MENTAL HEALTH AND PSYCHOLOGICAL DISORDERS

Diploma in Psychological Guidance and Counselling

Paper-V

Dept. of Psychology

Acharya Nagarjuna University

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FOREWORD

Since its establishment in 1976, Acharya Nagarjuna University has been forging ahead in the path of progress and dynamism, offering a variety of courses and research contributions. I am extremely happy that by gaining 'A' grade from the NAAC in the year 2016, Acharya Nagarjuna University is offering educational opportunities at the UG, PG levels apart from research degrees to students from over 443 affiliated colleges spread over the two districts of Guntur and Prakasam.

The University has also started the Centre for Distance Education in 2003-04 with the aim of taking higher education to the door step of all the sectors of the society. The centre will be a great help to those who cannot join in colleges, those who cannot afford the exorbitant fees as regular students, and even to housewives desirous of pursuing higher studies. Acharya Nagarjuna University has started offering B.A., and B.Com courses at the Degree level and M.A., M.Com., M.Sc., M.B.A., and L.L.M., courses at the PG level from the academic year 2003-2004 onwards.

To facilitate easier understanding by students studying through the distance mode, these self-instruction materials have been prepared by eminent and experienced teachers. The lessons have been drafted with great care and expertise in the stipulated time by these teachers. Constructive ideas and scholarly suggestions are welcome from students and teachers involved respectively. Such ideas will be incorporated for the greater efficacy of this distance mode of education. For clarification of doubts and feedback, weekly classes and contact classes will be arranged at the UG and PG levels respectively.

It is my aim that students getting higher education through the Centre for Distance Education should improve their qualification, have better employment opportunities and in turn be part of country's progress. It is my fond desire that in the years to come, the Centre for Distance Education will go from strength to strength in the form of new courses and by catering to larger number of people. My congratulations to all the Directors, Academic Coordinators, Editors and Lesson- writers of the Centre who have helped in these endeavours.

Prof. P. Raja Sekhar
Vice-Chancellor
Acharya Nagarjuna University

DDGC05: - MENTAL HEALTH AND PSYCHOLOGICAL DISORDERS

PAPER – V

Unit-I - Mental health definition, nature and need of this awareness in the society.

Unit-II - Stress – Coping, Maladaptive behaviors and clinical reaction to stress.

Unit-III - Anxiety disorders – Generalized anxiety disorder, panic disorder, obsessive, compulsive disorders.

Unit-IV - Personality Disorders–Cluster A, cluster B, cluster C of D S M VI

Unit-V - Mood Disorders – Depression, Bipolar, Suicide.

Unit I: Mental Health Definition

LEARNING OBJECTIVES

This paper aims at enabling the students to learn the Concept of Mental Health, The facts about the mental health and definition of mental health. What is Nature of mental health and what are significant points which must be brought to the notice of society to promote mental health from childhood. Chief ideas related to mental health which can help the society to understand the concept better and help the people with mental illness and the families having people with mental illness.

1.Introduction
2.Definition
3.Symptoms

INTRODUCTION

It is always good to learn about what actually is mental health. Usually we see people around us complain about some physical problems, immediately they take medicines for cure or maintenance of good physical health in supervision of medical doctor. We see some people complain and share about other people and their experiences as suffering, miss-understandings, regrets, or happy go life situations. So here we see Happiness and unhappiness among people because of physical or Psychological problems.

Good mental health is not simply the absence of diagnosable mental health
problems, although good mental health is likely to help protect against development of many such problems. Good mental health is characterized by a person's ability to fulfill a number of key functions and activities, including the ability to learn, the ability to feel, express and manage a range of positive and negative emotions, the ability to form and maintain good relationships with others, the ability to cope with and manage change and uncertainty.
So with this understanding of mental health, it is good to learn what actually mental health is by defining it.

DEFINITION

Definition by World Health Organization (WHO) : "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community".
So, According to WHO mental health includes "subjective well-being, perceived self-efficacy, autonomy, competence, intergenerational dependence, and self-actualization of one's intellectual and emotional potential, among others".

From the perspectives of positive psychology or of holism: mental health may include an individual's ability to enjoy life and to create a balance between life activities and efforts to achieve psychological resilience.
It is very much evident from the above that Cultural differences, subjective assessments,

and competing professional theories all affect how one defines "mental health".

An individual's capacity to feel, think, and act in ways to achieve a better quality of life whilst respecting the personal, social, and cultural boundaries.
So it is very important to have knowledge of some impairment of any of these. As it a risk factor for *mental disorders*, which are components of mental health.
The conditions or symptoms are studied systematically by dividing them in to childhood, adolescence adult and old age and also observing gender factors.

SYMPTOMS

Signs and symptoms of mental illness can vary, depending on the disorder, circumstances and other factors. Mental illness symptoms can affect emotions, thoughts and behaviors.

Mental disorders are defined as the health conditions that affect and alter cognitive functioning, emotional responses, and behavior associated with distress and/or impaired functioning.

Examples of signs and symptoms include: Feeling sad or down, Confused thinking or reduced ability to concentrate, Excessive fears or worries, or extreme feelings of guilt, Extreme mood changes of highs and lows, Withdrawal from friends and activities, Significant tiredness, low energy or problems sleeping, Detachment from reality (hallucinations and delusions), paranoia inability to cope with daily problems or stress, Trouble understanding and relating to situations and to people, Problems with alcohol or drug use, Major changes in eating habits, Sex drive changes, Excessive anger, hostility or violence, Suicidal thinking, Sometimes symptoms of a mental health disorder appear as physical problems, such as stomach pain, back pain, headaches, or other unexplained aches and pains. Mental health is absence of the above symptoms.

Mental health is associated with a number of lifestyle factors such as diet exercise, stress, drug abuse, social connections and interactions. Therapists, psychiatrists, psychologists, social workers, nurse practitioners, or family physicians can help manage mental illness with treatments such as therapy, counseling or medication.

Lesson-2: Mental health Nature

STRUCTURE

Defining mental health
Influences on mental health and wellbeing

NATURE OF MENTAL HEALTH

It is quite natural that people are exposed to life situations and day to day hassles regularly. The problems one faces can be a common problem for all, or sometimes it can be unique. Each individual faces and tackles with their intellectual and other skills. How one perceives a problem depends on their individualistic experiences or their exposure to situations.
According to APA dictionary Mental Health is a state of mind characterized by emotional well-being, good behavioral adjustment, relative freedom from anxiety and disabling symptoms, and a capacity to establish constructive relationships and cope with the ordinary demands and stresses of life.
Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.

DEFINING MENTAL HEALTH

Mental health is a positive concept related to the social and emotional wellbeing of individuals and communities. Having good mental health, or being mentally healthy, is more than just the absence of illness; rather it's a state of overall wellbeing.
The concept is influenced by culture, but it generally relates to:
To be resilient with the ability to cope with or to 'bounce back' from stress and sadness. Being able to set and fulfill goals, having the capability to build and maintain relationships with others. It is holistic view which includes social and emotional wellbeing.

INFLUENCES ON MENTAL HEALTH AND WELLBEING

Mental health is influenced by several biological, psychological, social and environmental factors which interact in complex ways. The structural factors, such as safe living environments, employment, education, freedom from discrimination and violence, and access to economic resources. The community factors such as a positive sense of belonging, community connectedness, and activities to highlight and embrace diversity, social support, and participation in society. The individual factors such as the ability to manage thoughts and cope with stressors and having communication and social skills to support connection with others.
Mental health and wellbeing is very important and it also needs management by prioritizing things in one's life. Sleeping sufficiently, taking rest affects physical and mental health. But we

lose both of them when one gets busy or stressed. Taking time for enjoyment of life is important, by doing small things which give happiness. So how we balance life by giving time for doing things to think and feel achievement and enjoyment.

