



ABNORMAL PSYCHOLOGY

BLEPP/PPL

Main References: Barlow & Durand 8th ed.; Kring et al., 14th ed.; DSM-5/5-TR

MANIFESTATIONS OF BEHAVIOR (5)

PSYCHOPATHOLOGY – the field concerned with the nature, development, and treatment of psychological disorders

ABNORMAL PSYCHOLOGY – a branch of psychology that studies unusual patterns of behaviors, emotions, and thought, which may or may not indicate an underlying condition

PSYCHOLOGICAL DISORDERS – psychological dysfunction within an individual associated with distress or impairment in functioning and a response that is not typical or culturally expected

- **Dysfunction** – breakdown in cognitive, emotional, or behavioral functioning
- **Distress** – the individual is extremely upset and cannot function properly
- **Deviance** (Atypical or Not Culturally Expected) – deviates from the average or the norm of the culture
- **Dangerousness** – creates potential harm to self and others
- **Disability** – impairment (limitations) in some important area of life
- **Duration** – how long the mental state has been persisting

NORMAL BEHAVIOR – one behavior that is like other people in society

- Normality is **social conformity**
- Normality is **personal comfort**
- Normality is a **process**

Indicators for Determining Abnormal Behavior

- Subjective Distress
- Maladaptiveness
- Statistical Deviancy
- Violation of the Standards of Society
- Personal/Social Discomfort
- Irrationality and Unpredictability
- Dangerousness

A

Describing Abnormal Behavior

- **Presenting Problem** – chief complaint
- **Clinical Description** – represents the unique combination of behaviors, thoughts, and feelings that make up a specific disorder
- **Diagnosis** – process of determining whether the particular problem afflicting the individual meets all criteria for a psychological disorder
- **Prevalence** – how many people experience the disorder (# of active cases)
- **Incidence** – how many cases occur during a given period (# of new cases)
- **Cause** – how the disorder will progress
 - **Chronic** – lifetime
 - **Episodic** – likely to recover
 - **Time-limited** – one time, will improve without treatment
- **Onset** – how the disorder develops
 - **Acute** – sudden
 - **Insidious** – gradual
- **Prognosis** – anticipated course of a disorder
 - **Good** – high chance of possibility to recover
 - **Guarded** – low chance of recovery
- **Sign** – manifestation of disease that the physician receives
- **Symptoms** – subjective representation of the complaints of the patient
- **Syndrome** – a group of symptoms that occur together more often by chance
- **Etiology** – study of the origins of why the disorder begins
- **Epidemiology** – study of the distribution of disease, or health-related behaviors in a given population
- **Ego Syntonic** – actions align with the client's personal goals, values, and beliefs
- **Ego Dystonic** – actions that are inconsistent with the client's ego



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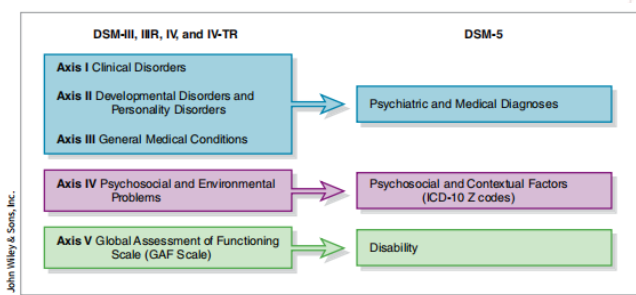
Multiaxial System (DSM-IV to DSM-5)

- **Axis I:** Mental Health and Substance Use Disorder (Clinical Disorder)
- **Axis II:** Personality Disorders and Mental Retardation
- **Axis III:** General Medical Conditions
- **Axis IV:** Psychosocial and Environmental Problems
- **Axis V:** Assessment of Overall Functioning (Global Assessment of Functioning)

PSYCHOLOGICAL DISORDERS AND SPECIFIC SYMPTOMS BASED ON DSM-5 (50)

DIAGNOSTIC STATISTICAL MANUAL OF MENTAL DISORDERS 5TH EDITION

- In 1952, the **American Psychiatric Association** published its first **Diagnostic and Statistical Manual (DSM)**
- DSM-5 was released in **2013**
- The DSM-5 **provides information about each disorder**
- The DSM-5 provides **specific diagnostic criteria—symptoms for a given diagnosis**



Mental Disorder (DSM-5)

- Is a syndrome characterized by a clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning
- Usually associated with significant distress

or disability in social, occupational, or other important activities

- An expectable or culturally approved response to a common stressor or loss, such as death of a loved one, is not a mental disorder
- Socially deviant behavior and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual

A Differentiating Anxiety Disorders, Trauma-and-Stressor-Related Disorders, and OCD-Related Disorders

Anxiety Disorders – excessive and persistent fear, worry, or anxiety that is disproportionate to the actual situation, which significantly impairs daily functioning

- **Fear** – is the emotional response to real or perceived imminent threat, more associated with surges of autonomic arousal necessary for fight or flight, thoughts of immediate danger, and escape behaviors
- **Anxiety** – is the anticipation of a future threat, more often associated with muscle tension and vigilance in preparation for future danger, and cautious or avoidant behavior
- **Panic Attack** – is featured prominently within the anxiety disorders as a particular type of fear response

ANXIETY DISORDERS (5)

Separation Anxiety Disorder – fearful or anxious about separation from attachment figures to a degree that is developmentally inappropriate

- At least 4 weeks (children and adolescents) or 6 months or more (adults)

Selective Mutism – consistent failure to speak in social situations in which there is an expectation to



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speak (e.g., school) even though the individual speaks in other situations

- At least 1 month

Specific Phobia – fearful or anxious about or avoidant of circumscribed objects or situations

- Typically lasting for 6 months or more
- Specific type: Animal, Nature Environment, Blood-injection Injury, Situational, Other

Social Anxiety Disorder – individual is fearful or anxious about or avoidant of social interactions and situations that involve the possibility of being scrutinized

- Lasting for 6 months or more
- Examples include social interactions (e.g., having a conversation, meeting unfamiliar people), being observed (e.g., eating or drinking), and performing in front of others (e.g., giving a speech)
- Specifier: performance only

Panic Disorder – experiences recurrent unexpected panic attacks and is persistently concerned or worried about having more panic attacks or changes his or her behavior in maladaptive ways because of the panic attacks

- At least 1 month
- **Panic Attacks** – are abrupt surges of intense fear or intense discomfort that reach a peak within minutes, accompanied by physical and/or cognitive symptoms
 - ◆ **Expected Panic Attack** – such as in response to a typically feared object or situation
 - ◆ **Unexpected Panic Attack** – panic attack occurs for no apparent reason
- Panic Attack Specifiers
 - ◆ Palpitations, sweating, trembling, shortness of breath, feelings of choking, chest pain, nausea, dizziness, chills, paresthesias (numbness or tingling sensation, burning or prickling), fear of losing control, fear of dying, derealization,

and depersonalization

Agoraphobia – fearful and anxious about two or more of the following situations: using public transportation; being in open spaces; being in enclosed places; standing in line or being in a crowd; or being outside of the home alone in other situations

- 6 months or more

Generalized Anxiety Disorders – persistent and excessive anxiety and worry about various domains, including work and school performance, that the individual finds difficult to control

- The individual experiences physical symptoms, including restlessness or feeling keyed up or on edge; being easily fatigued; difficulty concentrating or mind going blank; irritability; muscle tension; and sleep disturbance
- “The world is a dangerous place”
- At least 6 months

Trauma-and-Stressor-Related Disorders – development of psychological problems following exposure to a traumatic or stressful event

- Exposure to actual or threatened death, serious injury, sexual violence, or other severely stressful events

TRAUMA-AND-STRESSOR-RELATED DISORDERS (4)

Reactive Attachment Disorder – characterized by a pattern of markedly disturbed and developmentally inappropriate attachment behaviors, in which a child rarely or minimally turns preferentially to an attachment figure for comfort, support, protection, and nurturance

- Evident before the age of 5 years
- History of social neglect
- Has a developmental age of at least 9 months
- Persistent: more than 12 months
- Severe: all symptoms present at a high level of intensity



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Disinhibited Social Engagement Disorder – characterized by a pattern of overly familiar and disinhibited behavior towards unfamiliar adults

- Actively approach and interact with strangers without showing typical wariness or hesitation
- These behaviors are not solely due to impulsivity (as seen in ADHD) but include socially disinhibited behavior
- Has a developmental age of at least 9 months
- Persistent: more than 12 months
- Severe: all symptoms present at a high level of intensity

Posttraumatic Stress Disorder – exposure to actual or threatened death, serious injury, or sexual violence

- Intrusion Symptoms (1): distressing memories, dreams, dissociative reactions (flashbacks), psychological distress, physiological reactions to stimuli
- Avoidance (1): inability to remember, exaggerated negative beliefs, distorted cognitions about consequences, negative emotional state, diminished interest, feelings of detachment, inability to experience positive emotions
- Negative alterations in cognitions and mood (2): negative beliefs about oneself or the world, distorted cognitions about the cause or consequences of the event, difficulty remembering aspects of the event
- Arousal or reactivity (2): irritable behavior and anger outbursts, reckless, hypervigilance, exaggerated startle, problems with concentration, sleep disturbance
- More than 1 month
- With Delayed Expression – if the full diagnostic criteria are not met until at least 6 months after the event

Acute Stress Disorder – characterized by the presence of distressing symptoms similar to those

seen in Post-Traumatic Stress Disorder (PTSD), but the key difference is the duration

- 3 days to 1 month after trauma exposure
- If symptoms persist for longer than a month, the diagnosis may be revised to PTSD

Adjustment Disorder – emotional and behavioral symptoms develop in response to a specific stressor, such as a life change or stressful event

- Within 3 months of the onset of stressors
- Persist beyond 6 months: the diagnosis will no longer apply (other specified)
- Do not represent normal bereavement
- Subtypes
 - ◆ With Depressed Mood
 - ◆ With Anxiety
 - ◆ With Mixed Anxiety and Depressed Mood
 - ◆ With Disturbance of Conduct
 - ◆ With Mixed Disturbance of Emotions and Conduct
 - ◆ Unspecified

Prolonged Grief Disorder (DSM 5-TR)

- Referred to as complicated grief or persistent complex bereavement disorder (other specified in DSM-5)
- Characterized by intense and persistent grief that extends far beyond what is considered a typical or culturally expected period after the loss of a loved one
- The death occurred at least 12 months ago (adults) and at least 6 months ago (children and adolescents)

OCD-Related Disorders – Characterized by persistent, intrusive thoughts (obsessions) and/or repetitive behaviors or mental acts (compulsions) that an individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly

- **Obsessions** – recurrent and persistent thoughts, urges, or images that are experienced as intrusive and unwanted,



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causing marked anxiety or distress

- **Compulsions** – repetitive behaviors or mental acts that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly
- Obsessions are typically the primary trigger for compulsions
- **Accommodation** – involvement of family and friends in compulsive rituals

OCD-RELATED DISORDERS (4)

Obsessive-Compulsive Disorder – characterized by the presence of obsessions and/or compulsions

- Obsessions and compulsions are time-consuming (e.g., take more than 1 hour per day), cause significant distress, and impair daily functioning
- Obsessions usually do not involve real-life concerns and can include one irrational or magical content
- Not limited to concerns about food and weight

Body Dysmorphic Disorder – preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others

- Individuals engage in repetitive behaviors (e.g., mirror checking, excessive grooming, skin picking) or mental acts (e.g., comparing appearance with others) in response to the appearance concerns
- **With Muscle Dysmorphia** – preoccupied with the idea that his or her body build is too small

Hoarding Disorder – persistent difficulty discarding or parting with possessions, regardless of their actual value

- Difficulty is due to a perceived need to save the items and the distress associated with discarding them
- The accumulation of possessions congests and clutters active living areas and substantially compromises their intended

use

- **Prader-Willi Syndrome** – characterized by severe hypotonia, poor appetite, and feeding difficulties in early infancy, followed in early childhood by excessive eating and gradual development of morbid obesity
- **With Excessive Acquisition** – if difficulty discarding possessions is accompanied by excessive acquisitions of items that are not needed or for which there is no available space
- Animal Hoarding

Trichotillomania (Hair-Pulling Disorder) – recurrent pulling out of one's hair, resulting in noticeable hair loss

- Individuals experience an increasing sense of tension immediately before or when resisting the urge, and pleasure, gratification, or relief when pulling out the hair
- Repeated attempts to decrease or stop hair-pulling have typically been unsuccessful

Excoriation (Skin-Picking) Disorder – recurrent skin picking resulting in skin lesions

- Individuals have made repeated attempts to decrease or stop skin picking
- Causes clinically significant distress or impairment

Other Specified OCD-Related Disorders

- **BD-like Disorder w/ Actual Flaws** – the preoccupation is with a physical defect or flaw that is actually observable by others
- **BD-like Disorder w/o Repetitive Behaviors** – meets all the criteria for BDD except that the individual has not performed repetitive behaviors or mental acts in response to the appearance concerns
- **Body-Focused Repetitive Behavior Disorder** – involves repetitive behaviors (other than hair pulling or skin picking) such as nail biting, lip biting, cheek chewing



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- **Obsessional Jealousy** – a non-delusional preoccupation with a partner's perceived infidelity
- **Olfactory Reference Syndrome** – persistent preoccupation with the belief that one emits a foul or offensive body odor, even when this is not noticed by others

B Explaining Somatic Symptom and Related Disorders, Eating and Sleeping Disorders, Substance-Related and Addictive Disorders, Disruptive, Impulse-Control, and Conduct Disorders

Somatic Symptom Disorder and Related Disorders – individuals experiencing physical symptoms that are distressing and significantly disrupt their daily lives

- These symptoms are not fully explained by a medical condition
- The focus is on the individual's thoughts, feelings, and behaviors related to their physical symptoms

SOMATIC SYMPTOMS AND RELATED DISORDERS (4)

Somatic Symptom Disorder – characterized by one or more somatic symptoms that are distressing or result in significant disruption of daily life, along with excessive thoughts, feelings, or behaviors related to these symptoms or associated health concerns

- The state of being symptomatic is persistent, typically more than 6 months

Illness Anxiety Disorder (Hypochondriasis) – preoccupation with having or acquiring a serious illness, despite the absence of significant somatic symptoms

- High levels of anxiety about health and a tendency to be easily alarmed about personal health status
- May involve excessive health-related

behaviors (e.g., checking for signs of illness) or avoidance of medical care

- Present for at least 6 months
- Care-seeking or Care-avoidant type
- IAD without excessive health-related behaviors (other specified): Criterion D is not met

Conversion Disorder (Functional Neurological Symptom Disorder) – involves motor or sensory symptoms (e.g., weakness, paralysis, abnormal movement, swallowing difficulties, speech problems, blindness, deafness, anesthesia, or sensory loss) that suggest a neurological condition but are not explained by any neurological or medical disorder

- Clinical findings show inconsistency between the reported symptoms and recognized neurological pathways

Psychological Factors Affecting Other Medical Conditions – when psychological or behavioral factors have an adverse effect on a medical condition

- Examples include anxiety, worsening asthma, or stress, delaying wound healing

Factitious Disorder – falsification of physical or psychological signs or symptoms, or induction of injury or disease, associated with identified deception

- The individual presents themselves to others as sick, impaired, or injured.
- Behavior is evident even in the absence of obvious external rewards
- **Imposed on Another (Munchausen Syndrome by Proxy)** – presents another individual as ill
- **Imposed on Self** – presents him/herself to others as ill

Eating Disorders – characterized by persistent disturbances of eating or eating-related behavior that result in the altered consumption or absorption of food and that significantly impair physical health or psychosocial functioning



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EATING DISORDERS (1)

Pica Disorder – persistently eating non-nutritive substances

- Inappropriate to the developmental level of the individual
- At least 1 month

Rumination Disorder – characterized by repeated regurgitation of food that is re-chewed, re-swallowed, or spit out

- At least 1 month

Avoidant/Restrictive Food Intake Disorder (ARFID)

– involves restricted food intake due to a lack of interest in eating, sensory issues with food, or fear of negative consequences from eating

- This can lead to nutritional deficiencies and weight loss, but it is not driven by a fear of weight gain or distorted body image
- Eating problem-focus: ARFID; Weight problem-focus: Anorexia Nervosa

Anorexia Nervosa – characterized by restricted food intake, intense fear of gaining weight, and a distorted perception of body weight and shape

- Very underweight
- Subtypes: binge-eating/purging type, restricting type
- Severity
 - ◆ Mild: 17 or more BMI
 - ◆ Moderate: 16 to 17 BMI
 - ◆ Severe: 15 to 16 BMI
 - Extreme: under 15 BMI

