughts, impulses, or images are products of his or her own mind.
  + Compulsions
    - Repetitive, ritualistic **behaviors** or **mental acts** that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly
    - The compulsions are performed to prevent or “undo” some dreaded outcome
    - **At some point** during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable
    - The obsessions or compulsions cause marked distress, are time consuming (taking more than one hour a day), or significantly interfere with a person’s functioning
* **Changes in DSM-V**
  + Good or fair insight
    - The person recognized their beliefs are not true
  + Poor Insight
    - The person believes their OCD beliefs are probably true
  + Absent Insight
    - Convinced that their OCD belief is true
  + Hoarding is by itself under DSM-IV
* **Criteria for Hoarding under DSM-V**
  + Persistent difficulty discarding or separating from possessions
  + Difficulty is due to strong urges to save items or distress associated with discarding them
  + Symptoms result in accumulation in a large number of possessions
* **Characteristics**
  + 2% Lifetime
  + Equally prevalent in males and females
* **Causes**
  + Biological
    - Generalized Vulnerability
      * For anxiety
    - Low Serotonin Levels
  + Psychological
    - Operant Conditioning with Reinforcement
      * Sneezing on exam, using Lysol on it, then using Lysol again once you encounter germs
    - Some thoughts are unacceptable or dangerous
      * If raised and told sexual thoughts are bad they’ll have raised anxiety. When they have this anxiety they’ll do something to reduce it (compulsion).
      * **Enhanced thought-action fusion**
        + The belief thinking a thought is as bad as doing whatever the thought it
* **Treatment**
  + Biological
    - SSRI’s
      * Increased serotonin
      * Prozac and Zoloft
  + Psychological
    - Exposure with responsive prevention
      * Expose them to their feared situation and keeping them from doing their compulsions.
    - Cognitive Restructuring
      * Address and adjust the maladaptive thoughts the person has. Explaining that sexual thoughts and aggression is normal for everyone to have. If they’re afraid of getting sick explain the actual probability of getting sick from touching things. Getting the person to view the way consistent with the real world.

## Mood Disorders Overview

* **Overview**
  + Disorders with Depressed Mood
    - Major Depressive Disorder
    - Dysthymic (“of the mind”) disorder
  + Disorders with elevated, expansive, or irritable mood
    - Bipolar Disorder
      * Bipolar I Disorder
      * Bipolar II Disorder
    - Cyclothymic Disorder
* **Major Depressive Episode**
  + At least **five of the below**, almost everyday all day for **at least two weeks**. Must have one of the first two symptoms listed.
    - Emotion/Motivational Component
      * Depressed mood most of the day
      * Diminished interest or pleasure in activities most of the day
    - Behavioral and Psychological
      * Significant appetite/weight changes
      * Sleep problems
      * Psychomotor agitation or retardation
      * Fatigue or loss of energy
    - Cognitive
      * Feelings of worthlessness, intense inappropriate guilt
      * Unable to concentrate or make decisions
      * Recurrent thoughts of death, suicidal ideation, or suicide attempt
  + Significant distress or impairment; not due to substance or medical condition; not better accounted for by bereavement (response to significant death)
* **Manic Episode**
  + A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting **at least one week**
  + During this period, **3 or more** of the following present to significant degree
    - Inflated self-esteem or grandiosity (superpowers, smartest person on the earth, etc)
    - Decreased need for sleep (one or two hours a night)
    - Talkative / pressured speech
    - Flight of ideas, racing thoughts
    - Distractible
    - Increase in goal directed activity or psychomotor agitation
    - Excess of fun but risky activity (promiscuous behavior, making risky business ventures, shopping sprees, etc)
  + Distress or impairment; not due to substance or medical condition
* **Mixed Episode**
  + Meets criteria for both manic episode and major depressive episode nearly everyday for **at least one week**
  + Mood disturbance causes significant impairment
  + Not due to substance or medical condition
  + DSM-V Changes
    - Downgraded to a specified “with mixed features”
* **Hypomanic Episode**
  + Distinct period of elevated, expansive, or irritable mood, lasting **at least 4 days**
  + Same type of symptoms as a manic episode
  + NOT severe enough to cause marked impairment or to necessitate hospitalization
  + Can be seen with depression at the same time. Hypomanic episodes by themselves aren’t awful, they just tend to turn into manic episodes