To be active and eating well, regular exercise and intake of nutritious food every day can makes people feel better. The physical and mental health are closely linked, so adding Nurture relationships and connection to others is what builds us up and keeps us strong

For stress management, or winding down or managing thoughts, now a day's relaxation, yoga or writing of feelings are found helpful. Joining in groups with common interests provide a sense of belonging. So finding our own interests is important, such as sporting, music, volunteer or community groups locally. Confidence in doing things builds by learning to improve mental fitness and taking on a new challenge can build confidence and gives a sense of achievement. Knowledge of what we actually like or wish to achieve makes us comfortable by working towards reaching it. The unique nature of mental health individualistic in nature and can be achieved. The setting of realistic and achievable goals, working with each one of them with planning and efficient management leads to wellbeing and mental health.

Lesson-3: Need of Mental Health awareness in the society

STRUCTURE

Introduction
Need of awareness
Summing up of the Unit 1
Model examination questions
Suggested readings

NATURE OF MENTAL HEALTH

Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood. We need to discuss the need for awareness in the society about Mental Illness.

NEED FOR AWARENESS

1. Individual Care of self: It is very important to understand that the need for in person therapy in modern days is higher now than ever before. In general, we humans feel a need to decompress from the pressures and stresses of life as we learn new techniques for self-care and regulation that can improve our quality of life.
2. Individual and Community: Treating mental illness in modern day is different and no excuse to isolate yourself and wallow in your own unique set of issues. The community support with Love, friendship, by surrounding self with likeminded people, makes one happier and healthier mentally. It improves the quality of our life.
3. Body and Mind concept: Both body and mind are very much connected and the health of one affects the other. This awareness in the society is very much necessary to maintain good mental health of the people. Eating well, getting adequate exercise, sleep, and hydration are valuable actions you can take to preserve your physical well-being. Taking responsibility of self and others, having self-confidence, having positive attitude towards life, being proactive helps to maintain good mental and physical health.
4. Intellectual capacities play vital role and maintaining balance of mind which is very much necessary for good mental health. So, society benefits with awareness of how other members of society are solving any problems. Problem solving exercise to the brain, committing to being a lifelong learner is also a part of mental health of a person. So the awareness programs help the society.
5. Environmental health is also an important aspect awareness of what causing stress in the environment helps an individual to maintain good mental health. Doing what one can to remove those aspects of life that are stressing out----relationships, living conditions, social situations, physical health issues----will help to reduce the stress response in your brain that can contribute to poor cognitive function.

6. Setting Boundaries is also very important for good mental health, which one can learn from awareness of mental health causal situations. Learning to say “No” to safe guard mental health, to fulfill all of life's obligations and take care of one’s self as well one may initially feel guilty if haven't said no to friends and family before, but the more you stand up for yourself and take back your time, the easier it will be to practice the daily habits that preserve your mental wellness.
7. Caring Self by nurturing Body, soul and spirit will be up lifted with mental health of self and others around, as awareness of mental health is possible only be taking care of self.
8. Leading simple life by caring the nature, creating protective and safe surroundings, adopting and promoting activities like yoga, mindfulness, meditation, deep breathing will help for mentally healthy society.
9. Awareness of mental health related services and professional in case of need is also very important. If anyone experience mental health problems, thinking, mood, and behavior could be affected. Many factors contribute to mental health problems. Which includes Biological factors, such as genes or brain chemistry, Life experiences, such as trauma or abuse, Family history of mental health problems, mental health problems are common but help is available. People with mental health problems can get better and many recover completely.
10. Awareness of Early Warning Signs will help the society to take care of mental health of family members and society as a whole. Learning to live with people with mental health problems is also very important. The signs of mental health problems helps the people living with mentally ill people can understand and help them well. If anyone Experiencing one or more of the following feelings or behaviors can be an early warning sign of a problem:

    Disturbances in eating and sleeping, either too little or too much, Trying or be away from activities or from people, low or high energy levels, not having feelings or emotions, Having problems like unexplained aches and pains, too much dependency with feelings of helpless or hopeless, getting addicted to smoking, drinking, or using drugs more than usual, some type of frequent problems due to feeling unusually confused, forgetful, on edge, angry, upset, worried, or scared, frequent or more of yelling or fighting with family and friends, mood swings which cause relation problems, feeling or having persistent thoughts and memories those can't get out of mind, hallucinations, harming self and others, delusions, inability to perform daily tasks like taking care of self-others.
11. Awareness of mental health in the society helps in taking professional help. Awareness of Therapists’ **who is who** is also very much essential in maintain mental health conditions in the society. The professional who help in alcohol/Drug Abuse Counselor – often has a degree in social work, psychology, or psychiatry and works in a variety of settings, including drug treatment centers and family service agencies. School counselors helps in schools, and Industrial Psychologists is an Employee Assistance Professional, is an mental health professionals provided by employers to offer confidential services to employees and, often, to their families.
12. These counselors can be occupational physicians, nurses, psychologists, professional counselors, social workers, and/or trained union members. They provide assessment, brief counseling, and when appropriate, referral to community resources. Marriage Counselor or Family Therapist – has a degree in social work, psychology, or psychiatry with post-graduate study and training in marital and/or family problems. Psychiatric Nurse or Clinical Nurse Specialist – holds a degree in nursing, either as a Registered Nurse, a Bachelor’s in Nursing, or a Master’s in Nursing. In addition, they have specialized training in the care and treatment of psychiatric patients so referred as psychiatric nurses. Psychiatrist – a medical doctor (M.D.) or doctor of osteopathy

(D.O.) who has had a three or four year residency in a psychiatric facility and is board certified in psychiatry. A psychiatrist is the only mental health professional who can prescribe medication and/or medical treatments. **Psychoanalyst** – a psychiatrist, **clinical psychologist**, or **social worker** who has had specialized training in psychoanalysis and has gone through psychoanalysis. Psychologist – received either a doctorate degree in psychology, education, or counseling (i.e.,Ph.D).

13. This professional must also complete at least a one-year internship in a psychiatric hospital or mental health center and have specific training to do psychotherapy. **Social Worker** – has earned a Bachelor's Degree, Master's Degree, or Doctoral Degree, in social work. Graduate training involves coursework dealing with individual, group and family assessment and psychotherapy.
14. Awareness also includes about various treatment approaches like **Psychotherapy,** use of face-to-face discussions to talk about, define, and resolve personal problems. Several types of psychotherapy include, **Individual Therapy** – The most common form of professional assistance. A therapist works one-on-one with the client using a variety of treatment methods to sort out the problems and find resolutions. **Psychoanalysis** – Places emphasis on linking early childhood memories and events to current behaviors. It normally takes several years to complete this therapy and involves a basic rebuilding and modifying of a patient's personality to overcome psychological problems. Two drawbacks to this approach are that it takes a long time and it's very costly.
15. **Group Therapy** – An approach in which a therapist conducts treatment in a group setting of 6 - 12 members. Through this supportive environment, members help one another resolve their problems. **Family Therapy** – A type of counseling provided to two or more family members to assist a troubled individual and/or promote better functioning of the family unit. The interaction among members serves as the key to resolving conflicts. **Couple Therapy** – Helps couples understand how conflicts get expressed by their interactions with each other. The goal is to develop a more rewarding relationship.