Bulimia Nervosa – involves recurrent episodes of binge eating followed by compensatory behaviors to prevent weight gain, such as self-induced vomiting, misuse of laxatives, excessive exercise, or fasting

- Normal weight
- Once a week, for 3 months
- Severity
 - ◆ Mild: 1 to 3 episodes per week
 - ◆ Moderate: 4 to 7 episodes
 - ◆ Severe: 8 to 13 episodes
 - ◆ Extreme: 14+ episodes

Binge Eating Disorder – characterized by recurrent episodes of eating large amounts of food in a short period with a sense of lack of control, often leading to feelings of guilt and distress, but without regular compensatory behaviors

- Usually overweight
- Once a week, for 3 months

Elimination Disorders (1) – characterized by the inappropriate excretion of urine or feces

- **Enuresis** – the repeated voiding of urine into bed or clothes, whether involuntary or intentional
 - Repeated urination in inappropriate places
 - Occurs in children aged 5 or older
 - Frequency and duration criteria must be met
 - Can cause significant emotional distress and social problems (e.g., reluctance to participate in sleepovers)
 - Types: Nocturnal (during sleep), Diurnal (during waking hours), Primary (never achieved consistent nighttime dryness), Secondary (starts after a period of at least 6 months of nighttime dryness)
- **Encopresis** – is the repeated passage of feces into inappropriate places (e.g., clothing, floor), whether involuntary or intentional
 - At least once a month for at least three months, and the individual must be at least 4 years old
 - Types: with constipation and overflow incontinence (retentive), without constipation and overflow incontinence (nonretentive)

Sleeping Disorders – involves dissatisfaction regarding the quality, timing, and amount of sleep,



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resulting in daytime distress and impairment

- **Dyssomnias** – characterized by disturbances in the amount, quality, or timing of sleep
- **Parasomnias** – involve abnormal behaviors, experiences, or physiological events that occur in association with sleep, specific sleep stages, or the transitions between sleep and wakefulness
- **Breathing-Related Sleep Disorders** – characterized by abnormal breathing patterns during sleep that lead to disrupted sleep and other health problems
- **REM Sleep** – during which the majority of typical story-like dreams occur (20% – 25% of total sleep)

NREM Sleep Stages

- **Stage 1 (N1): Light Sleep** – transition from wakefulness to sleep, and occupies about 5% of time spent asleep in healthy adults
- **Stage 2 (N2): Deeper Sleep** – characterized by specific electroencephalographic waveforms (sleep spindles and K-complexes), occupied about 50% of the time spent sleeping
- **Stage 3 (N3): Deep Sleep** – slow wave sleep; deepest level of sleep

SLEEPING DISORDERS (1)

Insomnia Disorder – predominant complaint of dissatisfaction with sleep quantity or quality, associated with one or more of the following:

- Difficulty initiating sleep, difficulty maintaining sleep, or early-morning awakening with inability to return to sleep
- At least 3 nights per week, for at least 3 months
- **Rebound Insomnia** – sleep problems reappearing, but sometimes worse

Hypersomnolence Disorder – excessive sleepiness despite a main sleep period of at least seven hours,

with at least one of the following

- Recurrent periods of sleep or lapses into sleep within the same day, a prolonged main sleep episode of more than nine hours per day that is nonrestorative, or difficulty being fully awake after abrupt awakening
- At least 3 nights per week, for at least 3 months

Narcolepsy – recurrent periods of an irrepressible need to sleep, lapsing into sleep, or napping occurring within the same day, at least three times per week for at least three months, along with cataplexy (sudden bilateral muscle weakness elicited by strong emotion), hypocretin deficiency, or rapid eye movement (REM) sleep latency of ≤ 15 minutes on a multiple sleep latency test (MSLT)

Obstructive Sleep Apnea – at least 4 obstructive apneas or hypopneas per hour of sleep or evidence from polysomnography of 15 or more obstructive apneas and/or hypopneas per hour of sleep

- **Apnea** – absence of airflow
- **Hypopnea** – reduction in airflow

Central Sleep Apnea – evidence of polysomnography of 5 or more central apneas per hour of sleep

- **Cheyne-Stokes Breathing** – an abnormal pattern of breathing characterized by progressive, deeper, and sometimes faster breathing, followed by a gradual decrease, results in a temporary stop in breathing called an apnea

Sleep-Related Hypoventilation – polysomnography demonstrates episodes of decreased respiration associated with elevated carbon dioxide levels

Circadian Rhythm Sleep-Wake Disorders – a mismatch between the individual's internal sleep-wake cycle and the desired or required sleep-wake schedule

- Delayed Sleep Phase, Advanced Sleep Phase, Irregular Sleep-Wake Type, Non-24



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Hour Sleep-Wake Type, Shift Work Type

NREM Sleep Arousal Disorders – incomplete awakening from sleep: sleepwalking or sleep terrors

- Cannot remember anything when they woke up
- Occur mostly in childhood and NREM sleep
- Produce rapid and complete awakening without confusion, amnesia, or motor activity

Nightmare Disorder – repeated occurrences of extended, extremely dysphoric, and well-remembered dreams that usually involve efforts to avoid threats to survival, security, or physical integrity

- Upon awakening, they become oriented and alert
- Appear in children exposed to acute or chronic psychosocial stressors
- It occurs during REM sleep

Rapid Eye Movement (REM) Sleep Behavior Disorder – repeated episodes of arousal during sleep associated with vocalization and/or complex motor behaviors

Restless Legs Syndrome – an urge to move the legs, usually accompanied by or in response to uncomfortable and unpleasant sensations in the legs, with specific characteristics related to rest, movement, and time of day

- 3 times per week, for at least 3 months

Substance-Related and Addictive Disorders – encompass a range of problems associated with the use of psychoactive substances and addictive behaviors, most notably gambling disorder

- Characterized by a pattern of compulsive engagement in substance use or gambling despite significant harmful consequences
- The individual experiences a loss of control over their use or behavior, and this often leads to distress and impairment in various aspects of their life, including health,

relationships, work, and social functioning

- **Substance** – chemical compounds that are ingested to alter mood or behavior
- **Psychoactive Substances** – alter mood, behavior, or both
- **Substance Use** – ingestion of psychoactive substances in moderate amounts that does not significantly interfere with social, educational, or occupational functioning
- **Substance Intoxication** – physiological reaction to ingested substances

10 Separate Classes of Drugs

- **Alcohol** – various alcoholic beverages
- **Caffeine** – coffee, tea, energy drinks, and some medications
- **Cannabis** – marijuana and hashish
- **Hallucinogens**
 - ◆ Phencyclidine (PCP) and similar arylcyclohexylamines
 - ◆ Other Hallucinogens (e.g., LSD, psilocybin, mescaline, DMT)
- **Inhalants** – volatile solvents, aerosols, gases, and nitrites
- **Opioids** – heroin, morphine, codeine, oxycodone, hydrocodone, fentanyl, and others
- **Sedatives, Hypnotics, or Anxiolytics** – includes benzodiazepines (e.g., diazepam, alprazolam), barbiturates, and other sleep medications (e.g., zolpidem)
- **Stimulants**
 - ◆ Amphetamine-type substances (e.g., amphetamine, methamphetamine)
 - ◆ Cocaine
 - ◆ Other Stimulants (e.g., methylphenidate)
- **Tobacco** – cigarettes, chewing tobacco, and other nicotine-containing products
- **Other (or Unknown) Substances** – used for substances that do not fit neatly into the other classes



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SUBSTANCE-RELATED AND ADDICTIVE DISORDERS (2)

Substance Use Disorder – characterized by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance or engaging in the behavior despite significant substance- or behavior-related problems

- Impaired Control
- Social Impairment
- Risky Use
- Pharmacological Criteria (Tolerance and Withdrawal)

Substance-Induced Disorders – include substance intoxication, substance withdrawal, and substance-induced mental disorders (e.g., substance-induced psychotic disorder, substance-induced depressive disorder)

- Typically, temporary conditions that develop during or soon after substance use or withdrawal

Gambling Disorder – persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress, as indicated by a cluster of symptoms such as:

- Needing to gamble with increasing amounts of money to achieve the desired excitement,
- Repeated unsuccessful efforts to control, cut back, or stop gambling, restlessness, or irritability when attempting to cut down or stop gambling,
- Gambling to escape problems or relieve feelings of helplessness,
- Lying to conceal the extent of involvement with gambling,
- And jeopardizing or losing significant relationships, a job, or an educational or career opportunity because of gambling
- At least 4 symptoms within 12 months

Disruptive, Impulse-Control, and Conduct Disorders

– involves problems with self-control of emotions and

behaviors that violate the rights of others and/or bring the individual into significant conflict with societal norms or authority figures

- Often emerge in childhood or adolescence and can have significant consequences for social relationships, academic or occupational functioning, and legal involvement

DISRUPTIVE, IMPULSE-CONTROL DISORDERS AND CONDUCT DISORDER (3)

Oppositional Defiant Disorder (ODD)

- A pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness lasting at least 6 months
- Symptoms include often losing temper, being easily annoyed, being angry and resentful, arguing with authority figures, actively defying rules, deliberately annoying others, and blaming others for mistakes
- The behavior is directed towards at least one individual who is not a sibling
- Less severe than CD and do not include aggression towards people, property (IED)
- Diagnosis should not be made if the symptoms occur exclusively during the course of a mood disorder
- If the criteria for DMDD are met, then DMDD is given even if all criteria for ODD are met

Intermittent Explosive Disorder (IED)

- Recurrent behavioral outbursts represent a failure to control aggressive impulses
- Outbursts can involve verbal aggression (e.g., tantrums, arguments) or physical aggression towards property, animals, or other individuals twice weekly for a period of 3 months
- The aggression is often grossly out of proportion to the provocation
- There are specific criteria regarding the frequency and severity of outbursts
- DMDD diagnosis can only be given when the onset of recurrent, problematic,



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impulsive aggressive outbursts occurs before the age of 10

- Should not be made in children and adolescents aged 6 to 18 years

Conduct Disorder

- A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated
- This pattern includes at least three behaviors in the past 12 months (with at least one in the past 6 months) from categories such as aggression to people and animals, destruction of property, deceitfulness or theft, and serious violations of rules
- Subtypes can be specified based on childhood-onset vs. adolescent-onset, and with limited prosocial emotions
- When the criteria for both ODD and CD are met, both diagnoses can be given
- When the criteria for both ADHD and CD are met, both diagnoses can be given
- If the criteria for both IED and CD has been met, the diagnosis of IED should be given only when the recurrent impulsive, aggressive outbursts warrant independent clinical attention
- ASPD is diagnosed in individuals aged 18 or older, with evidence of CD before age 15

Pyromania

- Deliberate and purposeful fire setting on more than one occasion
- Fascination with, interest in, curiosity about, or attraction to fire and its related contexts
- Pleasure, gratification, or relief when setting fires or witnessing their aftermath
- The fire setting is not done for monetary gain, as an expression of sociopolitical ideology, to conceal criminal activity, to express anger or vengeance, to improve one's life circumstances, in response to delusions or hallucinations, or due to impaired judgment

Kleptomania

- Recurrent failure to resist impulses to steal objects that are not needed for personal use or for their monetary value
- An increasing sense of tension immediately before committing the theft
- Pleasure, gratification, or relief at the time of committing the theft
- The stealing is not committed to express anger or vengeance and is not in response to delusions or hallucinations

C

Evaluating Dissociative Disorders, Sexual Dysfunctions, Paraphilic Disorders, and Gender Dysphoria

Dissociative Disorders – characterized by a disruption in and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior

- **Detachment** – feeling disconnected from one's body, thoughts, feelings, or sense of self
- **Amnesia** – difficulty remembering personal information, often related to traumatic events
- **Identity Confusion** – feeling uncertain about one's identity, sense of self, or place in the world
- **Identity Alteration** – experiencing distinct shifts in sense of self, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning, as if experiencing different "selves"
- **Derealization** – feeling that the external world is unreal, dreamlike, or distorted
- **Depersonalization** – feeling detached from one's own body, thoughts, feelings, or actions, as if one is an outside observer



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DISSOCIATIVE DISORDERS (3)

Dissociative Identity Disorder (DID) – characterized by the presence of two or more distinct personality states or identities that recurrently take control of the individual's behavior

- Previously known as "Multiple Personality Disorder"
- Inability to recall everyday events, important personal information, and/or traumatic events that is too extensive to be explained by ordinary forgetfulness
- **Host Personality** – the person who becomes the patient and asks for treatment
- **Switch** – transition from one personality to another extreme subtype of PTSD
- **Hypnotic Trance** – tend to be focused on one aspect of their world, and they become vulnerable to suggestions by the hypnotist

Dissociative Amnesia – inability to recall important autobiographical information, usually of a traumatic or stressful nature, that is too extensive to be ordinary forgetfulness

- **Localized Amnesia** – loss of memory for a specific period of time, often immediately following a traumatic event.
- **Selective Amnesia** – loss of memory for some, but not all, events during a specific period.
- **Generalized Amnesia** – loss of memory for one's entire life history.
- **Continuous Amnesia** – loss of memory for events from a specific time up to the present.
- **Systematized Amnesia** – loss of memory for a specific category of information (e.g., memories related to an abusive family member)
- **Dissociative Fugue** – memory loss resolves around a specific incident, an unexpected trip; the individuals just take off and later find themselves in a new place, unable to remember why and how they got there

Depersonalization/Derealization Disorder – persistent or recurrent experiences of depersonalization, derealization, or both

- **Depersonalization** – experiences of unreality, detachment, or being an outside observer with respect to one's thoughts, feelings, sensations, body, or actions.
- **Derealization** – experiences of unreality or detachment with respect to surroundings (e.g., individuals or objects are experienced as unreal, dreamlike, foggy, lifeless, or visually distorted)

Sexual Dysfunctions – involve a clinically significant disturbance in a person's ability to respond sexually or to experience sexual pleasure

- **Lifelong** – present since the individual became sexually active
- **Acquired** – developed after a period of relatively normal sexual functioning
- **Generalized** – occurs in all or most sexual situations
- **Situational** – occurs only in specific situations

5 Stages of the Sexual Response Cycle

1. **Desire (Libido)** – initial phase characterized by sexual thoughts, fantasies, or the urge to have sex
2. **Excitement (Arousal)** – involves the body's initial responses to sexual stimulation, whether physical or mental
3. **Plateau** – represents the heightening of arousal, where the physical changes from the excitement phase become more intense and stabilize
4. **Orgasm** – the peak or climax of sexual excitement, characterized by a sudden release of accumulated sexual tension
5. **Resolution** – the body gradually returns to its pre-aroused state



ABNORMAL PSYCHOLOGY

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Main References: Barlow & Durand 8th ed.; Kring et al., 14th ed.; DSM-5/5-TR

SEXUAL DYSFUNCTIONS (2)

Delayed Ejaculation – characterized by a marked delay in, marked infrequency of, or absence of ejaculation during sexual activity with a partner

- At least 6 months and must be experienced in almost or all occasions

Erectile Disorder – characterized by marked difficulty in obtaining an erection during sexual activity, marked difficulty in maintaining an erection until the completion of sexual activity, and/or a marked decrease in erectile rigidity

- At least 6 months and must be experienced in almost or all occasions

Female Orgasmic Disorder – characterized by persistent or recurrent delay in, infrequency of, or absence of orgasm, or markedly reduced intensity of orgasmic sensations

- At least 6 months and must be experienced in almost or all occasions

Female Sexual Interest/Arousal Disorder – characterized by a persistent or recurrent lack of sexual interest and/or lack of subjective sexual arousal or genital or nongenital sensations

- At least 6 months and must be experienced in almost or all occasions

Genito-Pelvic Pain/Penetration Disorder – characterized by persistent or recurrent difficulties with one or more of the following

- Vaginal penetration during intercourse;
- Marked vulvovaginal or pelvic pain during intercourse or other attempts at penetration;
- Marked fear or anxiety in anticipation of, during, or as a result of genito-pelvic pain;
- And marked tensing or tightening of the pelvic floor muscles during attempted vaginal penetration
- At least 6 months and must be experienced in almost or all occasions

Male Hypoactive Sexual Disorder – characterized by persistently or recurrently deficient (or absent)

sexual fantasies and desire for sexual activity

- At least 6 months and must be experienced in almost or all occasions

Premature (Early) Ejaculation – characterized by a persistent or recurrent pattern of ejaculation occurring during partnered sexual activity within approximately one minute following vaginal penetration and before the individual wishes it to occur