## Major Depressive Disorder

* **Diagnosis under DSM-IV**
  + Presence of a major depressive episode
  + Never been a manic, mixed, or hypomanic episode
  + Either a single episode or recurrent
* **Changes in DSM-V**
  + No changes
* **Characteristics**
  + Why is there a higher prevalence in women?
    - Artifact Theory – The difference we see is merely for the fact that men do not want to get treatment but women will.
    - Hormone Theory – There are a number of hormonal changes in females during puberty and continually fluctuate. Men do not have such extreme fluctuations of hormones
    - Quality of Life – If you look at the gender breakdown, women are lower socioeconomically
    - Lack of Control – Women are socialized to be submissive and subserveant
    - Attributions – Women are more likely to blame themselves when something goes wrong
    - Social Creation – Women may be brought up or expected to be more expressive and bring up emotions. When they’re upset they’re taught to cry.
    - Reaction to Stress – There is evidence that women are more likely to reuinate problems and men are more willing to do problem solving
  + Behavioral Perspective
    - Lewinsohn’s Operant Conditioning Paradigm
      * Behaviors we engage in are reinforced
      * Two types of reinforcers (mastery vs pleasure)
        + Mastery – Relate to a sense of achievement, tends to be intrinsically motivating. Learning to ride a bike or a hard math problem.
        + Pleasure – Tend to be more extrinsic. They make us feel good such as exercise, relaxing, watching TV, and hanging out with friends.
      * Depression occurs due to an absence of reinforcers, leading to extinction of behaviors
        + Mimics withdrawal part of depression
        + Fewer opportunities of reward
        + Works on maintaining depression
      * 3 reasons for lack of reinforcement
        + Environment produces lack of reinforcement (loss of job)
        + Skill deficit inhibits obtainment of reinforcement (Socially unskilled)
        + Reinforcement is available but a person cannot enjoy it (Interfering anxiety)
  + Cognitive Perspective
    - Learned helplessness
      * When they’re put in a situation where they can change the situation they will not even try.
    - Attributions
    - Internal/External
    - Global/External
      * Applies to a wide range of events
      * Only in that one circumstance
    - Stable/Unstable
      * Always going to be that way
      * Specific to just now
    - **Internal global stable is the WORST to have**
    - Primary Model of Depression
      * Beck’s Cognitive Theory of Depression
        + Depression comes from negative thoughts
        + Core of depression is distorted cognitions (things you think are true but may not be true), although emotions might be more obvious
        + Develop maladaptive attitudes as children
        + Ideas on how the way the world works. If you start to think that your self worth is tied to you winning, you’re setting yourself up to feel bad when you lose
        + Upsetting situations trigger negative thinking, shown by a “cognitive triad”

Negative view of self

Negative view of world

Negative view of future – important predictor of suicide (hopelessness)

* **Types of thoughts in MDD**
  + Automatic Thoughts - Beliefs about the moment-to-moment occurrences in life
  + Attributions – Explanations for events
  + Expectancies – Predictions about the future
  + Basic Beliefs – Develop in childhood
  + Assumptions – Beliefs about the nature of the world on a basic level. If you believe the world is a dangerous place, things are out of control idea.
  + Schemas – Basic beliefs about nature of self. “No one will ever love me”
* **Development of MDD**
  + Person has vulnerabilities due to negative schemas or assumptions
  + Negative life situation (extreme stress, loss or thwarting of goals, etc)
  + Activation of schemas leads to distorted automatic thoughts through logical errors
  + Schemas also activate negative emotions related to cognitive schemas
  + Negative emotions further energize schemas
* Causes
* **Treatment**
  + Biological
    - Antidepressant Drugs
      * Monoamine Oxidase Inhibitors (MAO Inhibitors)
      * Tricyclics
        + Block reuptake of norepinephrine and serotonin
      * SSRI’s
    - Electroconvulsive Therapy (ECT)
      * May work for six months or so
      * Mimics the effects of having more serotonin
    - Transcranial Magnetic Stimulation
      * Stimulating the brain with magnetic pulses
  + Behavioral
    - Lewinsohn
      * Increase in individual’s rate of reinforcement of pleasure and mastery
      * Decrease depressive behaviors by not reinforcing depressive behaviors
        + No crying, no woah is me, etc
      * Social skills training
        + Teaching someone how to interact
  + Cognitive Behavioral Therapy
    - Behavioral Activation
      * Increasing activities and elevating mood
      * Since they’re withdrawing from activities you have to get them back involved
    - Identify and then alter/challenge automatic thoughts and cognitive errors
      * Thought records
    - Alter basic beliefs and underlying schemas
  + Sociocultural Tx for MDD
    - Interpersonal Therapy (IPT)
      * Identify core problem(s)
        + Interpersonal loss

Death, grief, divorce, etc

Come up with ways to remember that person by being positive

* + - * + Interpersonal Roll Disputes

Typically applied to difficult families or marriages where interpersonal conflict exists

Teach people new ways to way in those roles without disputes

Classification of desires within the relation

Marriage Counseling

* + - * + Interpersonal Role Transitions

A major life change

Becoming a parent, retiring, et

Find ways of coping with the negative aspects of that new role, develop meaning within that new role

* + - * + Interpersonal Deficits

Lack of social skills

Problem focused approach

Not as much emphasis on what got you to that point, or how you’re thinking, it’s just “what is the problem and how can we fix it?”