    Play Therapy – Most often used with young children. Uses play with dolls or puppets to identify and resolve problems. **Behavioral Therapy - Behavior Modification** – Uses techniques, such as relaxation training, biofeedback, positive reinforcement, punishment, and altering triggers to teach new substitute behaviors. The emphasis is on altering outward behavior rather than the resolution of early childhood events**. Hypnotherapy** – A state of heightened suggestibility that allows the client to tune out unimportant information and focus only on what the hypnotherapist is saying. The client then is given suggestions to change personal behavior, i.e., lose weight, manage stress, or overcome fears. Biomedical Therapies - **Drug Therapy** – Uses medicines, such as antidepressants and tranquilizers to help correct chemical imbalances, mood, and/or thinking disorders. Drug therapy is often used in conjunction with other treatment approaches. **Electroconvulsive Therapy (ECT)** – Low "doses" of electrical energy currents are delivered to a patient's brain. ECT is used only for certain extreme conditions, such as chronic depression or aggression that has not responded to other treatment methods.

a. People may have different opinions about mentally ill people or mental illness. But by knowing about different are misconceptions about mental illness, people can actually, get more knowledge about mental health maintenance in the society. One of the miss conceptions is, Children don't experience mental health problems – but the fact is Even very young children may show early warning signs of mental health concerns. These mental health problems are often

clinically diagnosable, and can be a product of the interaction of biological, psychological, and social factors. Half of all mental health disorders show first signs before a person turns 14 years old, and three quarters of mental health disorders begin before age 24.

Unfortunately, less than 20% of children and adolescents with diagnosable mental health problems receive the treatment they need. Early mental health support can help a child before problems interfere with other developmental needs.

b. Another popular misconception is, People with mental health problems are violent and unpredictable. The vast majority of people with mental health problems are no more likely to be violent than anyone else. Most people with mental illness are not violent and only 3%–5% of violent acts can be attributed to individuals living with a serious mental illness. In fact, people with severe mental illnesses are over 10 times more likely to be victims of violent crime than the general population. Probably we may know someone with a mental health problem and don't even realize it, because many people with mental health problems are highly active and productive members of our communities. People with mental health problems are just as productive as other employees. Employers who hire people with mental health problems report good attendance and punctuality as well as motivation, good work, and job tenure on par with or greater than other employees.

c. When employees with mental health problems receive effective treatment, it can result in:

Lower total medical costs
Increased productivity
Lower absenteeism
Decreased disability costs

Some people think that Personality weakness or character flaws cause mental health problems. People with mental health problems can snap out of it if they try hard enough. But it is known from research that Mental health problems have nothing to do with being lazy or weak and many people need help to get better. Many factors contribute to mental health problems, including - Biological factors, such as genes, physical illness, injury, or brain chemistry,

Life experiences, such as trauma or a history of abuse,, Family history of mental health problems, People with mental health problems can get better and many recover completely. So the misconception that mental health problems cannot be treated and life of such person cannot be improved is wrong. Studies show that people with mental health problems get better and many recover completely. Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. There are more treatments, services, and community support systems than ever before, and they work.

Promoting the social-emotional well-being of children and youth leads to:

Higher overall productivity
Better educational outcomes
Lower crime rates
Stronger economies
Lower health care costs
Improved quality of life
Increased lifespan
Improved family life

To maintain positive mental health is possible and it is highly required by everyone as positive mental health allows people to realize their full potential, cope with the stresses of life, work productively, and make meaningful contributions to their communities.

Mental health includes our emotional, psychological, and social well-being. It **affects how we think, feel, and act**. It also helps determine how we handle stress, relate to others, and make healthy choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.

To look after mental health, one should talk about their feelings; Talking about feelings can help to stay in good mental health and deal with times when feel troubled or disturbed. To maintain good mental health one should keep active physically, Eat well the healthy food, keep in touch with friends and loves ones, ask for help when in need, take a break periodically to spend time for self-relaxation, try to learn new things and do something in which you are good at.

Model examination questions

Choose the answer from multiple answers given below:

1. Medication is administered by --- for mental health problems ( )

A. Psychologist	B. Psychiatrist
C. Medical Social Worker	D. General Physician

Answer: 1. only A. 2. Only B, 3.Only C, 4. Only D, 5. All the above, 6. one of the above.

2.The professionals who work for people with mental illness are ( )

A. Psychologist	B. Psychiatrist
Medical Social Worker	. General Physician

Answer: 1. only A. 2. Only B, 3.Only C, 4. ABC, D, 5. ACD, 6. all the above, 7. None of the above.

3. The definition of mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". Is given by – ( )

1. WHO, 2. APA, 3. Freud, 4. Benjamin Rush

4. Mental Health of a person Depends on aspects ( )

1. Hereditary, psychological, physiological, Situational
2. Psychological, Physiological
3. Psychological, Physiological, Heredity
4. Hereditary, psychological, physiological, Situational, Socioeconomic Conditions

5. Study of Mental health is important for

1. Only Professionals
2. Only students of Psychology
3. Parents
4. People living with mentally ill persons
5. Everyone in the society
6. All the above

Lesson 4: Stress – Coping, Maladaptive behaviors and clinical reaction to stress.

Learning Outcomes

What are stressors?
Brief History of Stress
Stages and Types of Stress
How is stress diagnosed?
How long does stress last?
Physical symptoms of stress include
Stress can lead to emotional and mental symptoms like

Stress and it's types

STRUCTURE

1. Definition of Stress
2. What are individual differences in feeling stress?

DEFINITION OF STRESS

The National Institute of Mental Health defines stress as simply "the brain's response to any demand." Given that definition, not all stress is bad. It is simply a response. How harmful it ultimately depends on its intensity, duration and treatment.

WHAT ARE INDIVIDUAL DIFFERENCES IN FEELING STRESS?

There will be two aspects in the stress, first one is the person who is feeling the stress, and the second one is stressor.

The person who is getting stressed is having stress because he or she is prone to it. The physiological and mental conditions of such person are very much necessary as stressful condition varies it effects on the same person as the person perceives it.

If a student is having stress for taking examination, student will plan and study for exam, as he does not want to fail in the exam. But if a student, who is having stress, could not pay attention to study, as he already has physical or psychological problems, may try to study for exam but could not do it as he plans, because of some internal or external personal reasons. He knows very well that he has to face failure, and he has to protect his self from failure and its affects, so adopts alternative methods. If the same student who fears of failure, studies well for exams but could not do well in exams, because of fear of exam and there by feels nervousness and don't perform well in the exam. The reason for nervousness caused by his thinking and psychological aspects. So like how we just discussed, the stress feeling persons aspects are playing dominant

role in causing stress.

The stressor aspects also keep changing, like is exam date changes suddenly, the student may feel stress. The examination environment may be very cool or very hot, so the students feel stress. In another case, the exam questions may be framed taken from unknown syllabus that the student prepared, so the student feels stress. Likewise the stress may result from the individualistic point of view and some stressful examination conditions can be causing stress.

So while giving guidance or while doing counseling, it is very important to note many aspects from stressor point of view and from point view of the individual or group of people feeling stress. So the topic of stress is highly important for a student of psychology as equipping more skills to help the client is very much necessary by taking individualistic and situational points in to consideration.
Individual differences play very important role in this topic as the stress bearing nature of the support that an individual gets in facing stress changes from person to person. The stressful conditions can be the same but the individual facing it takes it according to his, physical, psychological and skill position.

WHAT ARE STRESSORS?

Stressful conditions are stressors. A stressor is the one causes the release of stress hormones. We can discuss stressors under two heads.

Physiological stressors (physical) and 2. Psychological Stressors.

Physiological (or physical) stressors are the stressors which cause problems physically and cause stress to the body. Stressors can be strain to body like extreme temperatures, injuries, pain or physical illness.
Psychological Stressors can be in the form of an event or situations, cause can be individual, comments made by someone which cause stress, anything negatively interpreted by stressed person as threatening or causing problem because stressed persons are unable to reach to take it or find it hard.

Brief History of Stress:

Hans Seley (1907–1982) is father of stress research. The word ‘stress’ is used in physics to refer to the interaction between a force and the resistance to counter that force, and it was Hans Selye who first incorporated this term into the medical lexicon to describe the “nonspecific response of the body to any demand “.. He noticed that no matter what his hospitalized patients suffered from, they all had one thing in common. They all looked sick. In his view, they all were under physical stress.
He proposed that stress was a non-specific strain on the body caused by irregularities in normal body functions. This stress resulted in the release of stress hormones. He called this the “General Adaptation Syndrome” (a closer look at general adaptation syndrome, our body’s short-term and long-term reactions to stress). Hans Selye pioneered the field of stress research and provided arguments that stress impacted health.