- At least 6 months and must be experienced in almost or all occasions

Paraphilic Disorders – characterized by intense and persistent sexual interests other than normative sexual interests that cause distress or impairment to the individual or involve personal harm or risk of harm to others (at least 6 months)

- **Voyeuristic Disorder** – sexual arousal from observing an unsuspecting person who is naked, disrobing, or engaging in sexual activity.
- **Exhibitionistic Disorder** – sexual arousal from the exposure of one's genitals to an unsuspecting person.
- **Frotteuristic Disorder** – sexual arousal from touching or rubbing against a non-consenting person.
- **Sexual Masochism Disorder** – sexual arousal from the act of being humiliated, beaten, bound, or otherwise made to suffer.
- **Sexual Sadism Disorder** – sexual arousal from the physical or psychological suffering of another person
- **Pedophilic Disorder** – sexual arousal from sexual activity with prepubescent children. The individual must be at least 16 years old and at least five years older than the child
- **Fetishistic Disorder** – sexual arousal from nonliving objects or non-genital body parts
- **Transvestic Disorder** – sexual arousal from cross-dressing, with significant distress or



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impairment

- **Other Specified Paraphilic Disorder**
 - *Zoophilia* (sexual attraction to animals)
 - *Necrophilia* (sexual attraction to corpses)
 - *Telephone Scatologia* (sexual arousal from making obscene phone calls)
 - *Urophilia* (sexual arousal involving urine)
 - *Coprophilia* (sexual arousal involving feces)
 - *Klismaphilia* (sexual arousal involving enemas)

Gender Dysphoria – refers to a conflict between a person's physical or assigned gender at birth and the gender with which they deeply identify (*at least 6 months*)

- Marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics
- Strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender
- Strong desire for the primary and/or secondary sex characteristics of the other gender
- Strong desire to be of the other gender
- Strong desire to be treated as the other gender
- Strong conviction that one has the typical feelings and reactions of the other gender

D **Illustrating Mood Disorders, Personality Disorders, and Schizophrenia and Other Psychotic Disorders**

Mood Disorders (3) – characterized by a significant disturbance in a person's predominant mood

- This disturbance involves either excessively low mood (depression) or excessively elevated mood (mania or hypomania)

2 Main Categories of Mood Disorders

1. **Depressive Disorders** – characterized by the presence of sadness, emptiness, or irritability, often accompanied by a loss of interest or pleasure in activities
2. **Bipolar Related Disorders** – characterized by significant shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks

Mood Disorders Specifiers

1. **Psychotic Features** – psychotic symptoms (hallucinations and delusions)
 - **Mood-congruent** – directly related to the depression
 - **Mood-incongruent** – does not seem consistent with the depressed mood
2. **Anxious Distress (mild to severe)** – presence and severity of accompanying anxiety; makes suicidal thoughts and completed suicide more likely
3. **Mixed Features** – have several (at least 3) symptoms of MANIA
4. **Melancholic Features specifier** – applies only if the full criteria for MDE have been met; includes some of the more severe somatic (physical) symptoms: early-morning awakenings, weight loss, loss of libido, excessive guilt
5. **Catatonic Features** – can be applied to MDE, whether they occur in a personality disorder or not, even with a manic episode (rare)
 - **Catalepsy** – absence of movement (stuporous state) which muscles are waxy and semirigid
6. **Atypical Features** – applies to both depressive episodes, whether in the context of PDD or not; individuals consistently



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oversleep and overeat during depression = gain weight; they can react with interest or pleasure to some things; a greater percentage of women and an earlier age onset

7. **Peripartum Onset** – can apply to both MDE and Manic Episode; higher incidence of depression is found postpartum; mothers had serious thoughts of harming themselves, difficulty understanding why she is depressed; extreme stress can be brought on by physical exhaustion

→ **Baby Blues** – normal responses to the stresses of childbirth, and disappear quickly

8. **Seasonal Pattern** – temporal specifier applies to recurrent MDD; begins in the late fall and ends with the beginning of spring; must have occurred for at least 2 years with no evidence of nonseasonal MDE

Unipolar Disorders

Disruptive Mood Dysregulation Disorder – a condition in children and adolescents characterized by severe and recurrent temper outbursts and persistent irritability or anger

- 3 or more times per week
- 12 or more months for at least 2 settings, and are severe in at least 1 of those
- Onset should occur after 6 to 18 years
- Do not occur exclusively in MDE
- Age onset is before 10 years
- Never been a distinct period lasting more than 1 day during which the full symptom criteria for a manic or hypomanic episode have been met

Major Depressive Disorder – characterized by a period of at least two weeks of persistent sadness or loss of interest, along with other symptoms like changes in appetite and sleep, fatigue, feelings of worthlessness, and difficulty concentrating

- At least 2 weeks
- There has never been a manic or

hypomanic episode

Persistent Depressive Disorder (PDD) (Dysthymia)

– a chronic form of depression with milder symptoms that last for at least two years in adults (one year in children and adolescents)

- Double Depression – suffer from both MDE and PDD with fewer symptoms
- Early onset: before 21 years
- Late onset: 21 years or older

Premenstrual Dysphoric Disorder (PMDD) – a mood disorder related to the menstrual cycle, with significant depressive symptoms, anxiety, and irritability occurring in the week before menstruation

- At least five symptoms must be present in the final week before the onset of menses

Bipolar Disorders

Bipolar I Disorder – at least one manic episode, which is a period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least one week and present most of the day, nearly every day

- Depressive episodes are also common, but not required for diagnosis

Bipolar II Disorder – at least one major depressive episode and at least one hypomanic episode (a less severe and shorter duration of elevated mood than mania), but no full manic episodes

- Must not experience manic episode

Cyclothymic Disorder – a milder form of bipolar disorder involving numerous periods of hypomanic symptoms and numerous periods of depressive symptoms that do not meet the criteria for a major depressive episode or a manic episode

- Mood swings persist for at least 2 years in adults (1 year in children and adolescents)



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Personality Disorders – are enduring and inflexible patterns of thinking, feeling, behaving, and relating to others that deviate markedly from the expectations of an individual's culture

- **Cluster A** – odd or eccentric
- **Cluster B** – dramatic, emotional, or erratic
- **Cluster C** – anxious or fearful

PERSONALITY DISORDERS (5)

Paranoid PD – pervasive distrust and suspiciousness of others and their motives

- Suspects without sufficient basis
- Unjustified doubts about loyalty or trustworthiness
- Reluctant to confide in others
- Reads hidden threatening images
- Persistently bears grudges
- Perceives attack on his/her character or reputation
- Recurrent suspicions regarding fidelity, without justification
- "I cannot trust people"
- Males = Females

Schizoid PD – detachment from social relationships and a restricted range of expression of emotions in interpersonal settings

- Neither desires nor enjoys close relationships
- Always chooses solitary activities
- Little interest in having sexual experiences with another person
- Takes pleasure in few activities
- Lack close friends other than relatives
- Appears indifferent to the criticisms of others
- Emotional coldness, detachment, flattened activity
- "Relationships are messy and undesirable"
- Males > Females

Schizotypal PD – acute discomfort in close relationships, cognitive or perceptual distortions, and eccentricities of behavior

- **Ideas of Reference** – false beliefs that random or irrelevant occurrences in the world directly relate to oneself
- Odd beliefs or magical thinking
- Unusual perceptual experiences
- Odd thinking and speech
- Suspiciousness or paranoid ideation
- Inappropriate or constricted affect
- Behavior or appearance that is odd, eccentric, or peculiar
- Lack of close friends other than relatives
- Excessive social anxiety
- "It's better to be isolated from others"
- Males > Females

Antisocial PD – a disregard for and violation of the rights of others, often involving deceitfulness, impulsivity, irritability, and lack of remorse

- Failure to conform social norms
- Deceitfulness
- Impulsivity or failure to plan ahead
- Irritability and aggressiveness
- Reckless disregard for safety of self or others
- Consistent irresponsibility
- Lack of remorse or concern or guilt
- At least 18 years old
- There is evidence of conduct disorder with onset before age 15 years
- CD will be given if the criteria for ASPD are not met
- "I'm entitled to break rules"
- Males > Females
- **Underarousal Hypothesis** – psychopaths have abnormally low levels of cortical arousal
- **Fearlessness Hypothesis** – psychopaths possess a higher threshold for experiencing fear than most other individuals

Borderline PD – instability in interpersonal relationships, self-image, affect, and impulsivity

- Frantic efforts to avoid real or imagined abandonment
- Pattern of unstable and intense interpersonal relationships



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- Identity disturbance
- Impulsivity in at least two areas that are potentially self-damaging
- Recurrent suicidal behavior or self-mutilating behavior
- Affective instability
- Chronic feelings of emptiness
- Inappropriate, intense anger or difficulty controlling anger
- Stress-related paranoid ideation or severe dissociative symptoms
- "Sad girl/boy"
- Females = Males

Histrionic PD – excessive emotionality and attention-seeking behavior

- Uncomfortable in situations in which he/she is not the center of attention
- Inappropriate sexually seductive and provocative behavior
- Rapidly shifting and shallow expression of emotions
- Uses physical appearance to draw attention to self
- Style of speech that is excessively impressionistic
- Self-dramatization; exaggerated expression of emotion
- Suggestible
- Consider relationships to be more intimate
- "Ako ang bida"
- Females > Males

Narcissistic PD – a sense of grandiosity, a need for admiration, and a lack of empathy

- Grandiose sense of self-importance
- Preoccupied with fantasies of unlimited success, power, brilliance, beauty or ideal of love
- Believes that he or she is "special" and unique
- Excessive admiration
- Sense of entitlement
- Interpersonally exploitative
- Lacks of empathy
- Often envious of others or believe others

- are envious of him or her
- Arrogant, haughty behaviors or attitudes
- "I'm the greatest in the world"
- Males > Females

Avoidant PD – social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation

- Avoids activities involve significant interpersonal contact
- Unwilling to get involved with people
- Restraint within intimate relationships
- Preoccupied with being criticized or rejected
- Inhibited in new interpersonal situations because of feelings of inadequacy
- Views self as socially inept
- Unusually reluctant to take personal risks
- "I'm avoiding them because I'm afraid of rejection"
- Females > Males

Dependent PD – an excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation

- Difficulty making everyday decisions
- Needs others to assume responsibility
- Difficulty expressing disagreement with Others
- Difficulty initiating or doing things alone
- Excessive lengths to obtain nurturance and support from others
- Feels uncomfortable or helpless when alone
- Urgently seeks another relationship
- Unrealistically preoccupied with fears of being left
- "I need others to survive every day"
- Females > Males

Obsessive-Compulsive PD – a preoccupation with orderliness, perfectionism, and control at the expense of flexibility, openness, and efficiency

- Preoccupied with details, rules, lists, order, organization, or schedules
- Shows perfectionism that interferes with



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task completion

- Excessively devoted to work and productivity
- Over conscientious, scrupulous, and inflexible
- Unable to discard worthless objects
- Reluctant to delegate tasks or to work with others
- Miserly spending style toward both self and others
- Shows rigidity and stubbornness
- "I'm a perfectionist"
- Males > Females

Schizophrenia and Other Psychotic Disorders – are a group of severe mental illnesses characterized by a disconnection from reality, referred to as **psychosis**

- **John Haslam** – superintendent of a British Hospital who outlined a description of the symptoms of Schizophrenia in his book *"Observations on Madness and Melancholy"*
- **Philippe Pinel** – French physician who described cases of schizophrenia
- **Benefit Morel** – *"démence précoce"* (early or premature loss of mind)
- **Emil Kraepelin** – unified the distinct categories of schizophrenia under the name *"dementia praecox"*
 - **Catatonia** – altering immobility and excited agitation
 - **Hebephrenia** – silly and immature emotionality
 - **Paranoia** – delusions of grandeur or persecution
- **Eugene Bleuler** – introduced the term "schizophrenia" (splitting of the mind)
- **Schizophrenogenic Mother** – used for a time to describe a mother whose cold, dominant, and rejecting nature was thought to cause schizophrenia in her children
- **Double bind Communication** – used to portray a communication style that produced conflicting messages, which caused schizophrenia to develop

Key Features of Psychotic Symptoms

- **Delusions** – false beliefs that are firmly held despite contradictory evidence
 - ◆ **Persecutory** – one is being harmed or plotted against
 - ◆ **Referential** – common cues or events have special meaning directed at oneself
 - ◆ **Grandiose** – one has exceptional abilities, wealth, or fame
 - ◆ **Erotomaniac** – believes falsely that another person is in love with him/her
 - ◆ **Nihilistic** – a major catastrophe will occur
 - ◆ **Somatic** – focus on preoccupations regarding health and organ function
 - ◆ **Thought Withdrawal** – thoughts have been removed by an outside force
 - ◆ **Thought Insertion** – thoughts have been put into one's mind
 - ◆ **Delusions of Control** – believing one's thoughts, feelings, or actions are being controlled by someone else
 - ◆ **Capgras Syndrome** – a person believes someone he/she knows has been replaced by a double
 - ◆ **Cotard's Syndrome** – a person believes he/she is dead
 - ◆ **de Clérambault's Syndrome** – characterized by the delusional idea, usually in a young woman, that a man whom she considers to be of higher social and/or professional standing is in love with her
 - ◆ **Fregoli Syndrome** – a person holds



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a delusional belief that different people are in fact a single person who changes his/her appearance or is in disguise

→ **Hallucinations** – sensory experiences that occur without an actual external stimulus

- ◆ **Hypnagogic** – falling asleep
- ◆ **Hypnopompic** – awakening from sleep
- ◆ **Auditory** – false perception of sound, usually voices, other noises, music; most common
- ◆ **Visual** – both formed images and unformed images
- ◆ **Olfactory** – smell; rare
- ◆ **Gustatory** – taste
- ◆ **Tactile (Haptic)** – touch or surface sensation
- ◆ **Somatic** – things occurring in or to the body

→ **Disorganized Thinking (Speech)** – an individual may switch from one topic to another (derailment or loose associations) or answers to questions may be related or completely unrelated (tangentiality)

- ◆ **Circumstantiality** – excessive and irrelevant detail in descriptions, with the person eventually making his/her point
- ◆ **Concrete Thinking** – unable to abstract and speaks in concrete, literal terms
- ◆ **Clang Association** – are groups of words chosen because of the catchy way they sound, not because of what they mean
- ◆ **Loose Association** – a loose connection between thoughts that are often unrelated
- ◆ **Neologism** – creating a new words

that have no meaning

- ◆ **Word Salad** – a combination of words that have no meaning

→ **Grossly Disorganized or Abnormal Motor Behavior** – unusual, unpredictable, or inappropriate for the situation

- ◆ Can range from childlike silliness to agitation, or even **catatonia** – a state of marked motor abnormalities, including immobility or excessive, purposeless movement

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

- ◆ **Diminished Emotional Expression (Flat Affect)** – reduced expression of emotions in the face, tone of voice, or body language
- ◆ **Avolition** – lack of motivation or directedness; difficulty initiating and persisting in goal-directed activities
- ◆ **Alogia** – reduced speech output
- ◆ **Anhedonia** – inability to experience pleasure
- ◆ **Asociality** – lack of interest in social interactions

SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDERS (5)

Delusional Disorder

- Characterized by the presence of one or more delusions with a duration of 1 month or longer
- These delusions are fixed, false beliefs that are firmly held despite clear evidence to the contrary
- Tend not to have Negative Symptoms
- Functioning is better than what is observed



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in schizophrenia

- Absence of the active phase of schizophrenia (*Attenuated Psychosis Syndrome*)
- **Shared Psychotic Disorder (Folie à Deux)** – a condition in which an individual develops delusions simply as a result of a close relationship with a delusional individual
- Types of Delusional Disorder: Erotomantic, Grandiose, Jealous, Persecutory, Somatic, Mixed, Unspecified, With bizarre content

Brief Psychotic Disorder

- Characterized by the sudden onset of at least one psychotic symptom (delusions, hallucinations, disorganized speech, or grossly disorganized or catatonic behavior)
- The disturbance lasts for at least one day but less than one month
- Full Return to Premorbid Functioning

Schizophreniform Disorder

- Similar to schizophrenia, but the total duration of the illness (including the prodromal, active, and residual phases)
- At least 1 month but less than 6 months
- If the symptoms persist beyond 6 months, the diagnosis is typically changed to Schizophrenia or Schizoaffective Disorder, depending on the full symptom picture

Schizophrenia

- Requires at least two of the characteristic symptoms (delusions, hallucinations, disorganized speech, disorganized or catatonic behavior, negative symptoms)
- Continuous signs of the disturbance persist for at least 6 months