* + - * + Develop strategies for resolving the problem

## Dysthymic Disorder

* **Diagnosis under DSM-IV**
  + A depressed mood for at least two years for most days
  + Two or more of the following while depressed
    - Poor appetite or overeating
    - Insomnia or hypersomnia
    - Low energy
    - Low self-esteem
    - Poor concentration or difficulty making decisions
    - Feelings of hopelessness
  + Symptoms absent for **no more than 2 months total added up**
  + No major depressive disorder for first two years
  + Never manic, mixed, or hypomanic episode
  + You can be diagnosed with dysthymic and major depressive disorder
* **Changes in DSM-V**
  + Rename chronic depressive disorder and eliminate “no major depressive disorder for first two years” and “never manic, mixed, or hypomanic episode”
* **Characteristics**
  + 3.6% Lifetime
* Causes
* Treatment

## Bipolar I Disorder (Manic History)

* **Diagnosis under DSM-IV**
  + Presence of a manic, hypomanic, or major depressive episode
  + If currently in a hypomanic or major depressive episode, history of a manic episode
  + Significant distress or impairment
* **Changes in DSM-V**
  + Now diagnosed with one of 4 subtypes
    - Current or Most Recent Episode Hypomanic
    - Current or Most Recent Episode Manic
    - Current or Most Recent Episode Depressed
    - Current or Most Recent Episode Unspecified
* **Characteristics**
  + .4% 1 Year
  + 1.6% Lifetime
  + Typically late adolescence onset
  + No racial or ethnic differences
  + Female:Male 1:1
  + 85% of people who have had a depressive episode will have another depressive episode
  + 90% of people who have had a manic episode will have another manic episode
* **Causes**
* **Treatment**
  + Biological Perspective
    - Neurotransmitters
      * Norepinephrine
      * Serotonin
      * Low Serotonin & Low Norepinephrine = Depression
      * Low Serotonin & High Norepinephrine = Mania or Hypomania
    - Animatic Medications (Mood Stabilizers)
      * No SSRI’s!
        + If you give them an antidepressant it could induce a manic episode
      * Lithium
        + Not given to improve depression, only reduce manic episodes
  + Psychological Perspectives
    - Cognitive Therapy and Psychoeducation
    - Not very effective for manic episodes, only depression
      * Not effective because manic episodes aren’t aversive to the individual

## Bipolar II Disorder (Hypomania + Depression)

* **Diagnosis under DSM-IV**
  + At least one or more **hypomanic episodes**, either past or present
  + One or more **major depressive episodes**, either past or present
  + Never been a manic or mixed episode
  + Mood symptoms cause significant impairment
* **Changes in DSM-V**
  + Now diagnosed with one of 2 subtypes
    - Current or Most Recent Episode Hypomanic
    - Current or Most Recent Episode Depressed
* Characteristics
* Causes
* Treatment

## Bipolar Disorder vs. Major Depression

* Bipolar vs MDD
  + Prevalence
    - Depression has a higher prevalence
  + Demographics
    - Females have a higher chance for depression
    - Equal for bipolar disorder
    - Bipolar is higher in higher socioeconomic individuals
  + Marriage
    - People married are less likely to be depressed
    - People married are equally likely to have bipolar
  + Personal History
    - In major depression there is a history of low self-esteem, dependencies, obsessive thinking, etc
    - In bipolar there’s history of hyperactivity
  + Depressive Episodes
    - In bipolar there is more likely to have psychomotor retardation
  + Course
    - Both are chronic
    - Bipolar has shorter mood episodes than depression
    - Median depression episode is 4-5 months, in bipolar they tend to be shorter
  + Prognosis
    - Depression is the “better” one to have
    - Tends to not be as severe, more options for treatment, etc
  + Genetics
    - More genetic links to bipolar
    - Depression seems to have more allowance for environmental factors
    - Monozygote Twins
      * 40% chance for twins with depression
      * 72% chance for twins with bipolar