The term "stress" had none of its contemporary connotations before the 1920s.
It is a form of the Middle English distress, derived via Old French from the Latin stringere, "to draw tight".

The word had long been in use in physics to refer to the internal distribution of a force exerted on a material body, resulting in strain. In the 1920s and '30s, biological and psychological circles occasionally used the term to refer to a mental strain or to a harmful environmental agent that could cause illness.
Walter Cannon used the word stress in 1926 to refer to external factors that disrupted what he called homeostasis. The Holmes and Rahe stress scale was developed as a method of assessing the risk of disease from life changes.

The scale lists both positive and negative changes that elicit stress. These include things such as a major holiday or marriage, or death of a spouse and firing from a job.
A physician named John Mason conducted an experiment in which two groups of monkeys were deprived of food for a short period of time.
In group 1, monkeys were alone, while in group 2, monkeys watched others receive food. Even though both groups of monkeys were under the physical stress of hunger, those that saw others eat had higher stress hormone levels. He therefore showed that psychological stress was as powerful as physical stress at inducing the body's stress response.

Many argued that if stress was a non-specific phenomenon then everyone should react the same way to the same stressors. BUT this did not seem right. Many were also convinced that there had to be common elements that would elevate everyone's stress hormone levels.

Stages and Types of Stress:

Human life includes many daily activities which cause stress physically and mentally.
When changes occur, in physical, emotional and intellectual levels, results in stress, and is a normal reaction the body has. Stress responses help body adjust to new situations. Stress can be positive, keeping us alert, motivated and ready to avoid danger.
For example, if a student has a test, a stress response might help students body to work harder and stay awake longer. But stress becomes a problem when stressors continue without relief or periods of relaxation. Adaptation takes place at this level.

In Hans Selye's theory, General Adaptation Syndrome had three stages.

Stage 1: Alarm reaction
This is the immediate reaction to a stressor. In the initial phase of stress, humans exhibit a "fight or flight" response. This stage takes energy away from other systems (e.g. immune system) increasing our vulnerability to illness.

Stage 2: Resistance
If alarm reactions continue, the body begins getting used to being stressed. But this adaptation is not good for your health, since energy is concentrated on stress reactions.

Stage 3: Exhaustion
This is the final stage after long-term exposure to a stressor. The body's resistance to stress is gradually reduced and collapses as the immune system becomes ineffective. In Selye's view, patients who experience long-term stress could succumb to heart attacks or severe infection due to their reduced resistance to illness.
These are the five stages you may experience when under stress: we can mention them in order as 1. Alarm (fight-or-flight), 2. Resistance, 3. Coping (recovery), .4. Adaptation (what happens when you don't take time to recover), 5.Burnout.

1.Alarm (fight-or-flight)

Is the person is in stressful situation, so chemical reactions take place as reaction, release of adrenaline and cortisol hormones mix in the body. This is called the acute stress response, but is more widely known as the fight-or-flight response. The heart rate increases and blood pressure elevates, boosting our energy supplies to cope with a perceived danger or threat. These common signs (Cooler skin, sweating, Dilated Pupil, Dry mouth etc) can help one to identify this stage of stress.

The signs are Cooler skin, (blood flow to the surface of our body decreases so that more blood can flow to the arms, legs, shoulders, brain, eyes, ears and nose – all of the body parts humans may have once needed when they entered the fight-or-flight mode (Young Diggers, 2019)). sweating - blood flow to the surface of our body decreases so that more blood can flow to the arms, legs, shoulders, brain, eyes, ears and nose – all of the body parts humans may have once needed when they entered the fight-or-flight mode (Young Diggers, 2019). Dilated pupils - Another biological reaction passed down from our ancestors, when your pupils dilate, more light enters your field of vision and subsequently, one can see better (Young Diggers, 2019). Dry mouth - As the blood flow is decreased from the digestive system, saliva production is also decreased. This is our body's way of refocusing on situation survival rather than digesting a past meal (Young Diggers, 2019

2.Resistance

In this stage whatever the responses the body gives to the stress are to resist the stress. So the body is trying to maintain normal state as it releases anti-inflammatory hormones to calm and ease the negative effects of stress. If the stress continues and if body could not take or continue to take stress for longer time, the higher levels of stress those are adaptation and burnout results. (Lumen, 2019) Students are very susceptible to entering the resistance stage of stress; constant studying, writing assignments, sleep-deprivation and poor diet are all situations where the bodies try to resist stress and keep pressing on.

3. Coping (recovery)

Image of recovery Perhaps the most important stage of the stress cycle, recovery is integral to bouncing back from a stressful period, being able to return to a state of equilibrium, and being your most well self. This stage can be achieved by handing in or completing a particularly taxing piece of assessment, or taking a day for self after an intensive period when one had to juggle all of life's priorities at once. We all experience stress differently and recover in different ways, but there are a few techniques one can withstand and get over the stress which are coping measures.

These include, Exercise, (releases endorphins make feel better, positively improves the state of recovery). Healthy Diet, Consistent sleep also helps to recover from stress.

4. Adaptation

The individual under stress can make a choice to take time to step back and recover or adapt to the environment. So it can lead to constant state of stress, if continue to adapt to environment.

The body will be in a constant state of stress, which can have long-term negative effects such as lower energy levels, low self-esteem, difficulty sleeping, an unhealthy change in weight, and difficulty managing your emotions (Cole, 2018).

5. .Burnout

Results when one get triggered into a stressful situation; it is recommended that it makes time to recover. If, due to circumstances or time frames, unable to allow adequate recovery, or may have unknowingly adapted to a situation that has resulted in being suspended in a heightened state of stress, it's likely that one will experience burnout. Examples of burnout include severe exhaustion, cynicism, feeling emotionally drained, lacking positivity, experiencing catastrophic thoughts, and a detachment from others (Robinson, 2015). In order to combat these symptoms of burnout, the following strategies will aid in long-term recovery and help you more quickly bounce back to your best self.

Types of stress can be discussed based on this discussion. It is scientifically proven that not all types of stress are harmful or even negative. The experience includes some types of stress, which can be identified with individual experience of it.
Simple Stress: The stress which any one feels in daily life. This stress lasts for short period and gaining of knowledge and experience can help to overcome it in daily day to day challenges.

Acute stress/ Distress: Acute stress is a very short-term type of stress that can either be positive or more distressing; this is the type of stress we most often encounter in day-to-day life.

Chronic stress: Chronic stress is stress that seems never-ending and inescapable, like the stress of a bad marriage or an extremely taxing job; chronic stress can also stem from traumatic experiences and childhood trauma.

Episodic acute stress: Episodic acute stress is acute stress that seems to run rampant and be a way of life, creating a life of ongoing distress.

Eustress: Eustress is fun and exciting. It's known as a positive type of stress that can keep you energized. It's associated with surges of adrenaline, such as when you are skiing or racing to meet a deadline.

How is stress diagnosed?

There are some psychological methods of stress assessment. But Stress is subjective — not measurable objectively with tests. Only the person experiencing it can determine whether it is present and how severe it feels. A healthcare provider may use questionnaires to understand stress and how it affects life.
Perceived Stress Scale (PSS). Originally created by Cohen et al (1983), it is a highly recognized psychological tool for measuring the perception of stress that's clinically validated and widely used by the NHS and other reputable medical services. Likewise there are many diagnosis methods and psychological tests are in use.