Schizoaffective Disorder

- A combination of psychotic symptoms of schizophrenia and a major mood episode (major depressive or manic episode)
- The mood episode and psychotic symptoms must occur for a significant portion of the illness

- Delusions or hallucinations for at least 2 weeks without mood symptoms
- Symptoms that meet criteria for a major mood episode (depressive or manic) must be present for the majority of the total duration of the active and residual portions of the illness
- Types: Bipolar or Depressive

Phases of Schizophrenia

1. **Prodromal Phase** – the *early phase* of schizophrenia, where subtle changes begin to appear, but full-blown psychotic symptoms are not yet present or are very mild and intermittent
 - It can last for weeks, months, or even years before the active phase
2. **Active Phase (or Acute Phase)** – the *most prominent and severe psychotic symptoms* become evident
 - This is typically when schizophrenia is first diagnosed, as the symptoms are noticeable and significantly disrupt the individual's life and those around them
3. **Residual Phase (or Recovery Phase)** – a reduction in positive symptoms, but negative symptoms and cognitive deficits may persist, sometimes becoming the most challenging aspects of the illness

Catatonia Specifiers

1. **Stupor** (no psychomotor activity; not actively relating to the environment)
2. **Catalepsy** (passive induction of a posture held against gravity)
3. **Waxy flexibility** (slight, even resistance to positioning by examiner)
4. **Mutism** (no or very little verbal response, exclude if aphasia)
5. **Negativism** (opposition or no response to



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instructions or external stimuli)

6. **Posturing** (spontaneous & active maintenance of posture against gravity)
7. **Mannerism** (odd, circumstantial caricature of normal actions)
8. **Stereotypy** (repetitive, abnormally frequent, non-goal-directed movements)
9. **Agitation**, not influenced by external stimuli
10. **Grimacing**
11. **Ecolalia** (mimicking another's speech)
12. **Echopraxia** (mimicking another's movement)

E Identify the different Neurodevelopmental and Neurocognitive Disorders based on DSM-5

Neurodevelopmental Disorders – a group of conditions with onset in the developmental period

- They are characterized by developmental deficits that produce impairments of personal, social, academic, or occupational functioning

NEURODEVELOPMENTAL DISORDERS (3)

Intellectual Developmental Disorder (Intellectual Disability)

- Characterized by deficits in general mental abilities (e.g., reasoning, problem-solving, planning, abstract thinking, judgment, academic learning, learning from experience)
- Also involves deficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility. These deficits limit functioning in one or more activities of daily life (e.g., communication, social participation, independent living)
- Onset is during the developmental period

→ Severity is specified based on adaptive functioning in conceptual, social, and practical domains (mild, moderate, severe, profound)

- ◆ Mild: 50 – 55 & 70
- ◆ Moderate: 35 – 40 & 50 – 55
- ◆ Severe: 20 – 25 & 35 – 40
- ◆ Profound: below 20 – 25

Global Developmental Delay

→ For children under 5 years old, when they fail to meet expected developmental milestones in several areas of functioning

Language Disorder – difficulties in the acquisition and use of language modalities due to deficits in comprehension and production

- Limited speech in all situations
- Expressive language is significantly below receptive language
 - ◆ Reduced vocabulary
 - ◆ Limited sentence structure
 - ◆ Impairments in disclosure

Speech Sound Disorder – persistently difficulty with speech sound production that interferes with speech intelligibility or prevents verbal communication or messages

- Causes limitations in effective communication

Childhood-Onset Fluency Disorder (Stuttering)

- Disturbances in the normal fluency and motor production of speech (e.g., sound repetitions, prolongations, broken words)

Social (Pragmatic) Communication Disorder – persistent difficulties in the social use of verbal and nonverbal communication (e.g., problems following conversation rules, understanding implied meanings, using communication for social purposes)

- Difficulties in social communication are seen in ASD, but without the restricted, repetitive patterns of behavior

Autism Spectrum Disorder – characterized by



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persistent deficits in social communication and social interaction across multiple contexts.

- Also requires restricted, repetitive patterns of behavior, interests, or activities.
- Symptoms must be present in the early developmental period, though they may not become fully manifest until social demands exceed limited capacities.
- Severity is specified based on the level of support required for social communication and restricted, repetitive behaviors
- Severity
 - ◆ Level 1 – requiring support
 - ◆ Level 2 – substantial support
 - ◆ Level 3 – very substantial support
- **Rett Disorder** – a genetic condition that affects mostly females and is characterized by hand wringing and poor coordination

Attention-Deficit/Hyperactivity Disorder (ADHD) – characterized by a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development

- ◆ Inattention (6 or more)
- ◆ Hyperactivity (6 or more)
- At least 6 months
- Symptoms must be present in multiple settings (e.g., school, home, work) and have been present before age 12
- Combined Presentation (ADHD-CP)
- Predominantly Inattentive Presentation (ADHD-PI)
- Predominantly Hyperactivity/Impulsivity Presentation (ADHD-HI)

Specific Learning Disorder – characterized by persistent difficulties in learning and using key academic skills (reading, writing, or mathematics) despite the provision of interventions targeting those difficulties

- The learning difficulties are substantially and quantifiably below those expected for the individual's chronological age
- At least 6 months
- With impairment in reading

- With impairment in expression
- With impairment in mathematics

Developmental Coordination Disorder

- Deficits in the acquisition and execution of coordinated motor skills (e.g., clumsiness, slowness, inaccuracy of motor performance) that interfere with daily activities

Stereotypic Movement Disorder

- Repetitive, seemingly driven, and apparently purposeless motor behaviors (e.g., hand flapping, body rocking, head banging), which can cause self-injury
- With self-injurious behavior
- Without self-injurious behavior

Tic Disorders – characterized by the presence of motor and/or vocal tics (sudden, rapid, recurrent, nonrhythmic, stereotyped movements or vocalizations)

- **Tourette's Disorder** – multiple motor tics and at least one vocal tic, persisting for more than 1 year
- **Persistent (Chronic) Motor or Vocal Tic Disorder** – single or multiple motor or vocal tics, but not both, persisting for more than 1 year
- **Provisional Tic Disorder** – single or multiple motor and/or vocal tics, present for less than 1 year

Neurocognitive Disorders – characterized by a decline from a previously attained level of cognitive functioning

- They typically involve cognitive deficits that are *acquired* (not developmental) and are often due to underlying brain pathology, disease, injury, or substance use
- The impact is primarily on cognitive domains such as memory, attention, language, and problem-solving



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NEUROCOGNITIVE DISORDERS (2)

Delirium

- Characterized by a disturbance in attention and awareness that develops rapidly (usually hours to a few days) and tends to fluctuate in severity over the course of a day
- Accompanied by an additional disturbance in cognition (e.g., memory deficit, disorientation, language, visuospatial ability, or perception)
- Evidence suggests it is a direct physiological consequence of another medical condition, substance intoxication or withdrawal, or multiple etiologies. It is an acute medical emergency

Major Neurocognitive Disorder

- Formerly *Dementia*
- Characterized by significant cognitive decline from a previous level of performance in one or more cognitive domains (complex attention, executive function, learning and memory, language, perceptual-motor, or social cognition).
- The cognitive deficits are sufficient to interfere with independence in everyday activities (e.g., managing medications, paying bills, maintaining hygiene).
- Not exclusively occurring during the course of a delirium.
- The cognitive deficits are not better explained by another mental disorder

Mild Neurocognitive Disorder

- Characterized by modest cognitive decline from a previous level of performance in one or more cognitive domains
- The cognitive deficits do not interfere with independence in everyday activities (though more effort, compensatory strategies, or accommodation may be required)
- Not exclusively occurring during the course of a delirium

- The cognitive deficits are not better explained by another mental disorder

Neurocognitive Disorders Etiologies

Neurodegenerative Diseases – these involve the progressive loss of neurons in the brain

- **Alzheimer's Disease** – characterized by the accumulation of amyloid plaques and neurofibrillary tangles in the brain, leading to gradual memory loss, cognitive decline, and behavioral changes. Genetic factors may also play a significant role in some cases
- **Frontotemporal Lobar Degeneration (FTLD)** – a group of disorders primarily affecting the frontal and temporal lobes of the brain. This results in prominent changes in personality, behavior, and/or language, with varying underlying proteinopathies (e.g., tau, TDP-43)
 - ◆ **Pick's Disease** – a rare neurological condition that produces symptoms similar to Alzheimer's, usually occurring relatively early in life
- **Lewy Body Disease** – distinguished by the presence of Lewy bodies (abnormal protein deposits) in the brain. This leads to fluctuating cognition, visual hallucinations, Parkinsonian motor features, and REM sleep behavior disorder
- **Parkinson's Disease** – primarily a motor disorder due to the loss of dopamine-producing neurons, but can also lead to cognitive impairment and eventually dementia in some individuals. Lewy bodies are also implicated
- **Huntington's Disease** – an inherited genetic disorder that causes the degeneration of nerve cells in the brain. It manifests with a triad of motor abnormalities (chorea), cognitive decline, and psychiatric symptoms
- **Prion Disease** – a rare and rapidly progressive neurodegenerative disorder



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Main References: Barlow & Durand 8th ed.; Kring et al., 14th ed.; DSM-5/5-TR

caused by infectious prions (abnormal proteins)

- ◆ **Creutzfeldt-Jakob Disease** – symptoms include spasms of the body caused by a slow-acting virus that may live in the body for years before the disease develops

Vascular Disease – results from problems with the blood supply to the brain

- **Vascular Neurocognitive Disorder** – caused by cerebrovascular events such as strokes (infarcts) or small vessel disease, leading to brain damage and cognitive impairment. The pattern of cognitive deficits can be variable depending on the location and extent of the vascular injury

Traumatic Brain Injury (TBI) – cognitive impairment resulting from a blow or jolt to the head that disrupts normal brain function. The severity pattern of cognitive deficits depends on the nature and extent of the injury. Repeated TBIs can lead to chronic traumatic encephalopathy (CTE)

Substance/Medication Use – cognitive decline that persists beyond the acute intoxication or withdrawal phase of substance use. Various substances can cause neurocognitive impairment. Certain medications can also have lasting cognitive effects

HIV Infection – the human immunodeficiency virus can directly and indirectly affect the brain, leading to HIV-associated neurocognitive disorder (HAND). The severity can range from mild to severe dementia

Prion Disease – (also listed under neurodegenerative, but also specified separately due to its unique infectious etiology. Caused by abnormal prion proteins leading to rapidly progressive neurodegeneration

Another Medical Condition – this is a broad category encompassing NCDs resulting from various systemic or neurological conditions not

listed specifically

- Multiple Sclerosis
- Brain Tumors
- Infections of the brain or meninges

Other Specified & Unspecified Disorder

Other Specified Disorder

- Used when the clinician chooses to specify the reason why the presentation does not meet the full criteria for a specific disorder
- It means the clinician has enough information to indicate why a more precise diagnosis isn't being made
- The clinician provides a brief explanation for why the criteria for a specific disorder are not met, but the symptoms cause clinically significant distress or impairment
- Example: Other Specified Depressive Disorder, with insufficient symptoms

Unspecified Disorder

- Used when the clinician chooses not to specify the reason why the criteria for a specific disorder are not met
- There is insufficient information to make a more specific diagnosis
- The clinician determines that a mental disorder is present, but the individual's symptoms are complex, atypical, or do not conform clearly to any specific psychiatric diagnosis, and the clinician isn't yet ready or able to specify the reason
- No specific reason is provided for not meeting the full criteria
- Example: Unspecified Depressive Disorder



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THEORETICAL APPROACHES IN EXPLAINING THE ETIOLOGY OF PSYCHOLOGICAL DISORDER (20)

ONE-DIMENSIONAL – looking for a single cause

MULTIDIMENSIONAL – looking for a systemic cause

A Genetic Contributions (4)

Genetic Paradigm – almost all behavior is heritable to some degree (i.e., it involves genes)

- People have **23 pairs of chromosomes; 46 total**
 - **22 Autosomes; 1 Sex Chromosome**
 - **XX (Females); XY (Males)**
- The carriers of the **genetic information (DNA)** are passed from parents to the child
- People have **between 20,000 and 25,000 genes**; the absolute number is hard to fully estimate
- **Gene Expression** – switch other genes on and off, the flexibility of genes and how they turn on or off has closed the door on beliefs about the inevitability of the effects of genes, good or bad
- **Polygenic** – meaning several genes, perhaps operating at different times during development, turning themselves on and off as they interact with a person's environment, is the essence of genetic vulnerability
- **Heritability** – refers to the extent to which variability in a particular behavior (or disorder) in a population can be accounted for by genetic factors

2 Environmental Factors

1. **Shared Environment** – includes those things that members of a family have in common, such as family income level, child-rearing practices, and parents' marital status and quality
2. **Nonshared Environment** – unique environment factors are those things

believed to be distinct among members of a family, such as relationships with friends or specific events unique to a person

- **Genotype** – the total genetic makeup of an individual, consisting of inherited genes, which cannot be observed outwardly
- **Phenotype** – the totality of observable behavioral characteristics
- **Endophenotypes** – genetic mechanisms that ultimately contribute to the underlying problems causing the symptoms and difficulties experienced by people with psychological disorders
- **Alleles** – different forms of the same genes, which are commonly found at the same location, or locus, of a chromosome pair
- **Genetic Polymorphism** – refers to a difference in DNA sequence on a gene that has occurred in a population
- **Single Nucleotide Polymorphism (SNPs)** – refers to differences between people in a single nucleotide (A, T, G, or C) in the sequence of a particular gene
- **Copy Number Variations (CNVs)** – can be present in a single gene or multiple genes.
 - The name refers to an abnormal copy of one or more sections of DNA within the gene(s)
- **Basic Genetic Epidemiology** – statistical analysis of family, twin, and adoption studies; whether the disorder can be inherited and how much is attributable to genetics
 - **Family Studies** – examine behavioral patterns or emotional traits in the context of the family
 - **Proband** – family member with the trait singled out for the study (possibly having a genetic disorder and who may receive genetic counseling or testing)
 - **Adoption Studies** – identify adoptees who have a particular behavioral pattern of psychological disorder and attempt to locate first-degree relatives who were raised in different



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family settings

- **Twin Studies** – usually conducted on identical twins because they share genetic makeup
- **Advanced Genetic Epidemiology** – studies the factors that influence the disorder
- **Gene Finding** – what gene influences the behavior
- **Molecular Genetics** – biological processes genes affect to produce symptoms of the disorder
- **Epigenetics** – “above or outside the gene” and refers to the chemical “marks,” such as DNA methyl tags or histones, that are attached to and protect the DNA in each gene

B

Biological and Neurological Bases (4)

Neuroscience Paradigm – psychological disorders are linked to aberrant processes in the brain

Neurotransmitters – are the body’s chemical messengers, acting as a crucial communication system for the nervous system

- They are released by neurons and travel across a tiny gap called a synapse to bind receptors on a neighboring cell (can be another neuron, a muscle cell, or a gland)
- This binding process allows the neurotransmitters to either “**excite**” or “**inhibit**” the receiving cell, influencing a vast range of bodily functions and psychological states
- **Three Categories of Neurotransmitters**
 - ◆ **Excitatory** – these neurotransmitters encourage a receiving cell to fire an action potential (an electrical signal), thereby passing the message along
 - **Inhibitory** – these neurotransmitters reduce the likelihood that a receiving cell

will fire, effectively acting as a “break” on the nervous system

- **Modulatory** – these neurotransmitters can influence a larger group of neurons at once and over a longer period, “fine-tuning” or adjusting how cells communicate

Neurons & Neurotransmitters

- The cells in the nervous system are called **neurons**, and the nervous system comprises billions of neurons
- **Synapse** – is the small gap between the terminal endings of the sending axon and the cell membrane of the receiving neuron
- **Reuptake** – is a process where some of what remains in the synapse is broken down by the enzymes, and some is taken back into the presynaptic cell
- **Agonist** – effectively increases the activity of the neurotransmitters (*Excitatory*)
- **Antagonist** – decrease or block neurotransmitter (*Inhibitory*)
- **Inverse Agonists** – produce effects opposite to those produced by neurotransmitters
- **Neurotransmitters** – are chemicals that allow neurons to send signals across the synapse to other neurons
 - **Glutamate (E)** – memory
 - **GABA (I)** – calming
 - **Serotonin (I)** – mood
 - **Dopamine** – pleasure/reward
 - **Epinephrine** – fight or flight
 - **Norepinephrine** – concentration
 - **Endorphins** – euphoria
 - **Acetylcholine (E)** – learning