## Cyclothymic Disorder

* **Diagnosis under DSM-IV**
  + For at least 2 years, numerous periods of hypomanic symptoms and periods of depressive symptoms (not concurrent)
  + Symptoms absent for no more than 2 months cumulatively
  + No major depressive, manic, or mixed episodes
  + Mood disturbances causes significant impairment; not due to substance or medical condition
* Changes in DSM-V
* Characteristics
  + Onset during the teens
  + More common in females
* Causes
* Treatment

## Specifiers

* Depressive
* Atypical
  + When they gain weight and/or sleep more when depressed. Retained ability to have interest in things.
* Metancholic
  + When they report physical symptoms, loss of libido, lack of energy, losing weight, guilt feelings, or loss of interests
* Chronic
  + If you have major depressive episodes that last over 2 years continuously
* Bipolar I & Bipolar II
  + Catatonic (Bipolar I & Depressive)
    - Shows a lack of movement, like gumby
  + Psychotic
    - Loss of reality, hear voices or delusions, only when in a mood episode. They can be mood congruent (negative voices when depressive, great voices when in a manic episode)
  + With Postpartum Onset
    - Bipolar mood within one month of childbirth. In DSM-V it will be within 6 months of childbirth.

## Suicide

* Suicide rates
  + Race/Gender
    - Caucasian individuals are twice as likely to commit suicide than African American individuals
    - Native Americans are twice as likely to commit suicide
    - Men are 4-5x more likely to commit suicide than women
    - Females are about 3x more likely to attempt suicide
    - Men use more violent means
  + By age
    - Suicide is much higher at older age
      * Declining health, role transitions, etc
    - Elderly white males have the highest rate for suicide, 6x as likely as the national average
    - Among adolescents it’s the 3rd highest reason for death
  + Types of Suicide
    - Edwin Schneidman Research
      * Four main types of people who commit suicide
        + Death Seekers

Individuals intend to commit suicide, their goal is to truly be successful

Typically use means that are highly effective

* + - * + Death Initiators

Intend to die, but they do it because they believe they’re hurrying along the natural process

They might consider assisted suicide

Usually old, health is declining, etc

* + - * + Death Ignorers

Individuals who still indent to die, but they don’t believe death is the end of their experience

Tend to have the idea that they are trading in their current existence into something else

Heavens Gate people, suicide bombers, etc

Doing it for a larger purpose, there will be a reward in the end

* + - * + Death Darers

Individuals who attempt suicide but are ambivalent about whether or not work. Do not indent to die, instead they do it because of a secondary gain (e.g. attention, crying out for help)

* + - Suicide Risk Factors
      * Demographics
      * Stressful events
      * Mood and thought changes
      * Alcohol
        + 60% of individuals who attempt suicide do it while intoxicated
      * Having a disorder
        + About half of people who attempt suicide will be diagnosed with a disorder
        + 90% of people who complete suicide have a disorder
      * Modeling
    - Suicide Assessment
      * Suicidal Ideation
        + Are they having suicidal thoughts?
        + Do they have a plan?
      * Specific Plan
        + If there’s a well drawn out plan or not
      * Means for carrying out the plan
        + Do you have a gun? If so, where is it?
      * Life in order
        + Have they said goodbye to significant people in their life?
        + Have they made sure their will is in order?
      * Previous Attempts
      * Presence of a Model
      * Drinking
      * Impulsivity
        + Do they tend to be someone who makes decisions on a whim?
      * Hopelessness
        + For individuals who are hopeless there is a much higher risk
    - Suicide Intervention
      * Validate feelings and give the person a chance to express thoughts/emotions
      * “No suicide contract”
      * Take their means of committing suicide away
      * Get support
      * Hotlines
      * Psychotherapy
      * Medication
        + Typically SSRI’s
        + If this is a longer, drawn out process, then medications could be given
      * Hospitalization
        + If at considerable risk, all the risk factors, then they’ll require hospitalization