If we take a simple situation of life, like an examination for a student, some students study for it from the beginning and may not feel stress, but some students, even though they prepare well for exam, may feel stress and perform well or may not perform well in the same exam, some students take it easy, even though they don't prepare well. So stress assessment for an individual differs based on his levels of attachment to it, how serious they are in achieving it, etc.

How long does stress last?

The stressor (needs skill, performance, hard work, higher levels of perfection etc) based stress is different from individual's basic psychological aspects towards the stress. (Expectations, need, fear, anxiety etc) Stress can be a short-term issue or a long-term problem, depending on what changes in one's life. Stress can be chronic if it continues for longer period. We can observe that the chronic stress can be evaluated with symptoms that result from stress. For example, high blood pressure can be diagnosed and treated.

Physical symptoms of stress include

Some body Aches and pains, Chest pain or a feeling like heart is racing, Exhaustion or trouble sleeping, Headaches, dizziness or shaking, High blood pressure, Muscle tension or jaw clenching, Stomach or digestive problems, Trouble having sex, Weak immune system or any problem in the body which disturbs in our daily life activities. **Stress can lead to emotional and mental symptoms like**
People suffering from stress may become or feel Anxiety or irritability, feel Depression undergo Panic attacks, look and feel Sadness.

Stress Coping

STRUCTURE

What is coping?
Strategies
Ability or Skill
Culture and Coping Strategies

What is coping?

The term "coping" usually refers to dealing with the stress that comes after a stressor is presented, but many people also use proactive coping strategies to eliminate or avoid stressors before they occur. A way to control stress is first dealing with what is causing the stress if it is something the individual has control over.

Stress can be managed efficiently with the Professional help. It is a conscious effort to spend time and energy to reduce stress. When a problem is identified as causing stress to a person, the person uses a coping mechanism which can help either to master or minimize, or tolerate the stress and stressors in life. Such coping skills or coping strategies helps the individual to have an adaptive goal of reducing or dealing with stress. All individuals do not adapt adaptive strategies for coping, but can choose non-adaptive strategies (Unhealthy) or ineffective strategies.

A person's capacity to tolerate the source of stress may be increased by thinking about another topic such as a hobby, listening to music etc. Painful shocks were applied to married women's ankles. In some trials women were able to hold their husband's hand, in other trials they held a stranger's hand, and then held no one's hand. When the women were holding their husband's hand, the response was reduced in many brain areas. When holding the stranger's hand the response was reduced a little, but not as much as when they were holding their husband's hand. Social support helps reduce stress and even more so if the support is from a loved one

So the maladaptive strategies may give temporary relief, and inhibit the user's ability to adjust to particular situations. Maladaptive strategy may reduce one's anxiety, but the result is dysfunctional and non-productive. Personal choice in coping strategies is determined by personality traits and type, social context, and the nature of the stressor involved.

STRATEGIES

The three most common distinctions in strategies are appraisal-focused, problem-focused, and emotion-focused coping strategies as there are hundreds of coping strategies.

Appraisal-Focused Strategies – modify the thought process which is causing stress.
Problem-Focused Strategies – deal with cause of the problem or stressor. Try to find the source of the problem and learn management skills.

Emotion-Focused Strategies – Address the feelings associated with the stress. Modifying the emotions that accompany stress perception, by releasing, distracting
or managing their mental state.

Ability or Skill:

The skills play a crucial role as the ability to do the same will influence the coping. A person may employ all by mixing strategies in coping with the stress. The required skill or ability may change according the situation over time.

Coping Abilities of individual play crucial role in stress release. The abilities include, 1. The capacity to tolerate or cope with stress. 2. The root of stress is the cognitive appraisal of an event as stressful or stress-inducing, 3. The Primary appraisal is the extent to which a person perceives an event as benign or threatening and harmful. 4. Secondary appraisal is the estimation of whether a person has the resources or abilities necessary to deal with what has already been deemed stressful. 5. Having confidence in their ability to handle situations that are stressful.

Variations in Coping Abilities include selection of strategy, which are based on personality, gender, and culture. A person with a positive demeanor and outlook on life will perceive less stress and be better equipped to handle stress when it does arise. Those people who employ a static view of the world will perceive more stress and be less adept at addressing the stressor in their lives. Men and women also assess stress differently but tend to cope with stress similarly. Evidence shows that men more often develop career- or work-related stress, while women are more prone to stress about interpersonal relationships. The small amount of variation in coping-strategy selection shows that women will engage in more emotion-focused coping while men tend to use problem-focused strategies.

Culture and Coping Strategies

Culture and surroundings also affect what coping strategies are practically available and socially acceptable. Some cultures promote a head-on approach to stress and provide comforting environments for managing stressful situations, while others encourage independence and self-sufficiency when it comes to coping with stress. A person's perception of stress and ability to cope with that stress are products of many different influences in life.

An individual can effectively cope with stressors by appraising stressful situations and having confidence in their ability handle situations that are stressful. Stressful situations are addressed considering their characteristics such as Novelty, Unpredictability, Threat to the ego, Sense of Control.

Lesson 5: STRESS-Maladaptive Behaviors

STRUCTURE

1. Adaptive and maladaptive behavior
2. Adaptive Behaviors
3. Maladaptive Behavior
4. Avoidance behaviors include
5. Adaptive vs. Maladaptive Strategies

Adaptive and maladaptive behavior

If a student wants to go for higher studies, having some financial problems to pay his fee etc., may take decision to do some part time job or take educational loan. That is adaptive behavior. The same students don't go for studies is adapting to adaptive behavior if he thinks that after doing a job he can go for higher studies. But the same student if he worries for his financial problems, get sick, starts drinking alcohol etc. is maladaptive.

Adaptive Behaviors

The life situations change from individual. The life may not take place as expected. When faced with an obstacle, we can adapt or not. In the moment, it's not necessarily a conscious choice. It could be a temporary reaction until we have a chance to think about it. Adaptive behavior is making the choice to solve a problem or minimize an unwanted outcome. People might do something they don't necessarily want to do or find a way to work around it. It is adjusting to circumstances.

Adaptive behaviors would be to seek help for social anxiety, try exposure therapy, or find a more suitable job.

Maladaptive Behavior

Often, people with chronic stress try to manage it with unhealthy behaviors. We see some may be Drinking too much or too often, do activities like Gambling, Overeating or developing an eating disorder, may result in participating compulsively in sex, shopping or internet browsing, may be Smoking and Using drugs. Maladaptive behaviors like these can become a self-destructive pattern, like Avoidance, Avoiding a threat or disengaging from unpleasantness is often the best move, especially for temporary things over which one have no control. When one continually avoids something that they shouldn't, its maladaptive behavior.

Maladaptive behavior would be not acknowledging the need for change. It feels out of control and painful to think about, so no action is taken. They end up missing out on something they enjoy. Sometimes, people not having necessary skill to withstand problems like social anxiety, or any stressful problems might adapt to mal-adaptive behaviors.

Avoidance behaviors include

Not making eye contact during conversation, speaking too softly or not at all, not asking questions when you need more information, Withdrawal from situations.
The mal-adaptive behaviors can be in the form of Passive-aggressiveness - (Passive-aggressiveness is when you express negative feelings indirectly rather than head-on. One says one thing but really mean another. The true feelings are woven into ones actions. For example, a boy want his hair to be long and his parents want him to cut it short, so this upsets him. Instead of expressing disappointment, he may be silent, smile and say its fine. Later, he goes from there, slamming doors and complaining about unrelated things. (He is angry, but no closer to making his feelings understood), Self-harm - Some people deal with stressful events by hurting themselves. (such as: cutting, scratching, or burning skin, picking at scabs or wounds, pulling out hair, eyelashes, or eyebrows, self-hitting or banging head, refusal to take needed medications.