	High	Low
Dopamine	Schizophrenia	Parkinson’s
Acetylcholine		Alzheimer’s (Dementia)
Norepinephrine	Mania	Depression



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GABA	Relaxation	Anxiety OCD
Serotonin	Mania	Depression Anxiety Eating Disorders
Epinephrine	Stress Sleeping Disorders	Fatigue
Glutamate	Psychosis Neuron death	Huntington's
Endorphin		Eating Disorders

Structure and Function of the Human Brain

- **Gray Matter** – the cortex of the human brain is composed of the neurons that form the thin outer covering of the brain
- **Cerebral Cortex** – provides us with our distinctly human qualities, allowing us to look to the plan, to reason, and to create
 - **Left Hemisphere** – responsible for verbal and other cognitive processes
 - **Right Hemisphere** – perceiving the world around us and creating images
 - **Lobes:** frontal, parietal, occipital, temporal
- **Prefrontal Cortex**
 - One important area of the cortex
 - Located in the very front of the cortex
 - Helps to regulate the amygdala and is important in many different disorders
 - Area responsible for higher cognitive functions
- **White Matter** – made up of large tracts of myelinated (sheathed) fibers that connect cell bodies in the cortex with those in the spinal cord and in other areas of the brain
- **Ventricles** – cavities deep within the brain
 - Filled with cerebrospinal fluid
 - **Cerebrospinal Fluid** – circulates

through the brain through these ventricles, which are connected with the spinal cord

- **Brain Stem** – lower and more ancient part of the brain; essential for autonomic functions
 - **Hindbrain** – contains the medulla, pons, cerebellum; regulates many autonomic activities
 - **Cerebellum** – controls motor coordination abnormalities associated with autism
 - **Thalamus and Hypothalamus** – involved in regulating behavior, emotions, and hormones
- **Limbic System** – located around the edge of the center of the brain
- **Anterior Cingulate (Subcortical Structures)**
 - **Hippocampus** – associated with memory
 - **Hypothalamus** – regulates metabolism, temperature, perspiration, blood pressure, sleeping, and appetite
 - **Amygdala** – is an important area for attention to emotionally salient stimuli
- **Basal Ganglia** – base of the forebrain, related to Parkinson's
- **Pruning** – a number of synaptic connections begin to be eliminated
- **Brain Networks** – are clusters of brain regions that are connected in that activation in these regions is reliably correlated when people perform certain types of tasks or are at rest
- **Somatic NS** – controls muscles
- **Autonomic NS** – innervates the endocrine glands, the heart, and the smooth muscles that are found in the walls of blood vessels, stomach, intestines, kidneys, and other organs
 - **Sympathetic NS** – fight or flight response
 - **Parasympathetic NS** – helps to calm down the body
- **Endocrine System** – glands produce hormones that are released into the bloodstream



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- **Pituitary** – master gland
- **Thyroid** – controls metabolism and growth
- **Parathyroid** – controls the levels of calcium
- **Adrenal** – metabolism, blood pressure, sex development, stress
- **Pineal** – melatonin
- **Pancreas** – insulin
- **Testes** – testosterone
- **Ovaries** – estrogen, progesterone, testosterone

HPA Axis– is central to the body's response to stress figures prominently in many of the disorders

- When people are faced with a threat, the hypothalamus releases *corticotropin-releasing factor (CRF)*, which then communicates with the **pituitary gland**.
- The pituitary then releases *adrenocorticotrophic hormone*, which travels via the blood to the adrenal glands. The outer layers of the adrenal glands are referred to as the **adrenal cortex**; this area promotes the release of the hormone cortisol
- **Cortisol** – often referred to as the “stress hormone”

- **Temperament** – refers to a child's reactivity and characteristic ways of self-regulation
- **Permissive Hypothesis** – when serotonin levels are low, other neurotransmitters are permitted to range more widely, become dysregulated, and contribute to mood irregularities

Frontal Lobe	Learning, abstracting, reasoning, inhibiting
Hypothalamus	Regulation of metabolism, temperature, and emotions
Temporal Lobe	Discrimination of sounds, verbal, and speech behavior
Reticular Formation	Arousal reaction, information screening
Medulla	Breathing, blood pressure, and other vital functions
Cerebellum	Fine motor coordination, posture, and balance
Occipital Lobe	Visual discrimination and some aspects of visual memory
Thalamus	A major relay station for messages from parts of the body, and an important sensation of pain
Parietal Lobe	Somesthetic and motor discriminations and functions
Sensory Strip	Integration of sensory information from various parts of the body
Motor Strip	Regulation of voluntary movement

Monoamine Hypothesis of Depression – is a theory that suggests a **deficiency** in certain monoamine neurotransmitters in the brain is the underlying cause of depression

- The three primary neurotransmitters implicated are serotonin (5-HT), norepinephrine (NE), and dopamine (DA)
- The hypothesis posits that increasing the levels of these monoamines in the synaptic

Structure	Associated Behaviors
Corpus Callosum	Communication between the left and right hemispheres
Limbic System	Attention, emotion, fight or flight



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cleft, the space between neurons, can alleviate depressive symptoms

- Originated from observations in the 1950s that drugs that increased monoamine levels seemed to improve mood, while drugs that decreased them could induce depressive symptoms, which led to the development of modern antidepressants (SSRIs)

C Learning (4)

Classical Conditioning – response to a stimulus is evoked after repeated association with a stimulus that normally elicits a response

- Involves forming an association between a neutral stimulus and a stimulus that naturally elicits a response
- Over time, the neutral stimulus alone becomes a conditioned stimulus, capable of triggering a learned, or “conditioned,” response
- **Unconditioned Stimulus (US)** – a stimulus that naturally and automatically triggers a response (e.g., food)
- **Unconditioned Response (UR)** – the natural, automatic response to the unconditioned stimulus (e.g., salivation)
- **Neutral Stimulus** – a stimulus that, before conditioning, does not trigger a specific response (e.g., a bell)
- **Conditioned Stimulus (CS)** – the neutral stimulus that, after being paired with the unconditioned stimulus, triggers a conditioned response (e.g., the bell)
- **Conditioned Response (CR)** – the learned response to the conditioned stimulus (e.g., salivation)
- **Extinction** – the gradual weakening of the conditioned response when the CS is no longer paired with the US
- **Generalization** – the tendency for a conditioned response to occur in response to stimuli that are similar to the conditioned

stimulus

John B. Watson

- Founder of behaviorism
- Little Albert Experiment

Operant Conditioning – consequences of “operating” on the environment; reinforcements and punishments

- **Reinforcement** – increasing the likelihood that the behavior will be repeated
- **Punishment** – decreasing the likelihood of repetition, reinforcement is most effective when it immediately follows a behavior
- **Extinguished** – behavior returns to its original level when a response is no longer reinforced

Mowrer’s Two-Factor Theory of Avoidance Learning

– explains how fear-based avoidance behaviors are learned and maintained through a combination of classical conditioning and operant conditioning

- **Stage 1: Acquisition (Classical Conditioning)**
 - A neutral stimulus (like a specific sound or place) is paired with an unconditioned stimulus that naturally elicits a fear response (such as a painful shock)
 - Through this pairing, the neutral stimulus becomes a conditioned stimulus that, on its own, evokes fear (a conditioned response)
- **Stage 2: Maintenance (Operant Conditioning)**
 - Once the fear is conditioned, the individual learns to avoid the conditioned stimulus
 - Avoiding the stimulus provides relief from the fear and anxiety. This reduction of fear acts as a form of **negative reinforcement**
 - Because avoidance leads to the removal of an unpleasant feeling (fear), the behavior becomes more likely to occur in the future, thus



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maintaining the phobia or other avoidance behaviors

Association in Psychopathology

- Phobias: avoidance of the feared stimulus (e.g., a spider, an elevator, heights) provides immediate, though temporary, relief from anxiety
 - ◆ This relief reinforces the avoidance behavior, preventing the person from ever learning that the stimulus is not actually dangerous
 - ◆ The phobia, therefore, becomes a self-perpetuating cycle of fear and avoidance
- Obsessive-Compulsive Disorder (OCD): an obsession (e.g., "my hands are dirty" 🤢) causes intense anxiety. The person then performs a compulsion (e.g., washing their hands 🧼) to reduce that anxiety
 - ◆ The relief provided by the handwashing negatively reinforces the compulsive behavior, making them more likely to repeat it whenever they feel anxious

Social Learning – learning occurs through observation, imitation, and modeling, emphasizing that people learn by observing others and their consequences, rather than solely through direct experience

- Hitting Doll Experiment
- **Self-efficacy** – confidence in one's ability
- **Observational Learning** – people learn appropriate social behavior chiefly by observing and imitating models, that is, by watching other people
- **Social Cognitive Theory** – cognitive processes are at work as people observe models, learn chunks of behavior, and mentally put the chunks together into complex new behavior patterns

Learned Helplessness – how individuals (and animals) can develop a perceived lack of control over

their circumstances after repeated exposure to uncontrollable, adverse events

- Perceived Lack of Control
- Passivity and Reduced Motivation
- Emotional Symptoms

3 Dimensions of Reformulated Learned Helplessness Model

- **Internal** – internal failings
- **Stable** – "always be my fault"
- **Global** – extend across a variety of issues

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

Prepared Learning – we have become highly prepared for learning about certain types of objects or situations over the course of evolution because this knowledge contributes to the survival of the species

Hopelessness Theory – a negative expectation that highly desired outcomes will not occur, or that highly aversive outcomes will occur, and that one has no control over these outcomes

Primary Gain	Secondary Gain
Refers to the relief from psychological conflict or anxiety that a person experiences by developing physical or psychological symptoms (unconscious)	Are the external advantages or benefits a person receives as a result of their symptoms, often unconsciously
The symptoms act as a defense mechanism, allowing the individual to avoid dealing with	These benefits reinforce the continuation of the symptoms, as they provide some form of gratification or relief from other issues (unconscious or conscious)



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internal conflicts or
painful emotions.

D Cognitive Theories with Psychoanalytic (2)

Introjection – direct all their feelings for the loved one, including sadness and anger, toward themselves

- **Introjected Loss** – actual death of a person

Attributional Style – ways in which people explain the cause of events within their lives

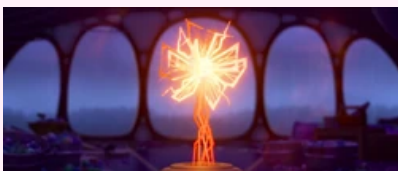
- **Internal vs. External** – Is the cause due to something about me (internal) or something outside of me (external)?
- **Stable vs. Unstable** – Is the cause permanent (stable) or temporary (unstable)?
- **Global vs. Specific** – Does the cause affect all areas of my life (global) or just this specific situation (specific)?

Cognitive Theory of Depression – depression is primarily caused and maintained by maladaptive or irrational ways of thinking

- Aaron Beck

Beck's Cognitive Triad

- **Negative view of the self** – tend to see themselves as flawed, inadequate, worthless, or unlovable



- **Negative view of the world/experiences** – perceive their experiences and the world around them as negative, depriving, or overwhelming
 - ◆ “No one cares about me”
- **Negative view of the future** – hold pessimistic and hopeless outlooks about the future, believing that their current

difficulties will continue indefinitely and that things will never improve

- ◆ “Things will never get better”

- **Negative Schema** – an enduring negative cognitive system about some aspects of life
- **Self-Blame Schema** – people feel personally responsible for every bad happening
- **False Consensus Effect/Bias** – people tend to overestimate the extent to which their opinions, beliefs, preferences, values, and habits are typical of others

Cognitive Distortions (Thinking Errors)

- **Dichotomous Thinking** – viewing situations in extreme terms, with no middle ground
 - ◆ “If I’m not perfect, I’m a total failure”
- **Overgeneralization** – drawing a sweeping conclusion based on a single negative event
 - ◆ “I failed this one test, so I’m going to fail all my exams and never succeed in life”
- **Selective Abstraction** – receiving many compliments but dwelling only on one minor criticism
- **Arbitrary Inference** – an individual concludes without sufficient or relevant evidence
- **Magnification (Catastrophizing) and Minimization** – exaggerating the importance of negative events while downplaying positive ones
 - ◆ “This minor setback is a disaster!”
- **Emotional Reasoning** – believing that what you feel must be true
 - ◆ “I feel like a failure, therefore I am a failure”
- **Labeling/Mislabeling** – attaching a global, negative label to oneself or others based on a single event or behavior
 - ◆ “I made a mistake, so I’m a complete idiot”
- **Personalization** – taking disproportionate blame for negative events, even when



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there are other contributing factors

- ◆ "It's my fault that the party wasn't fun"

→ **"Should" Statements** – holding rigid rules about how oneself and others "should" or "must" behave, leading to guilt, anger, or frustration when these rules are violated

- ◆ "I should always be happy and productive"

General Adaptation Syndrome Theory – is a widely recognized model that describes the body's universal and predictable physiological response to stress

- Hans Selye
- **Alarm Reaction Stage** – the initial shock phase, where the body mobilizes its resources to deal with the threat
- **Resistance Stage** – tries to adapt to the persistent stressor and return to a state of equilibrium (homeostasis), but it remains on high alert
- **Exhaustion Stage** – the body's ability to cope with stress becomes overwhelmed

Stress-Appraisal/Cognitive Appraisal Theory – stress is a two-way process; it involves the production of stressors and the response of an individual subjected to these stressors

- **Primary Appraisal:** "Is this a threat or a challenge?"
- **Secondary Appraisal:** "What can I do about it?"
 - Positive: I can do it if I do my best
 - Negative: I cannot do it

Memory Disorders

- **Anosognosia** – no memories of his own illness
- **Confabulation** – filling in memory gaps with imaginary experiences
- **Disorientation** – cannot identify or

recognize time, places, and persons

- **Deja Vu** – unfamiliar perceived as familiar
- **Jamais Vu** – familiar perceived as unfamiliar
- **Hypermnnesia** – increased memory
- **Paramnesia** – false perverted memory
- **Amnesia** – loss of memory

Type of Amnesia

- **Biogenic** – caused by brain damage or disease
 - **Retrograde Amnesia** – remote memory loss
 - **Anterograde Amnesia** – recent memory loss
- **Organic Amnesia (Neurological Amnesia)** – caused by physical damage or dysfunction to the brain
- **Dissociative Amnesia (Psychogenic Amnesia)** – involves an inability to recall important personal information, often related to a traumatic or stressful event
 - **Localized Amnesia** – cannot recall events within a specific, usually short, period (e.g., the hours immediately after a traumatic event)
 - **Selective Amnesia** – can recall some, but not all, events during a specific period
 - **Generalized Amnesia** – a rare and severe form where the individual forgets their entire life history, including their identity, name, and personal relationships
 - **Continuous Amnesia** – cannot recall events from a specific point in time up to the present
 - **Systematized Amnesia** – an individual loses memory for a specific category of information (e.g., all memories related to a particular person or a specific type of event, like childhood abuse)

Memory – the process by which we encode, store, and retrieve information



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- **Declarative** – factual information
- **Procedural** – skills and habits
- **Semantic** – general knowledge
- **Episodic** – events

Three-System Approach to Memory – information must travel if it is to be remembered

- **Sensory** – initial storage of information, perceived by the senses
- **STM** – holds info for 15 to 20 seconds
- **LTM** – stores on a relatively permanent basis

Chunks – meaningful grouping of stimuli that can be stored as a unit in STM

Rehearsal – repetition of information that has entered the STM

- **Repetitive** – stays in STM
- **Elaborative** – transfers to LTM

Tip-of-the-Tongue Phenomenon – inability to recall information that one realizes one knows

Retrieval Cue – allows us to recall more easily

- **Recall** – memory task with specific information is retrieved
- **Recognition** – the individual is presented with a stimulus and asked whether they have been exposed to it in the past or to identify it from the list of alternatives

Level of Processing Theory – the degree to which new materials are mentally analyzed

- **Implicit Memory** – can be recalled automatically without thinking
- **Explicit Memory** – requires conscious retrieval of information

Constructive Processes – memories are influenced by the meaning we give to them

- **Autobiographical** – episodes from our own lives
- **Flashbulb Memories** – specific or surprising events that are so vivid in memory it as if they represented a snapshot of the event

Forgetting – permits us to form general impressions

and recollections

- **Failure of Encoding** – failure to pay attention and place information in memory
- **Decay** – loss of information due to nonuse
- **Cue-Dependent Forgetting** – insufficient retrieval cues
- **Proactive Interference** – you forget the new information
- **Retroactive Interference** – you forget the old information

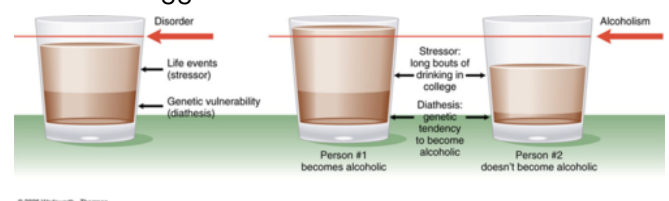
Lewinsohn's Behavioral Theory – depression is caused by a combination of stressors in a person's environment and a lack of personal skills

E

Diathesis-Stress Model (3)

Diathesis-Stress Model – individuals inherit tendencies to express certain traits or behaviors, which may then be activated under conditions of stress

- Eric Kandel
- **Diathesis** – a person's underlying predisposition or vulnerability to developing a particular disorder
- **Stress** – are environmental factors or life events that can trigger the onset or exacerbation of a disorder in someone with a diathesis
- Individuals with a strong diathesis may develop a disorder with relatively low levels of stress
- Individuals with a weaker diathesis may require more significant or prolonged stress to trigger a disorder





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4 Factors in Developing a Disorder

- **Predisposing Factor** – cause of a disorder
 - ◆ Underlying vulnerabilities or long-term influences that increase a person's risk of developing a particular mental health condition
 - ◆ "Why me?"
- **Precipitating Factor** – factors that allow the disorder to develop
 - ◆ The immediate triggers or specific events that lead to the onset or exacerbation of a mental health condition
 - ◆ "Why now?"
- **Protective Factor** – reduces the severity of the problems
 - ◆ Strengths, resources, and supportive elements that buffer against the development or worsening of a mental health condition, or that promote recovery
 - ◆ "What can I rely on?"
- **Perpetuating Factor** – maintain the problem once established
 - ◆ Ongoing influences that maintain or worsen the mental health condition once it has developed, preventing recovery
 - ◆ "Why does it continue?"