## Eating Disorders

* Prevalence
  + 90% females
  + More often in high socioeconomic individuals
  + Individuals who come form competitive environments
  + High degree of comorbidity with anxiety and depression
  + 0.6% for anorexia
  + 1% for bulimia
  + 18-21 onset
  + 50% of anorexics will binge and purge
* Anorexia
  + Often found with OCD
* Bulimia
  + 80% of individuals will at some point meet the criteria for anxiety disorder
  + 50-70% of individuals will at some point meet the criteria for a mood disorder
  + Not found as often with OCD as Anorexia
  + Tooth decay, calicies on back of hands
* Anorexia Nervosa
  + **Refusal to maintain body weight** at or above a minimally normal weight for age and height
  + **Intense fear of gaining weight** or becoming fat, even though underweight
  + Disturbance in the way in which one’s body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of seriousness of current low body weight
  + In postmenarcheal females, amenorrhea – The absence of at least three consecutive menstrual cycles
  + Types
    - Restricting
      * Restrict the amount of food intake
      * Includes compensatory Behavior (Exercising)
    - Binge-eating / Purging
      * Engage in purging, through vomiting or laxatives
      * Below 85% of their normal weight
      * Hair loss, skin discoloration, grow fine hair all over the body (Anglo – to maintain body temperature), dangerous levels of dehydration, up to 20% will end up dying from health related complications
* **Changes in DSM-V (Anorexia Nervosa)**
  + Removal of three missing cycles
* **Bulimia Nervosa**
  + **Recurrent episodes of binge eating (2-40 per week)**
    - Large food amount; sense of lack of control over eating
    - Usually soft in texture and sweet because it goes down soft
  + Recurrent **inappropriate compensatory behavior** in order to prevent weight gain
    - Vomiting, laxative use, use of enema, etc
  + The cycle occurs for at least twice a week for 3 months
  + Self-evaluation is unduly influenced by body shape and weight
  + The disturbance does not occur exclusively during episodes of anorexia nervosa
  + Types
    - Purging and Non-Purging
* Changes in DSM-V (Bulimia Nervosa)
  + New disorder for non-purging subtype
    - Binge eating Disorder
      * Recurrent episodes of binge eating
      * The binge eating episodes are associated with three (or more) of the following
        + Eating much more rapidly than normal
        + Eating until feeling uncomfortably full
        + Eating large amounts of food when not feeling physically hungry
        + Eating alone because of embarrassed by how much one is eating
        + Feeling disgusted with ones self, depressed, or very guilty after overeating
      * Market Distress
      * The binge eating occurs, on average, at least once a week for 3 months
      * The binge eating is not associated with the recurrent use of inappropriate compensatory behavior (i.e. purging) and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa
* **Anorexia vs Bulimia**
  + Similarities
    - Prior experimentation with dieting by individuals fearful of becoming obese
    - Preoccupation with food, weight, and appearance
    - Feeling of anxiety, depression, need to be perfect
    - Believe they weigh too much and look too heavy
  + Differences
    - Anorexics have significant weight loss and typically bulimics do not
    - Bulimics are more likely to recognize behavior as pathological
    - Bulimics display fewer obsessive qualities
    - Bulimics have fewer cognitive distortions revolving around the perception of their body
    - Medical complications differ
* Biopsychosocial Model
  + Biological Components
    - Genetic transmission of the disorder
    - History of being overweight
    - Parental obesity
    - Low serotonin
      * Messes with thalamus
  + Dieting History
    - Disturbs serotonin levels
    - Begins pattern of rigid control of food intake
  + Psychological Factors
    - Stress during adolescence
    - Difficulty tolerating negative emotion
    - Associated family factors
      * Emeshment
        + Over involvement and lack of independence of the family

The mother may know everything the daughter is doing, there’s no autonomy or independence

* + - * Overprotective parents
      * Modeling of perfection
      * Interparental Conflicts
    - Social/Cultural Factors
      * Society’s emphasis on being thin
      * Acceptance of unrealistic body types
* Treatment of Anorexia Nervosa
  + No effective drugs
  + Usually requires hospitalization
  + Psychological intervention
    - Family therapy
    - Cognitive behavioral intervention
      * Self esteem, body image, etc
      * Goal is to make them have an accurate perception of their body. Health is NOT weight
  + 75% recovery rate
  + Relapses are incredibly common
* Treatment of Bulimia Nervosa
  + Drug Therapy
    - Antidepressants (SSRIs)
      * Helps between 25-40% stop purging
  + Cognitive Behavioral Intervention
    - Focus on heavier
    - Plan and monitor eating schedule
      * 5-6 small meals per day
    - Change attitudes and belief
    - Coping skills to handle stressful life events
      * Call a friend, exercise, etc

Axis I – Symptom Disorders and "Clinical Disorders", which would include major mental and learning disorders.

Axis II – Personality Disorders and a decrease of the use of intellect disorder.

Axis III – General medical conditions and "Physical disorders"

Axis IV – Psychosocial/environmental problems, which would contribute to the disorder.

Axis V – Global assessment of functioning (often referred to as GAF) or "Children's Global Assessment Scale" (for children and teenagers under the age of 18). [edit]