These may provide temporary relief, but only exacerbates problems and can potentially harm health. Anger - Anger is a normal emotion. Anger that spurs one to constructive action is useful. It's not useful if it often angry or have angry outbursts. Uncontrolled anger doesn't solve problems. It alienates others and hampers ability to communicate effectively. A child's temper tantrum would fall into this category. Most children eventually see that there are better ways to get to the desired result. Substance use - Whether it's alcohol, prescribed drugs, or non-prescribed drugs, substance use can be a type of avoidance behavior. It's a problem when you use it to ease anxiety or to obliterate your feelings. Any escape from reality is temporary at best. This behavior can lead to emotional and physical addiction, creating a whole new set of problems. Maladaptive daydreaming - Daydreaming is generally a healthy pastime. It frees the mind and helps you work out problems. It's estimated that the average person has hundreds of daydreaming episodes per day. Maladaptive daydreaming is when one engage in extensive fantasy in place of human interaction or participation in real life. These daydreams can last hours at a time and involve intricate plots and characters that keep one going back. They can then keep one from facing reality.

Adaptive vs. Maladaptive Strategies

Coping strategies can also be positive (adaptive) or negative (maladaptive). Positive coping strategies successfully diminish the amount of stress being experienced and provide constructive feedback for the user. Examples of adaptive coping include seeking social support from others (social coping) and attempting to learn from the stressful experience (meaning-focused coping). Maintaining good physical and mental health, practicing relaxation techniques, and employing humor in difficult situations are other types of positive coping strategies. Proactive coping is a specific type of adaptive strategy that attempts to anticipate a problem before it begins and prepare a person to cope with the coming challenge.

Negative coping strategies might be successful at managing or abating stress, but the result is dysfunctional and non-productive. They provide a quick fix that interferes with the person's ability to break apart the association between the stressor and the symptoms of anxiety. Therefore, while these strategies provide short-term relief, they actually serve to maintain disorder. Maladaptive strategies include dissociation, sensitization, numbing out, anxious avoidance of a problem, and escape.

Lesson 6- Clinical Reactions to Stress

STRUCTURE

1. What happens to the body during stress? – Clinical Reactions
2. Physiological Effects of Stress on the Brain and Amygdala
3. Stress and Adrenaline
4. Cortisol Levels
5. Effects of Chronic Stress on the Brain
6. Learning and Memory
7. Effects of Stress on the Body
8. Plasticity and the Brain
9. Recovery from stress effects
10. Recovery from stress effects
11. Promoting Health
12. Stress isn't just something that happens:
13. Maladaptive behaviors:
    14. Coping:
    15. Summing up of the unit II
    16. Model examination questions
    17. Suggested readings

What happens to the body during stress? – Clinical Reactions

When the professional help is required for stress related problems, the clinical observation and treatment takes place and the focus will be on Body and Mind of the Patient. The Daily activities and diet conditions also will be taken in to consideration.
The person suffering with stress related problems may be having clinical features of changes in heart rate, breathing, Vision changes and more. These will be general complaints of the stressed person. The clinical tests will be done by the physician gets the details of internal body reports through clinical tests.

The body's autonomic nervous system controls heart rate, breathing, vision change and others. Its built-in stress response, the "fight-or-flight response," helps the body face stressful situations. When a person has long-term (chronic) stress, continued activation of the stress response causes wear and tear on the body. Physical, emotional and behavioral symptoms develop.

In one interesting experiment, researchers measured the stress hormone levels of experienced parachute jumpers. Jumping out of a plane surely had to be stressful! Strangely, their stress hormone levels were normal. Stress hormone levels were then measured in both people jumping for the first time and their instructors. They found a big difference! On the day before the jump, student's levels were normal while instructors' levels were very high. On the jump day, students' levels were very high, while instructor's levels were normal.

They concluded that 24 hours before the jump, the instructors' anticipation resulted in higher stress hormone levels because they knew what to expect. The students were oblivious! But on jump day, the novelty and unpredictability of the situation made the students stress hormone

levels sky rocket! Over the next 30 years researchers conducted experiments showing that although the type of stressors resulting in the release of stress hormones are different for everyone there are common elements to situations that elevate stress hormones in everyone.

Physiological Effects of Stress on the Brain and Amygdala

Stress is a chain reaction. "When someone experiences a stressful event, the amygdala, an area of the brain that contributes to emotional processing, sends a distress signal to the hypothalamus," Harvard Health Publications of Harvard Medical School explains. "This area of the brain functions like a command center, communicating with the rest of the body through the nervous system so that the person has the energy to fight or flee." The hypothalamus sends signals the Pituitary for release of stress hormones by releasing adrenal stimulating hormones.

Stress and Adrenaline

This "fight-or-flight" response is responsible for the outward physical reactions most people associate with stress including increased heart rate, heightened senses, a deeper intake of oxygen and the rush of adrenaline.

Cortisol Levels

Finally, a hormone called cortisol is released, which helps to restore the energy lost in the response. When the stressful event is over, cortisol levels fall and the body returns to stasis. Cortisol's functions are part of the natural process of the body. In moderation, the hormone is perfectly normal and healthy. Its functions are multiple, In addition to restoring balance to the body after a stress event, cortisol helps regulate blood sugar levels in cells and has utilitarian value in the hippocampus, where memories are stored and processed.

But when chronic stress is experienced, the body makes more cortisol than it has a chance to release. This is when cortisol and stress can lead to trouble. High levels of cortisol can wear down the brain's ability to function properly. According to several studies, chronic stress impairs brain function in multiple ways. It can disrupt synapse regulation, resulting in the loss of sociability and the avoidance of interactions with others.

Effects of Chronic Stress on the Brain

While stress itself is not necessarily problematic, the buildup of cortisol in the brain can have long-term effects. Thus, chronic stress can lead to health problems.

While stress can shrink the prefrontal cortex, it can increase the size of the amygdala, which can make the brain more receptive to stress. "Cortisol is believed to create a domino effect that hard-wires pathways between the hippocampus and amygdala in a way that might create a vicious cycle by creating a brain that becomes predisposed to be in a constant state of fight-or-flight,"

Learning and Memory

Stress can kill brain cells and even reduce the size of the brain. Chronic stress has a shrinking effect on the prefrontal cortex, the area of the brain responsible for memory and learning.

Effects of Stress on the Body

Chronic stress doesn't just lead to impaired cognitive function. It can also lead to other significant problems, such as increased risk of heart disease, high blood pressure and diabetes. Other systems of the body stop working properly too, including the digestive, excretory and reproductive structures. Toxic stress can impair the body's immune system and exacerbate any already existing illnesses.

Plasticity and the Brain

The Body's Recovery System, Plasticity, or neuroplasticity, refers to the ways that neural pathways are able to re-form in the brain. It's true that these pathways — like the one between the hippocampus and the amygdala — can get severely damaged due to constant exposure to stress, but such changes are not necessarily permanent.

While stress can negatively affect the brain, the brain and body can recover. Young adults, especially, are able to recover from the effects of stress; age has a direct correlation with the reversibility of stress-related damage. It's much more difficult for older adults to regain or create new neural pathways than their younger counterparts.
That's not to say all hope is lost for older adults, but "interventions," or activities that combat stress' wear-and-tear on the brain, are effective regardless of age. Interventions including activities like exercising regularly, socializing and finding purpose in life enable plasticity.

Promoting Health

It can seem like stress is an inevitable part of life, but chronic stress can have real and significant consequences on the brain. Understanding these effects and how to combat them can help promote overall health.

Stress isn't just something that happens

In fact, it has five stages: alarm, resistance, possible recovery, adaptation, and burnout. Not everyone will go through each stage sequentially – but by familiarizing, and observing early symptoms and taking professional help is necessary. **Maladaptive behaviors**
These are those that inhibit a person's ability to adjust to particular situations. This type of behavior is often used to reduce one's anxiety, but the result is dysfunctional and non-productive.