F

Gene-Environment Interaction (2)

Gene-Environment Interaction – the effect of the environment depends on the genotype

- e.g., stress affects people with gene A more than people with gene B

Gene-Environment Correlation Model – genotypes influence their exposure to certain environments

- It proposes that nature and nurture are not independent forces but rather are constantly intertwined, with our genes often shaping the very environments we experience

- **Reciprocal Gene-Environment Model** – claims that people with a genetic predisposition to a disorder may also have a genetic tendency to create environmental factors that promote the disorder

3 Kinds of Gene-Environment Correlation Model

- **Passive Gene-Environment Correlation** – Parents provide both genes and an environment correlated with those genes
 - ◆ E.g., musically inclined parents provide musical genes and a home with musical instruments
- **Evocative Gene-Environment Correlation (or Reactive)** – a child's genetically influenced traits evoke certain responses from others
 - ◆ E.g., a cheerful child evokes more positive attention
- **Active Gene-Environment Correlation (or Niche-Picking)** – individuals actively select environments that are compatible with their genetic predispositions
 - ◆ E.g., an extroverted person seeks out social gatherings

G

Role of Culture, Social Interactions, and Interpersonal in the Development of Psychological Disorder (1)

- Culture defines what is considered "normal" or "abnormal" behavior
- Behaviors that might be deemed pathological in one culture could be accepted or even celebrated in another
- In some cultures, mental health issues are seen as weaknesses, moral failings, or even spiritual problems, leading to reluctance to seek professional help and increased shame
- Strong, positive social connections (friends, family, community) act as a powerful protective factor against psychological



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Main References: Barlow & Durand 8th ed.; Kring et al., 14th ed.; DSM-5/5-TR

disorders

- Lack of social interaction, loneliness, and social isolation are major risk factors for various mental health conditions, including depression, anxiety, and even physical health problems
- Exposure to substance abuse, risky behaviors, or negative peer groups can increase the likelihood of developing certain disorders
- Early relationships with primary caregivers (attachment) are crucial. Secure attachments foster a sense of safety, trust, and healthy emotional regulation, while insecure attachments can contribute to difficulties in future relationships, anxiety, and other disorders
- Chronic conflict, abuse, neglect, or lack of support within family, romantic, or close friendships can be significant stressors and perpetuating factors for psychological disorders
- Experiences like the death of a loved one, divorce, or betrayal can precipitate psychological distress and disorders like depression or PTSD
- The quality of the therapeutic relationship itself (e.g., in psychotherapy) is a significant factor in successful treatment and recovery, demonstrating the healing power of positive interpersonal connections

Suicide – self-inflicted death in which the person acts intentionally, directly, and consciously

- **Death Seekers** – clearly intend to end their lives at the time they attempt suicide
- **Death Initiators** – clearly intend to end their lives, but they act out of a belief that the process is already underway and that they are simply hastening the process
- **Death Ignorers** – do not believe that their self-inflicted death will mean the end of

their existence

- **Death Darers** – experience mixed feelings, or ambivalence about their intent to die, even at the moment of their attempt, and they show this ambivalence in the act itself
- **Subintentional Death** – a death in which the victim plays an indirect, hidden, partial, or unconscious role
- **Suicidal Ideation** – thinking seriously about suicide
- **Suicidal Plans** – formulation of a specific method for killing oneself
- **Suicidal Attempts** – the person survives attempts

Emile Durkheim's Suicide Types

1. **Egoistic Suicide: Too Little Social Integration** – happens when a person feels extremely isolated and detached from their community, family, or social groups
2. **Altruistic Suicide: Too Much Social Integration** – occurs when a person is too integrated into a group, and their individual life is seen as less important than the group's goals or honor
3. **Anomic Suicide: Too Little Social Regulation** – happens when society's rules, norms, or expectations suddenly break down or become unclear
4. **Fatalistic Suicide: Too Much Social Regulation** – a person's life is excessively controlled, oppressive, and without any hope or freedom

THERAPEUTIC INTERVENTIONS OF PSYCHOLOGICAL DISORDERS (10)

DEFINITION OF TERMS

- **Idiographic Data** – specific details and background information
- **Nomothetic** – broad information, nature, and treatment
- **Treatment** – a.k.a therapy, a procedure designed to change abnormal behavior to a more normal behavior



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Main References: Barlow & Durand 8th ed.; Kring et al., 14th ed.; DSM-5/5-TR

A

Different Psychological Interventions (3)

Psychodynamic Interventions

- **Free Association** – the client is encouraged to say whatever comes to mind without censorship, regardless of how trivial or illogical it may seem
- **Transference** – unconscious redirection of feelings and attitudes from a significant person in the client's past (e.g., a parent) onto the therapist
- **Resistance** – conscious or unconscious opposition by the client to the therapeutic process or to exploring certain thoughts or feelings
- **Dream Interpretation** – where the therapist helps the client explore the symbolic meanings of their dreams
 - **Manifest** – consciously remembered dream
 - **Latent** – meaning
- **Catharsis** – process of releasing, and thereby providing relief from, strong or repressed emotions
- **Working Through** – confronting, clarifying, and integrating insights into one's understanding of self and relationships, leading to lasting change
- **Short-term Psychodynamic Therapies** – a more focused and time-limited approach to psychodynamic therapy, often targeting specific problems or relational patterns rather than a complete overhaul of the personality
- **Relational Psychoanalytic Therapy** – focuses on how past and present relationships shape the individual's sense of self and interactions
- **Hypnotherapy** – use of hypnosis to induce a state of heightened suggestibility and relaxation, allowing access to the subconscious mind to address psychological

or physical issues

- **Play Therapy** – primarily used with children, where play is utilized as a natural medium for expression and communication

Humanistic

- **Client-Centered Therapy** – therapist provides a non-directive, empathic, and genuinely accepting environment to facilitate the client's self-exploration and actualization
- **Support Group** – a gathering of individuals who share a common experience or concern, providing mutual support, understanding, and encouragement
- **Home-Based Self-Help Programs** – programs or materials (e.g., workbooks, online resources) that individuals can use independently at home to address specific psychological concerns or promote well-being
- **Social Skills Therapy** – helps individuals develop and improve their interpersonal communication, assertiveness, and other social competencies to navigate social situations more effectively
- **Family Therapy** – works with families as a system to address communication patterns, relational dynamics, and conflicts that affect individual members and the family as a whole
 - **Maudsley Model** – a specific, intensive family therapy approach primarily used for adolescents with anorexia nervosa
- **Psychological Debriefing** – structured intervention, typically offered soon after a traumatic event, designed to reduce the risk of post-traumatic stress disorder (PTSD) by allowing individuals to recount their experiences and normalize their reactions
 - Note: Its effectiveness is debated and



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Main References: Barlow & Durand 8th ed.; Kring et al., 14th ed.; DSM-5/5-TR

sometimes considered potentially harmful if not done carefully

- **Interpersonal Psychotherapy** – time-limited therapy that focuses on improving interpersonal relationships and social functioning to alleviate psychological symptoms (particularly depression)
- **Motivational Interviewing** – a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence
- **Milieu Therapy** – a therapeutic approach that involves structuring the entire environment (e.g., a hospital ward, residential facility) to be therapeutic
- **Parent Management Training** – a behavioral intervention that teaches parents specific skills and strategies to manage their children's challenging behaviors and improve family relationships
- **Gestalt Therapy** – holistic, experiential therapy that emphasizes present moment awareness ("here and now"), personal responsibility, and the integration of fragmented aspects of the self
- **Interpersonal Social Rhythm Therapy** – specific therapy for bipolar disorder that combines interpersonal psychotherapy with a focus on regulating daily routines and social rhythms (e.g., sleep, wake, meal times) to stabilize mood

Cognitive

- **Cognitive Behavioral Therapy** – focuses on identifying and changing distorted thinking patterns and problematic behaviors
 - **Rational-Emotive Behavioral Therapy** – a highly directive form of CBT that challenges irrational beliefs and helps individuals develop more rational and self-helping thoughts,

feelings, and behaviors

- **Mindfulness-Based CBT** – teaches individuals to observe their thoughts and feelings without judgment, fostering a sense of detachment from negative cognitive patterns
- **Cognitive Remediation** – a set of interventions designed to improve cognitive functions such as attention, memory, executive functioning, and problem-solving, often used in conditions like schizophrenia or traumatic brain injury
- **Panic Control Treatment** – specific CBT protocol for panic disorder that involves psychoeducation, interoceptive exposure (exposure to physical sensations of panic), and cognitive restructuring
- **Enhanced CBT (CBT-E)** – a transdiagnostic form of CBT developed for eating disorders, addressing the core psychopathology of eating disorders and relevant maintaining mechanisms
- **Hallucination Reinterpretation and Acceptance** – a cognitive therapy approach for psychosis that helps individuals reframe their understanding of hallucinations, reducing distress and encouraging acceptance rather than fighting or fearing them
- **Dialectical Behavior Therapy** – a comprehensive CBT-based treatment developed for Borderline Personality Disorder, emphasizing distress tolerance, emotion regulation, interpersonal effectiveness, and mindfulness skills
- **Neutralizing** – often seen in OCD, where an



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individual performs a mental or behavioral act to “undo” or cancel out the perceived negative consequences of an intrusive thought or obsession

- **Exposure and Response (Ritual) Prevention** – where individuals are gradually exposed to anxiety-provoking stimuli or situations while being prevented from engaging in their typical compulsive rituals or avoidance behaviors
- **Beck’s Cognitive Therapy** – focusing on identifying and challenging “automatic thoughts” and underlying dysfunctional core beliefs that contribute to emotional problems
- **Aversion Therapy** – pairs an undesirable behavior with an unpleasant stimulus to reduce the frequency of that behavior
- **Relapse-Prevention Therapy** – teaches individuals to identify high-risk situations, develop coping strategies, and manage cravings or urges to prevent a return to problematic behaviors
- **Cognitive Processing Therapy** – helps individuals process traumatic memories and challenge distorted beliefs related to the trauma, such as self-blame or safety concerns
- **Mentalization** – helps individuals improve their ability to reflect on their own and others’ internal experiences
- **Affectual Awareness** – it involves helping clients become more attuned to their emotional states and the underlying meaning of those emotions
- **Positive Family Interaction Therapy** – focuses on enhancing positive communication, warmth, and supportive interactions within families, aiming to build family strengths and improve overall well-being

Biological

- **Sedative-Hypnotic Drugs** – a class of drugs that depress the central nervous system, leading to calming (sedative) or sleep-inducing (hypnotic) effects
 - **Benzodiazepines** – common type of sedative-hypnotic drug that enhances the effect of the neurotransmitter GABA, leading to reduced anxiety and muscle relaxation
 - **Barbiturates** – an older class of sedative-hypnotic drugs that are highly addictive and have a narrow therapeutic window, now largely replaced by benzodiazepines due to safety concerns
- **Antidepressants** – primarily work by affecting neurotransmitters like serotonin, norepinephrine, and dopamine in the brain
- **Antipsychotics** – primarily work by blocking dopamine receptors
- **Vagus Nerve Stimulation** – involves implanting a device that sends electrical impulses to the vagus nerve in the neck
- **Electroconvulsive Therapy** – involving the induction of a controlled seizure by passing small electrical currents through the brain
- **Transcranial Magnetic Stimulation** – a non-invasive brain stimulation technique that uses magnetic fields to stimulate nerve cells in the brain
- **Mood Stabilizers** – a class of medications primarily used to treat bipolar disorder by helping to regulate mood swings (both manic and depressive episodes)
 - **Lithium** – reduces the frequency and severity of manic and depressive episodes
- **Detoxification** – the process of safely withdrawing from a substance of abuse



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under medical supervision

- **Disulfiram** – produces an unpleasant reaction (nausea, vomiting, flushing) when alcohol is consumed, deterring individuals from drinking
- **Antagonist Drug** – blocks or reverses the effects of another drug or a natural substance in the body by binding to and blocking receptor sites
- **Antianxiety** – used to reduce anxiety
- **SSRIs** – a common class of antidepressant medications that work by increasing the amount of serotonin in the brain by blocking its reabsorption

Behavioral

- **Exposure Treatment** – it involves systematically exposing individuals to feared objects, situations, or memories in a safe and controlled environment to help them habituate to the anxiety and learn that the feared stimulus is not dangerous
 - **Virtual Therapy/Virtual Reality Treatment** – use of virtual reality technology to create immersive and interactive environments for therapeutic purposes
 - **Prolonged Exposure** – involves imaginal exposure (repeatedly recounting the traumatic memory) and in vivo exposure (confronting situations, people, or objects that trigger fear related to the trauma)
 - **Eye Movement Desensitization and Reprocessing** – involves recalling distressing memories while simultaneously engaging in bilateral stimulation (e.g., eye movements, tapping), which is thought to help process and integrate the traumatic memory

- **Participant Modeling** – a therapist models the desired behavior for the client, and then guides the client through performing the behavior themselves
- **Interoceptive Exposure** – involves intentionally inducing physical sensations that are similar to those experienced during a panic attack (e.g., dizziness, shortness of breath) to help the individual habituate to these sensations and learn that they are not dangerous
- **Systematic Desensitization** – involves teaching relaxation techniques and then gradually exposing the individual to increasingly anxiety-provoking situations (either real or imagined) while maintaining a relaxed state, eventually leading to desensitization
- **Following (Implosive Therapy)** – involves prolonged and intense exposure to a feared object, situation, or memory without the opportunity to escape or avoid it
- **Token Economy Programs** – individuals earn “tokens” (e.g., points, chips) for engaging in desired behaviors, which can then be exchanged for tangible rewards or privileges
- **Contingency Management** – uses systematic reinforcement (rewards) or punishment to increase desirable behaviors and decrease undesirable ones

B

Illustrate the Application of Psychological Interventions for Treatment (5)

Disorder

Treatment

IDD

Augmentative



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Main References: Barlow & Durand 8th ed.; Kring et al., 14th ed.; DSM-5/5-TR

	Communication Strategies Behavioral Therapy Cognitive Therapy Psychodynamic Therapy Family Education Social Intervention
Language Disorder	May be self-correcting and may not (be) require special intervention
Childhood-Onset Fluency Disorder (Stuttering)	Regulated-breathing method Altered auditory feedback Psychosocial Therapy
Social (Pragmatic) Communication Disorder	Individualized social skills training
Autism Spectrum Disorder	No completely effective treatment exists Major tranquilisers and SSRIs Behavioral approaches Naturalistic teaching strategies Incidental teaching Pivotal response training Milieu teaching Behavior therapy combined with pharmacologic treatment CBT UCLA/Lovaas-based Model Early Start Denver Model Parent Training Approaches Social Skills Approaches Treatment and education of autistic and communication-related handicapped children Broad-based approaches Computer-based approaches and virtual reality Neurofeedback Management of insomnia