Coping

The term "coping" usually refers to dealing with the stress that comes after a stressor is presented, but many people also use proactive coping strategies to eliminate or avoid stressors before they occur. Personal choice in coping strategies is determined by personality traits and type, social context, and the nature of the stressor involved. Taking steps to recover from stress related problems by taking professional help is very much popular in the modern days.

Summing up of the unit II

Stressor experience can evoke changes at the molecular, cellular, synaptic and structural level along a continuum, with putative adaptive and maladaptive consequences emerging based on the nature of stressor, timing of exposure, controllability and predictability of stress, life history and the context in which stress effects are tested.

Stressors have a major influence upon mood, our sense of well-being, behavior, and health. Acute stress responses in young, healthy individuals may be adaptive and typically do not impose a health burden. However, if the threat is unremitting, particularly in older or unhealthy individuals, the long-term effects of stressors can damage health. Coping means to invest one's own conscious effort, to solve personal and interpersonal problems, in order to try to master, minimize or tolerate stress and conflict. The relationship between psychosocial stressors and disease is affected by the nature, number, and persistence of the stressors as well as by the individual's biological vulnerability (i.e., genetics, constitutional factors), psychosocial resources, and learned patterns of coping. Psychosocial interventions have proven useful for treating stress-related disorders and may influence the course of chronic diseases.

Model examination questions

Answer the following by choosing correct answer

These are the five stages you may experience when under stress: we can mention them in order as ( )

a. Alarm, b. Resistance, c. Coping .d. Adaptation, e. Burnout.
a. Resistance b. Alarm, c. coping .d. Adaptation, e. Burnout
a. coping .b. Adaptation , c. .Burnout, d. resistance, e. alarm
a. Adaptation, b. Resistance c. Alarm, d. Coping e. Burnout

1. Cortisol levels will be high when the person is ( )
   a. Very happy b. Very stressed, c. When relaxed, d. During sleep

2. Maladaptive behaviors like these can become a self-destructive pattern; identify adaptive behavior from below behaviors. ( )

a. Voidance, b. not making eye contact during conversation, c. Withdrawal from situations. d. seeking social support.

3. Which is not one of the common sign of "Fight or Flight" stage of stress is ( )

Cooler skin, b. sweating, c. Dilated Pupil, d. Dry mouth, e. stable breath

4. One of the below is not maladaptive behavior… ( )

Passive-aggressiveness, b. Self-harm, c. Anger, d. Maladaptive daydreaming, e. Substance use, f. Coping behavior

5. According to ------- Mental Health is a state of mind characterized by emotional well-being, good behavioral adjustment, relative freedom from anxiety and disabling symptoms, and a capacity to establish constructive relationships and cope with the ordinary demands and stresses of life. ( )

a. WHO, b. DSM-5, c. ICD-10, d. APA Dictionary

Suggested readings: Links

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5915631/
https://en.wikipedia.org/wiki/Stress_(biology)#Etymology_and_historical_usage
https://www.bemindfulonline.com/test-your-stress
https://www.healthline.com/health/maladaptive-behavior#maladaptive-traits
https://www.verywellmind.com/stress-and-health-3145086
https://humanstress.ca/stress/what-is-stress/history-of-stress/
https://en.wikipedia.org/wiki/Stress (biology) #Coping

Books

1. D M Pestonjee, 1998, Stress and Coping: The Indian Experience, SAGE Publications Pvt. Ltd Second edition (978-0761993124)
2. **Srinivas,** STRESS ANALYSIS AND EXPERIMENTAL TECHINIQUES, **Narosa , ISBN:9788184871616.**
3. Irwin G. Sarason, Abnormal Psychology: The Problem of Maladaptive Behavior, Prentice Hall India Learning Private Limited.
4. Jeffrey S. Nevid, 1996, The Problem of Maladaptive Behavior, Pearson College 978-0130849533

Lesson 7: Mental Health Definition, Panic Disorder

PANIC DISORDER

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), panic disorder is a type of anxiety disorder that is characterized by intense, recurrent, and unexpected panic attacks.

DSM IV excluded Panic disorder in the list of childhood anxiety disorders.
Experience of sever feeling of terror, rapid breathing, rapid heart rate are some symptoms and experience them unexpectedly without any apparent reason, may be preceded by some triggering event or situation.

In 2000, the World Health Organization found prevalence and incidence rates for panic disorder to be very similar across the globe. Age-standardized prevalence per 100,000 ranged from 309 in Africa to 330 in East Asia for men and from 613 in Africa to 649 in North America, Oceania, and Europe for women.

In an article examining the phenomenon of panic disorder in youth, Diler et al. (2004) found that only a few past studies have examined the occurrence of juvenile panic disorder. They report that these studies have found that the symptoms of juvenile panic disorder almost replicate those found in adults (e.g. heart palpitations, sweating, trembling, hot flashes, nausea, abdominal distress,

ANXIETY

Fear and anxiety can be normal reactions to specific situations and stressful events. Panic disorder differs from this normal fear and anxiety because it is often extreme, and may seem to strike out of the blue.

ANXIETY DISORDER

Feeling anxious about a few things some of the time, like giving a speech or taking a test, is in itself not a disorder. An anxiety disorder is a condition in which there is a significant distress and functional impairment.

PANIC ATTACKS

A panic attack is a sudden episode of intense fear that triggers severe physical reactions when there is no real danger or apparent cause. Panic attacks can be very frightening. When panic attacks occur, patient might think as losing control, having a heart attack or even dying.
Many people have just one or two panic attacks in their lifetimes, and the problem goes away, perhaps when a stressful situation ends.
Although panic attacks themselves aren't life-threatening, they can be frightening and significantly affect ones quality of life. Types of Panic Attacks can be divided under two headings. 1. Expected, and 2. Unexpected.

People with panic disorder most commonly experience unexpected panic attacks, but some do experience both types. As named, unexpected panic attacks occur suddenly without any external or internal cues. In other words, they seem to happen "out of the blue" when patient feel relaxed. The Expected panic attacks occur when someone is exposed to a situation for which they carry fear. If someone has fear of something which they can avoid may get panic attack as expected by them. So they can take care of the situation.

PANIC DISORDER

Many people living with panic disorder describe feeling as though they are having a heart attack or on the verge of dying, and experience some or all of the symptoms such as Chest pain, Dizziness, Feelings of extreme terror that occur suddenly without warning, Numbness in the hands and feet, Pounding heart, Rapid breathing, Sweating, Trembling and Weakness.
Symptoms go away if anxiety situation is complete and not there anymore. But if one had recurrent, unexpected panic attacks and spent long periods in constant fear of another attack, he may have a condition called panic disorder.

DESCRIPTION OF PANIC DISORDER

The Panic disorder includes mental and behavioral issues, and is specially an anxiety disorder. The panic disorder includes recurring and unexpected panic attacks. The attacks are sudden periods of intense fear that may include palpitation, shortness of breathing with shaking and sweating. Numbness and a feeling that something terrible going to happened. The avoidance places where attacks taken earlier, worry of ongoing attacks can also be present.
. In fact, many people have had problems with personal relationships, education and employment while struggling to cope with panic disorder. Some people with panic disorder may conceal their condition because of the stigma of mental illness. In some individuals, symptoms may occur frequently for a period of months or years, and then many years may pass with little or no symptoms. In some cases, the symptoms persist at the same level indefinitely. There is also some evidence that many individuals (especially those who develop symptoms at an early age) may experience symptom cessation later in life (e.g., past age 50)

THE CAUSE OF PANIC DISORDER

The common cause for panic disorder is anxiety but cause is unknown. It runs in families, and there are evidence from research that it more among smokers and among those who undergo stress. Some people with record of child abuse, it occurs far more often in people with above average intelligence.
The cause of panic disorder is unknown. Panic disorder often runs in families. Risk factors include smoking, psychological stress, and a history of child abuse. Diagnosis involves ruling out other potential causes of anxiety including other mental disorders, medical conditions such as heart disease or hyperthyroidism, and drug use. Screening for the condition may be done using a questionnaire.
Although the exact causes of panic disorder are not clearly understood, many mental health experts believe that a combination of environmental, biological, and psychological factors play a role.