ADHD	Methylphenidate (Ritalin, Adderall) Other non-stimulant medications: Atomoxetine (Strattera), Guanfacine (Tenex), and Clonidine Improving academic performance Decreasing disruptive behavior Social skills training Reinforcement programs Parent education programs CBT
Specific Learning Disorder	Methylphenidate (Ritalin, Adderall) Restricted to individuals who may also have comorbid ADHD Specific skills instructions Strategy instruction Direct instruction Remedial treatment
Motor Disorders	Self-monitoring Relaxation training Habit reversal Sensory integration programs Modified physical education
Delirium	Antipsychotic medications
Separation Anxiety Disorder	CBT Exposure Therapy Relaxation Techniques
Selective Mutism	Behavior Therapy
Specific Phobia	Behavior Therapy Insight-Oriented Therapy Virtual Therapy Exposure Therapy Systematic Desensitization In-Vivo (real life) Exposure Other Therapeutic Modalities



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Main References: Barlow & Durand 8th ed.; Kring et al., 14th ed.; DSM-5/5-TR

	Hypnosis
Social Anxiety Disorder	Paxil (SSRI) or Zoloft (SSRI) Effexor (SSRI) D-cycloserine (DCS) + CBT treatments = enhanced effect of treatment Cognitive therapy program Interpersonal Psychotherapy (IPT) Family-based treatment Cognitive retraining, desensitization, rehearsal during sessions, and a range of homework assignments Role-playing Social skills training
Panic Disorder	Gradual exposure exercises, combined with anxiety-reducing coping mechanisms such as relaxation or breathing retraining Panic Control Therapy CBT
Agoraphobia	Supportive Psychotherapy Insight-Oriented Psychotherapy Behavior Therapy CBT Virtual Therapy
GAD	Anxiolytics (sedatives, minor tranquilizers) Benzodiazepines Antidepressants (SSRIs) Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs) Behavior, Cognitive & Psychodynamic Therapies Using images Relaxing deeply to combat tension
RAD	Behavior Management

	Training (BMT) Attachment Therapy Holding Therapy Holding Therapy Play Therapy
DSED	Talk Therapy Play Therapy Art Therapy Behavioral Management Training Parent-Child Interaction Therapy CBT
PTSD Acute Stress Disorder	SSRIs: Prozac, Paxil Hospitalization Cognitive Processing Therapy Prolonged Exposure Therapy Stress Management Eye Movement Desensitization and Reprocessing Group Therapy Family Therapy Catharsis Imaginal Exposure
Adjustment Disorder	Group Therapy Individual Psychotherapy Short-term treatments
OCD	Deep Brain Stimulation Clomipramine (a.k.a Anafranil) Antidepressant SSRIs Behavior therapy Exposure and Ritual Prevention Cognitive Treatments Neurosurgery
BDD	Clomipramine (a.k.a Anafranil) Fluvoxamine CBT Dermatology (skin) treatment



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	Plastic surgery
Hoarding Disorder	Exposure and Ritual Prevention CBT Motivational interviewing Teaching people to assign different values to objects Reducing anxiety about throwing away items (with less value)
Trichotillomania Excoriation	SSRIs Habit Reversal Training Behavior Therapy Hypnotherapy
SSD IAD	Antidepressant (SSRI) Patients with this disorder usually resist psychiatric treatment Schedule a physical examination Group Psychotherapy CBT Reassurance and education Reducing the frequency of help-seeking behaviors Individual Insight-Oriented Psychotherapy, Behavior Therapy, Cognitive Therapy, and Hypnosis
Psychological Factor Affecting Medical Condition	Stress Management and Relaxation Therapy CBT Aware, educate, teach Stress Management Training
Conversion Disorder	Insight-oriented therapy and Psychoanalysis Behavior Therapy Hypnosis, anxiolytics, and behavioral relaxation exercises
Factitious Disorder	No specific treatment has

	been effective Treatment is best focused on management rather than on cure Legal intervention
Pica	Nutrition Counseling
Rumination Disorder	Behavior Modification Habit Reversal Training Diaphragmatic Breathing Exercises
ARFID	CBT-AR (CBT for avoidant/restrictive disorder) Family-Based Therapy Occupational Therapy
Anorexia Nervosa	Nutritional Rehabilitation Tube & Intravenous Feedings Motivational Interviewing Restore the patient's weight CBT Cognitive-Behavioral Therapy-Enhanced Family-based Treatment
Bulimia Nervosa	Fluoxetine (Prozac) Antidepressants Nutritional Rehabilitation Short-term cognitive-behavioral treatments Cognitive-Behavioral Therapy-Enhanced Exposure and Response Prevention Interpersonal Psychotherapy
Binge-Eating Disorder	Antidepressants CBT For Obesity: Bariatric Surgery
Enuresis	Desmopressin Tricyclic Antidepressants Urine Alarm (Bell and Pad) Dry Bed Training



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	Fluid Management Scheduled Voiding Bladder Training Exercises Positive Reinforcement Hypnotherapy Counseling/Therapy Parent Education and Support
Encopresis	Disimpaction Maintenance Therapy Dietary Changes Scheduled Toilet Sitting Positive Reinforcement Bowel Retraining Education and Demystification Symptom Diary Biofeedback CBT Parent Education and Support
Insomnia Disorder	Benzodiazepine Triazolam (Halcion) Zaleplon (Sonata) Zolpidem (Ambien) Flurazepam (Dalmane) Cognitive Therapy Guided Imagery Relaxation Graduated Extinction Paradoxical Intention Progressive Relaxation
Hypersomnolence Disorder	Amphetamine Methylphenidate Modafinil Antidepressants Monoamine Oxidase Inhibitors (MAOIs)
Narcolepsy	Stimulants Amphetamines Antidepressants (SNRIs, SSRIs) Sodium Oxybate Histamine-affecting Drugs
Breathing-Related Sleep Disorders	Polysomnography Home sleep apnea testing

	Positive Airway Pressure (PAP) Non-Invasive Ventilation (NIV)
Circadian Rhythm Sleep-Wake Disorder	Phase delays (moving bedtime later) Phototherapy Stimulus Control Progressive relaxation or sleep hygiene CBT Sleep restriction
Parasomnias	Benzodiazepines Tricyclic Prazosin Melatonin Clonazepam (Klonopin) Schedule Awakening Hypnosis Relaxation Therapy CBT Imagery Rehearsal Therapy (IRT)
SUDs	First step: help someone through the withdrawal process Ultimate goal: abstinence Sedative drug (benzodiazepines) Clonidine Nicotine Replacement Therapy Agonist Substitution Aversive Treatment Psychosocial Treatments
ODD IED CD	Family Intervention CBT Individual psychotherapy
Pyromania Kleptomania	Family Therapy CBT Antidepressants: Naltrexone Systematic desensitization, Aversive Conditioning



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Dissociative Disorders	Benzodiazepines Psychoanalytic Therapy Cognitive Therapy Hypnosis Movement Therapy Occupational Therapy Electroconvulsive Therapy Group Therapy
Delayed Ejaculation	Include techniques to reduce performance anxiety and increase stimulation
Erectile Disorder	Sildenafil (Viagra) Tease Technique
Female Orgasmic Disorder	Directed Masturbation Training
Female Sexual Interest/Arousal Disorder	Estrogen Therapy Androgen Therapy Flibanserin (Addyi) Bremelanotide (Vyleesi) Mindfulness-Based Cognitive Therapy (MBCT)
Genito-Pelvic Pain/Penetration Disorder	Practice tightening and relaxing vaginal muscles Gradual behavioral exposure treatment Botox
Male Hypoactive Sexual Desire Disorder	Sildenafil (Viagra) Levitra Cialis Injection of vasodilating drugs Surgery Vacuum Device Therapy Basic education Senate focus Nondemand pleasuring
Premature (Early) Ejaculation	SSRIs Squeeze Technique Stop, Start, or Pause Procedure

Paraphilic Disorders	Cyproterone acetate Medroxyprogesterone (Depo-Provera is the injectable form) Covert sensitization Organismic reconditioning Relapse prevention
Gender Dysphoria	Psychological evaluation and education Administration of gonadal hormones to bring about desired secondary sex characteristics Sex Reassignment Surgery Gynecomastia Hormonal Replacement Therapy Actively affirming and encouraging cross-gender identification
Bipolar I & II Disorder Cyclothymic Disorder	Lithium Carbonate (Lithium) Antipsychotic Medication (Olanzapine) Interpersonal and Social Rhythm Therapy Sleep Deprivation
DMDD	Stimulants Antidepressants (SSRIs) Atypical antipsychotic medications CBT Dialectical Behavior Therapy for Children Computer Training Parent Training
MDD PDD	Antidepressants Electroconvulsive Therapy Transcranial Magnetic Stimulation Vagal Nerve Stimulation Cognitive Therapy CBT



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	Interpersonal Psychotherapy Behavioral Activation Therapy Psychoanalytically Oriented Therapy Family Therapy Phototherapy Sleep Deprivation
PMDD	Antidepressants (SSRIs or SNRI) Hormone therapies or medications Aerobic exercise Consumption of complex carbohydrates and frequent meals Relaxation training Light therapy Sleep deprivation CBT
Paranoid PD	CBT Anxiety-reduction Techniques Antipsychotic Drugs
Schizoid PD	Social Skills Program Group Therapy CBT
Schizotypal PD	CBT Speech Lessons Social Skills Training Antipsychotic Drug
Antisocial PD	Antipsychotic Drugs, CBT
Borderline PD	Relational Psychoanalytic Therapy DBT Mentalization Antidepressant, Antipsychotic, Antianxiety antipsychotic
Histrionic PD	CBT Psychodynamic Therapy Group Therapy

Avoidant PD Dependent PD	CBT Psychodynamic Therapy Exposure Treatments Antianxiety Antidepressant Short-term psychotherapy
OCPD	SSRIs
Schizophrenia and Other Psychotic Disorders	Antipsychotic Medications Insulin Coma Therapy Psychosurgery Electroconvulsive Therapy Transcranial Magnetic Stimulation Reattach/Complex social skills, Role-playing Virtual assessments and treatments Behavioral Family Therapy Vocational rehabilitation Assertive Community Treatment Program Social Skills Training Case Management CBT Individual Psychotherapy Personal Therapy Dialectical Behavior Therapy Art Therapy Cognitive Training or Remediation

C

Evaluate the Efficacy of Psychological Interventions (2)

Psychodynamic Interventions

- Research over the past few decades has increasingly supported the efficacy of psychodynamic therapies for a range of conditions
- Contrary to earlier beliefs, many studies now suggest that psychodynamic therapy can be as effective as other established treatments,



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including CBT, for various mental health conditions like depression, anxiety disorders, and some personality disorders (e.g., borderline personality disorder with structured approaches)

- A notable aspect often highlighted is that the benefits of psychodynamic therapy can be long-lasting and continue to develop even after treatment ends, possibly due to its focus on deeper personality changes and self-knowledge, beyond just symptom reduction
- Assessing the full efficacy can be challenging because it aims for broader outcomes like personality change and improved relational patterns, which are harder to quantify than specific symptom reduction
- Short-term psychodynamic therapies have also shown effectiveness for specific issues, offering a more time-limited approach
- Relational psychoanalytic therapy, while newer, also emphasizes the therapeutic relationship as a core mechanism of change

Humanistic Interventions

- Humanistic-experiential psychotherapies, including client-centered therapy and Gestalt therapy, have solid data proving their effectiveness and efficacy
- Meta-analyses show significant improvement in clients and equivalent effectiveness when compared to other therapeutic approaches
- These therapies are often growth-oriented rather than solely problem-oriented, aiming to empower individuals to achieve personal growth, self-actualization, and a greater sense of meaning and purpose
- Approaches like Emotionally Focused Therapy (EFT), which has humanistic roots, have strong evidence for treating relationship issues and couple distress
- While effective for a broad range of difficulties,

including relationship issues, self-damaging activities, and coping with chronic medical conditions, some meta-analyses show more controversial data regarding the treatment of depression specifically, compared to other therapies

- The lack of a rigid structure can be a disadvantage for clients seeking quick, specific symptom reduction

Cognitive Interventions

- Cognitive Behavioral Therapy (CBT) is considered one of the most extensively researched and empirically supported psychological treatments. It is widely recognized as the “gold standard” for many mental health conditions
- CBT and its variations (like REBT, DBT, MBCT, CPT) have demonstrated strong efficacy for a very wide range of disorders, including:
 - Anxiety Disorders: Generalized Anxiety Disorder, Panic Disorder, Social Anxiety Disorder, Specific Phobias, OCD, PTSD (with specific protocols like ERP and CPT)
 - Mood Disorders: Depression (including severe depression), Bipolar Disorder (often in combination with medication)
 - Eating Disorders: CBT-E is particularly effective
 - Substance Use Disorders: Highly effective for relapse prevention and managing cravings
 - Insomnia, Chronic Pain, and other medical conditions
- CBT is highly structured, goal-oriented, and often time-limited, which can make it more accessible and cost-effective. It teaches concrete skills that clients can use independently
- Its focus on identifiable thoughts and behaviors allows for relatively straightforward measurement of outcomes
- Dialectical Behavior Therapy (DBT), a highly



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specialized form of CBT, has strong evidence for treating Borderline Personality Disorder and other conditions involving severe emotion dysregulation and self-harm

Biological Interventions

- Biological interventions, primarily psychopharmacology (medications), are highly effective for many severe mental illnesses and are often a first-line or crucial adjunctive treatment
- They work by directly affecting brain chemistry and function
- Medications:
 - Antidepressants: very effective for moderate to severe depression, anxiety disorders, and OCD
 - Antipsychotics: essential for managing positive symptoms (e.g., hallucinations, delusions) in psychotic disorders like schizophrenia and acute manic episodes in bipolar disorder
 - Mood Stabilizers (e.g., Lithium): highly effective in preventing mood swings in bipolar disorder
 - Benzodiazepines/Sedative-Hypnotics: effective for acute anxiety and insomnia, but their use is often limited due to dependence potential and side effects.
- Brain Stimulation Therapies:
 - Electroconvulsive Therapy (ECT): considered one of the most effective treatments for severe, treatment-resistant depression, severe mania, and catatonia, often yielding rapid and significant improvement
 - Transcranial Magnetic Stimulation (TMS): an effective non-invasive option for treatment-resistant depression, with fewer side effects than ECT
 - Vagus Nerve Stimulation (VNS): an option for long-term treatment-resistant

depression, though its effects are typically more gradual

- For many severe conditions (e.g., severe depression, bipolar disorder, schizophrenia), the combination of medication and psychotherapy often yields better outcomes than either treatment alone

Behavioral Interventions

- Behavioral therapies are highly effective, particularly for anxiety disorders, phobias, and obsessive-compulsive disorder. They are firmly rooted in learning theory and directly target maladaptive behaviors
 - Exposure-Based Treatments (Exposure Treatment, Prolonged Exposure, Systematic Desensitization, Flooding, Interoceptive Exposure): these are among the most robustly supported interventions for anxiety disorders, phobias (e.g., specific phobias, social anxiety disorder), and PTSD
 - Eye Movement Desensitization and Reprocessing (EMDR): has strong evidence for the treatment of PTSD
 - Token Economy Programs and Contingency Management: highly effective for behavioral management, particularly in structured environments or for substance use disorders, by systematically applying reinforcement principles
- The mechanisms of change in behavioral therapies are often clear and directly observable, focusing on changing specific behaviors through techniques like habituation, counterconditioning, and reinforcement
- A promising and increasingly utilized behavioral intervention, especially for exposure therapy for phobias and PTSD, showing comparable efficacy to in-vivo exposure



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General Considerations for Efficacy

- The “gold standard” in mental health care emphasizes using treatments supported by the best available research evidence, clinician expertise, and patient values/preferences
- The therapist’s competence, empathy, and the quality of the therapeutic alliance (the collaborative relationship between therapist and client) are consistently found to be significant predictors of positive outcomes across various therapeutic modalities
- Client motivation, readiness for change, and the severity and complexity of the presenting issues also influence treatment outcomes
- How closely the therapy is delivered according to its established protocol (treatment fidelity) can impact its efficacy
- Many individuals present with more than one mental health condition (comorbidity), which can complicate treatment and influence outcomes. Some therapies, like CBT and DBT, have transdiagnostic applications, meaning they can address common underlying processes across different disorders

SOCIO-CULTURAL FACTORS AND ETHICAL PRINCIPLES IN DIAGNOSIS CASES OF ABNORMAL BEHAVIOR (5)

STIGMA – refers to the destructive beliefs and attitudes held by a society that are ascribed to groups considered different in some manner, such as people with psychological disorders

The Four Characteristics of Stigma

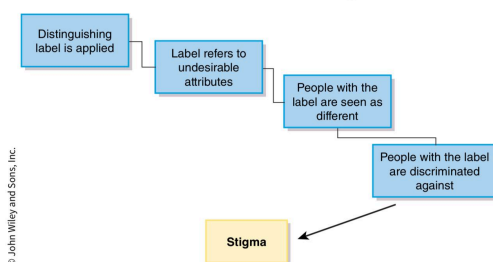


FIGURE 1.1 The four characteristics of stigma.

A

Identifying Socio-Cultural Factors (2)

Culture-Bound Syndromes – are patterns of atypical behavior and distressing experiences that are specific to certain cultural groups or localities

- **Locality-Specific** – they are typically found in a particular region, ethnic group, or cultural community
- **Not Always Directly Mappable to Western Diagnoses** – the overall constellation of symptoms, the cultural interpretation, and the traditional healing practices associated with them are distinct
- **Culturally Sanctioned Explanations** – the symptoms and their causes are often explained through cultural beliefs about the body, spirit, social relationships, or supernatural forces
- **Influence on Help-Seeking** – often influences how individuals seek help (e.g., from traditional healers, shamans, or spiritual leaders)

Examples of Culture-Bound Syndromes (Cultural Concepts of Distress)

- **Ataque de Nervios** (Latin America/Caribbean) – translated as “attack of nerves,” this syndrome is a culturally recognized response to stressful events, particularly those involving family or loss
 - Symptoms can include uncontrollable shouting, crying, trembling, heat in the chest rising to the head, and verbal or physical aggression
- **Koro** (Southeast Asia, China) – an intense, irrational fear that one’s genitals are retracting into the body and will disappear, often believed to lead to death
- **Amok** (Malaysia, Indonesia, Philippines) – characterized by a sudden, often unprovoked, violent outburst, usually following a period of brooding or perceived insult, often involving attacking others



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indiscriminately, followed by exhaustion, amnesia, and sometimes death

- **Susto** (Latin America) – meaning “fright” or “soul loss,” this illness is attributed to a frightening event that causes the soul to leave the body
 - Symptoms include appetite disturbances, inadequate or excessive sleep, troubled dreams, sadness, lack of motivation, and physical complaints like muscle aches and stomach aches
- **Taijin Kyofusho** (Japan) – intense fear that one’s body, its parts, or its functions (e.g., body odor, facial expression, eye contact) are displeasing, embarrassing, or offensive to other people
- **Dhat Syndrome** (India and South Asia) – common anxiety and hypochondriacal concern among men related to the discharge of semen
- **Hikikomori** (Japan) – severe social withdrawal, where individuals isolate themselves from society, often remaining in their homes for months or even years, avoiding social interaction and participation
- **Latah** (Southeast Asia) – a hypersensitivity to sudden fright, often leading to exaggerated startle responses, involuntary actions, echolalia (repeating words), and automatic obedience to commands
- **Khyal Cap** (Cambodia) – panic attacks
- **Maladi Moun (Haiti)** – sent sickness; interpersonal envy and malice cause people to harm their enemies by sending illness
- **Shenjing Shuairuo** – weakness, emotions, excitement, nervous pain, and sleep
- **Dissociative Trance** – counterpart of DID in eastern countries; *sapi*

strive to understand, respect, and effectively address the diverse cultural backgrounds, beliefs, values, and practices of their patients

- Patients must fully understand the purpose, procedures, potential risks, and benefits of the diagnostic process and proposed treatment
- This information should be presented in a culturally appropriate and understandable manner, considering language proficiency and educational background
 - Informed consent when:
 - When conducting research, providing assessment, therapy, counseling, or consultation
 - For legally incapable, they must provide an appropriate explanation, obtain assent, consider the client’s preferences and best interests, and obtain permission from a legally authorized person
 - If court orders, they must inform the nature of the services, whether it is a court order or mandated, as well as its limits of confidentiality before proceeding
 - Must document written or oral consent, permission, and assent
 - Informed Consent, except: mandated by the law, routine, evaluating decisional capacity
- Maintaining secure records and sharing information only with authorized individuals, while also being mindful of cultural norms around privacy and family involvement
 - Exemptions from disclosure
 - If the client is disguised or the identity is protected
 - Has consent
 - Legally mandated
- Clinicians must be vigilant against diagnostic biases stemming from cultural assumptions, stereotypes, or a lack of understanding of a patient’s cultural context
- Non-Maleficence (Do No Harm)
 - The diagnostic process should not cause harm
 - Misdiagnosis can lead to

B Ethics (2)

- Mental health professionals must actively



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inappropriate or ineffective treatment, stigmatization, and negative life consequences (e.g., impact on employment, social relationships)

- Beneficence (Do Good)
 - The diagnosis should aim to benefit the individual by leading to effective and culturally sensitive interventions that improve their well-being
- Justice
 - Ensuring equitable access to quality mental healthcare and diagnostic services for all individuals, regardless of their cultural background, socioeconomic status, or other social identities. This includes addressing systemic inequalities in healthcare
- Respect for Rights and Dignity
 - Upholding the autonomy and dignity of the individual, respecting their cultural beliefs, values, and choices, even if they differ from the clinician's own
 - Challenging stigmatizing beliefs and educating patients and communities about mental health
- Professional Competence and Ongoing Learning
 - Clinicians have an ethical responsibility to continuously update their knowledge and skills, particularly in cultural competence, to provide the best possible care in an increasingly diverse world
- **Telepsychology** – provision of psychological services using telecommunication technologies

GLOBAL HEALTH CRISIS (COVID-19) AND MENTAL HEALTH LAW (RA 11036) (10)

GLOBAL HEALTH CRISIS (COVID-19) AND ITS IMPACT ON MENTAL HEALTH IN THE PHILIPPINES

- Fear of Infection and Illness: constant worry about contracting the virus, severe illness, or

death for oneself and loved ones

- Lockdowns and Isolation: strict community quarantines, stay-at-home orders, and social distancing measures led to widespread isolation, loneliness, and disruption of social support networks. Studies in the Philippines showed increased feelings of loneliness
- Economic Strain: job losses, reduced income, business closures, and financial uncertainty caused immense stress and anxiety for many Filipino families
- Disruption of Daily Life: closure of schools, shift to remote work/learning, restrictions on movement, and changes in routines contributed to stress, anxiety, and feelings of disarray
- Grief and Loss: the sheer number of deaths from COVID-19 led to widespread grief, often compounded by restrictions on traditional mourning rituals
- Increased Domestic Issues: lockdowns were associated with a spike in cases of domestic violence and child abuse as individuals were confined with their oppressors
- Overwhelmed Healthcare Workers: frontline healthcare workers experienced extreme stress, burnout, and trauma due to long hours, high patient loads, fear of infection, and witnessing severe illness and death
- Prevalence of Symptoms: surveys in the Philippines during the early phase of the pandemic reported high rates of moderate-to-severe anxiety (28.8%), depressive symptoms (16.9%), and stress (13.4%). Younger individuals reported greater levels of stress, anxiety, and depression
- Suicide Rates: the Philippines saw a significant rise in suicide rates during and after the pandemic. Preliminary estimated numbers showed an annual average of 4,085 deaths from 2020-2022, compared to a



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pre-pandemic average of 2,752 from 2017-2019. Calls to mental health hotlines, especially suicide-related calls, surged dramatically

THE MENTAL HEALTH ACT (RA 11036): KEY PROVISIONS AND RESPONSE TO THE CRISIS

- Establish a National Mental Health Policy: aimed at enhancing the delivery of integrated mental health services
- Promote and Protect Rights: safeguard the rights of persons utilizing psychiatric, neurologic, and psychosocial health services
- Integrate Mental Health into Primary Care: mandates the provision of basic mental health services in community settings (barangays) and psychiatric, psychosocial, and neurological services in all hospitals
- Strengthen Leadership and Governance: calls for the formulation and implementation of national policies, strategies, and programs
- Protect Rights of Service Users: ensures freedom from discrimination, protection from torture, the right to informed consent, aftercare, and rehabilitation. It explicitly recognizes the rights of persons with mental health conditions under international human rights conventions
- Mental Health in Various Settings: integrates mental health care into educational institutions, workplaces, and communities
- Mental Health Professionals: protects the rights of mental health professionals, ensuring a safe working environment, access to continuing education, and autonomy in practice
- Suicide Prevention: although not solely focused on suicide, the Act mandates comprehensive suicide prevention services, including crisis intervention

A

RA 11036's Response to COVID-19

Foundation for Psychosocial Support

- The law mandates integrating mental health into basic health services and providing psychosocial support during calamities (which COVID-19 certainly was), allowing government agencies like the DSWD to develop technology-based mental health and psychosocial support (MHPSS) programs (e.g., DSWD WiSUPPORT) to cater to individuals and families affected by the pandemic

Telehealth Expansion

- The pandemic significantly accelerated the use of telepsychology and online consultations, aligning with the spirit of the Act to make mental health services more accessible, especially with physical restrictions

Increased Awareness and Advocacy

- The visible mental health toll of the pandemic spurred greater public awareness and advocacy for mental health services, reinforcing the objectives of RA 11036

National Suicide Prevention Strategy

- The Act's provisions supported initiatives like the NCMH Crisis Hotline ("Kamusta Ka?, Tara Usap Tayo"), which saw a massive increase in calls during the pandemic, providing immediate psychological first aid

Legislative Review

- The surge in mental health concerns prompted Senate inquiries into the implementation of RA 11036 to identify challenges and recommend further legislative interventions, highlighting the Act's importance even if its existing provisions were insufficient to fully address the scale of the pandemic's impact



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B Challenges to RA 11036 Implementation Amplified by the Crisis

Under-Resourced System

- **Lack of Manpower:** the severe shortage of psychiatrists, psychologists, psychiatric nurses, and other mental health professionals (especially outside Metro Manila) became glaringly obvious. RA 11036 aims to strengthen the mental health workforce, but training and deployment could not keep pace with the sudden surge in demand. For instance, reports indicate a dire shortage of child psychiatrists and guidance counselors, areas acutely affected by the pandemic
- **Insufficient Funding:** mental health continues to receive a disproportionately small share of the national health budget (reportedly 3-5%), making it difficult to fund the comprehensive programs, facilities, and personnel mandated by the Act. Funds were also reallocated to direct the COVID-19 response
- **Inadequate Facilities:** the Act aims for community-based mental health care and improved facilities, but many areas still lack proper infrastructure, which was critical when access to central hospitals was limited due to lockdowns

Accessibility and Affordability Barriers

- **Geographic Disparities:** the pandemic highlighted how remote and rural areas, already underserved, had even more limited access to mental health professionals and services during lockdowns
- **Cost of Services:** despite the Act's intent for accessible care, private mental health services remained largely unaffordable for the majority of Filipinos, forcing many to rely on overwhelmed public services or none at all
- **Digital Division:** while telehealth expanded, the lack of internet access and appropriate devices for many Filipinos, particularly in marginalized communities, created new barriers to care

Weak Integration into Primary Healthcare

- RA 11036 mandates integrating mental health into primary care. However, many barangay health centers and general practitioners lacked the training, resources, and confidence to identify and manage mental health conditions effectively, especially with the added pressure of the pandemic
- The breakdown of routine healthcare services during lockdowns further hampered this integration

Persistent Stigma

- While RA 11036 aims to combat discrimination and stigma, the intense societal focus on physical health during the pandemic may have inadvertently pushed mental health concerns to the background for some, or made individuals even more reluctant to admit distress for fear of being seen as a "burden"

Disruption of Implementation Plans

- The pandemic necessitated a pivot in government priorities and resources. Planned training, policy formulations, and infrastructure developments related to RA 11036 often had to be delayed or put on hold, as resources were diverted to emergency health and economic responses

Additional Notes

- **Leta Hollingworth** – believed that many mentally defective individuals were actually suffering from emotional and behavioral problems, primarily due to inept treatment by adults and a lack of appropriate intellectual challenge
- **Monomania** – partial delusion
- **Neurasthenia** – characterized by persistent and distressing complaints of increased fatigue after mental effort, or persistent and distressing complaints of bodily weakness and exhaustion after minimal effort
- **Psychasthenia** – anxiety, excessive



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worrying, and doubting

- **Phonasthenia** – weakness or hoarseness of voice
- **Jean Esquirol** – first described a medical disorder quite similar to contemporary OCD and classified it as monomania
- **Pierre Janet** – proposed that obsessional patients possessed an abnormal personality with features such as anxiety, excessive worrying, and doubting, and described the successful treatment of compulsions and rituals with techniques that are similar to those used in current behavioral therapy

ADDITIONAL INFORMATION: SCHIZOPHRENIA PATHWAYS

SCHIZOPHRENIA – is a complex and multifaceted disorder, and its neurobiological basis is not fully understood

- However, research has identified several key pathways and neurotransmitter systems that are believed to play a role in its development and symptoms

Dopamine Hypothesis – proposes that an imbalance in dopamine activity is a central component of the disorder

- **Mesolimbic Pathway** – an excess of dopamine activity in this pathway, which connects the ventral tegmental area to the limbic system (including the nucleus accumbens and amygdala), is thought to be responsible for the **positive symptoms** of schizophrenia, such as hallucinations, delusions, and disorganized thought
 - This is supported by the fact that many antipsychotic drugs work by blocking dopamine D2 receptors in this pathway
- **Mesocortical Pathway** – a deficit of dopamine activity in this pathway, which

projects from the ventral tegmental area to the prefrontal cortex, is believed to be linked to the **negative symptoms** of schizophrenia (e.g., apathy, blunted affect, social withdrawal) and **cognitive symptoms** (e.g., poor attention, memory deficits, executive dysfunction)

- **Nigrostriatal Pathway** – this pathway connects the substantia nigra to the striatum and is involved in motor control. The D2 receptor blockade by antipsychotic medications in this pathway can lead to motor side effects, such as Parkinsonism and tardive dyskinesia
- **Tuberoinfundibular Pathway** – this pathway connects the hypothalamus to the pituitary gland and regulates prolactin release. Antipsychotic-induced D2 receptor blockade here can cause an increase in prolactin levels

Glutamate Hypothesis – provides a more comprehensive explanation for the range of schizophrenia symptoms, particularly the negative and cognitive ones

- It suggests that deficient activity at glutamate synapses, specifically those involving NMDA receptors, plays a significant role
- **NMDA Receptor Hypofunction** – drugs like phencyclidine (PCP) and ketamine, which block NMDA receptors, can induce schizophrenia-like positive, negative, and cognitive symptoms in healthy individuals and worsen them in people with schizophrenia
- **Interaction with Dopamine** – the glutamate and dopamine systems are closely interconnected
 - It is thought that hypofunction of NMDA receptors on GABAergic interneurons in the prefrontal cortex



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leads to a disinhibition of dopamine neurons in the mesolimbic pathway, resulting in the hyperdopaminergic state associated with positive symptoms

Other Neurotransmitter System

- **Serotonin** – has been implicated in the disease, and many second-generation antipsychotics work by modulating both dopamine and serotonin receptors
 - The serotonin 5-HT_{2A} receptor is a key target for these medications
 - Serotonin dysfunction may be linked to mood-related symptoms and cognitive deficits in schizophrenia
- **GABA** – plays a crucial role in regulating neural activity
 - Disruption of GABAergic interneurons is thought to lead to problems with neural synchrony and information processing, which may contribute to the cognitive and perceptual disturbances seen in schizophrenia
- **Acetylcholine** – abnormalities in the cholinergic system, particularly in nicotinic and muscarinic receptors, have been observed in post-mortem studies and neuroimaging
 - Acetylcholine signaling is important for attention and sensory gating, both of which are impaired in schizophrenia

Broader Neurological Factors

- **Neurodevelopmental Abnormalities** – schizophrenia is often considered a neurodevelopmental disorder
 - Genetic and environmental factors can disrupt early brain development, leading to subtle abnormalities in

brain structure and circuitry that become clinically apparent in late adolescence or early adulthood

- **Structural and Functional Brain Changes** – neuroimaging studies have consistently shown abnormalities in the brains of people with schizophrenia, including enlarged ventricles and reduced volume in areas such as the prefrontal cortex, hippocampus, and amygdala
- **Inflammation and Immune System** – growing evidence suggests that immune system dysfunction and neuroinflammation may play a role in the development of schizophrenia

END