ONSET OF PANIC DISORDER

Research shows that childhood trauma, smoking, and who don’t have disciplined planning of life

events, people who have lagged behind in achieving their life goals may undergo panic attacks. Panic disorder affects about 2.5% of people at some point in their life. It usually begins during adolescence or early adulthood, but may affect people of any age. It is less common in children and older people. Women are more often affected than men.
Age: Panic disorder typically develops between the ages of 18 and 35.
Gender: According to the National Institute of Mental Health, women have more than twice the risk of panic disorder than men.
Genetics: If any have a close biological family member with panic disorder, they are much more likely to develop the condition. Although up to half or more of people with panic disorder do not have close relatives with the condition.
Trauma: Experiencing a traumatic event, such as being the victim of physical or sexual abuse, can increase risk of panic disorder as well.
Life transitions: Going through a life transition or difficult life event, including the death of a loved one, divorce, marriage, having a child, or losing a job may increase also risk.

DIAGNOSIS

To be diagnosed with a panic disorder, a person must experience recurrent and often unexpected panic attacks, according to the DSM-5. In addition, at least one attack needs to be followed by one month or more, of the person fearing that they'll have more attacks. Diagnosis rule out other potential causes of symptoms, including the direct physiological effects of a substance (such as drug use or a medication) or a general medical condition, another mental disorder, including social phobia or another specific phobia, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), or separation anxiety disorder.
The DSM criteria include avoidance behavior by Panic disorder patients as one of the symptoms. People with panic disorder often avoided certain situations or objects; it can also lead to the development of phobias. So, For example, a person living with panic disorder might stop leaving home in order to prevent having an attack or losing control in public. In time, this person might develop agoraphobia, a marked fear of being in a variety of situations outside of the home in which escape might be difficult or help might not be available if debilitating symptoms develop. While previous versions of the DSM categorized panic disorder as occurring with or without agoraphobia, the newest edition of the diagnostic manual lists the two as distinct and separate disorders.
Panic disorder should not be given as the main diagnosis if the person has a depressive disorder at the time the attacks start; in these circumstances, the panic attacks are probably secondary to depression. The Panic Disorder Severity Scale (PDSS) is a questionnaire for measuring the severity of panic disorder.

BRAIN AND NEURAL BASE FOR PANIC DISORDER

Studies on neuroanatomical conditions of panic disorder give same results as it was observed in anxiety disorders. The parts of neural connections related to Insula, (Insula in the brain is linked to and involved in consciousness, and play vital and diverse role in emotions, regulation of body's homeostasis. The compassion, empathy, taste, perception, motor control, self-awareness, cognitive functioning, interpersonal experience, keep awareness of homeostasis related emotions such as hunger, fatigue and pain. It is also involved in psychopathology), Amygdala, (it plays very major role in memory, decision making, and emotional responses, which include fear, anxiety, and aggression. It is part of Limbic system and the name given to it by Karl Friedrich Burdach in 1822), Hippocampus, (A part of Limbic system concerned with consolidation of information from short term memory to long term memory, and in spatial memory that enables navigation), Anterior Cingulate cortex (ACC), (it is plays major role in

higher levels of functioning such as Attention, reward anticipation, ethics, morality, decision making etc., impulse control, emotions and performance monitoring and error detection), Lateral prefrontal cortex, (This part of the brain is very important as it is involves functions like inhibition of urges, motivation, identification of rewarding and significant stimuli, mood and empathy. It primarily involved in working memory, planning, reasoning, and active forms of imagination, prefrontal synthesis, mental rotation, integration of modifiers.), and periaqueductal grey, (this brain region play critical role in pain reduction as it has encephalin – producing cells that suppress pain, autonomic function, motivated behavior, behavioral responses to threatening stimuli).

With the above information about brain parts related to various emotional and cognitive functions, scientists concluded that, chemical imbalances with in the limbic system and regulatory chemical GABA – A is reduced and sends falls information to the Amygdala which regulates the body's fight or flight response mechanism and produce physiological symptoms of panic disorder.

In recent research on two mediators and moderators of panic disorder. The partial pressure of carbon dioxide, which helps in training of breathing exercise and anxiety sensitivity for panic disordered people.

Another mediator is hypochondriacal concerns, which mediate the relationship between anxiety sensitivity and panic symptomatology, thus, anxiety sensitivity affects hypochondriacal concerns which, in turn, affect panic symptomatology.

Perceived threat is important in panic disorder. Perceived sensitivity and agoraphobia dictate the degree to which anxiety sensitivity results in agoraphobia.

Another recently identified moderator of panic disorder is genetic variations in the gene coding for galanin, (included in biologically diverse functions such as nociception, waking and sleep regulation, cognition, feeding, regulation of mood, regulation of blood pressure, Galanin is linked to a number of diseases including Alzheimer's disease, epilepsy as well as depression, eating disorders, cancer, and addiction). These genetic variations moderate the relationship between females suffering from panic disorder and the level of severity of panic disorder symptomatology.

RISK FACTORS

The studies show the following risk factors.

It starts in late adulthood and affects more women. People with family history are more prone to get it, major stress in the life, (death or serious illness of a loved one), Traumatic event like serious accident or sexual assault, major changes in job, family life, divorce etc., excessive smoking, excessive caffeine intake, childhood trauma or physical or sexual abuse.

PREVENTION

Prevention always depends on determination and support from loved ones. There is no sure way to prevent panic attacks or panic disorder. Getting treated for panic attacks as soon as possible, as it prevents from worsening the situation, the frequency of attacks reduces. Treatment plan must be implemented regularly as suggested by the doctors involved, regular physical activity is very much necessary under supervision of experts.

TREATMENT

The Anxiety problems are treated with relaxation techniques, coping strategies, cognitive behavior therapy and medication. Comparative clinical studies suggest that muscle relaxation techniques and breathing exercises are not efficacious in reducing panic attacks. In fact, breathing exercises may actually increase the risk of relapse.

In various studies on effectiveness of professional help show that, the professional help play very important role if personal presence is applied than on line services or just giving instructions. Gloster et al. (2011) went on to examine the role of the therapist in CBT. They randomized patients into two groups: one being treated with CBT in a therapist guided environment and the second receiving CBT through instruction only, with no therapist guided sessions. The findings indicated that the first group had a somewhat better response rate, but that both groups demonstrated a significant improvement in reduction of panic symptomatology. These findings lend credibility to the application of CBT programs to patients who are unable to access therapeutic services due to financial, or geographic inaccessibility

Appropriate treatment by an experienced professional can prevent panic attacks or at least substantially reduce their severity and frequency—bringing significant relief to 70 to 90 % of people with panic disorder. Relapses may occur, but they can often be effectively treated just like the initial episode.

Apeldoorn, F.J. et al. (2011) demonstrated the additive value of a combined treatment incorporating an SSRI (selective serotonin reuptake inhibitors/serotonin-norepinephrine reuptake inhibitors (SSRIs/SNRIs) treatment intervention with cognitive behavior therapy (CBT).

Koszycky et al. (2011) discuss the efficacy of self-administered cognitive behavioral therapy (SCBT) in situations where patients are unable to retain the services of a therapist. Their study demonstrates that it is possible for SCBT in combination with an SSRI to be as effective as therapist-guided CBT with SSRI. Each of these studies contributes to a new avenue of research that allows effective treatment interventions to be made more easily accessible to the population

As with many disorders, having a support structure of family and friends who understand the condition can help increase the rate of recovery. During an attack, it is not uncommon for the sufferer to develop irrational, immediate fear, which can often be dispelled by a supporter who is familiar with the condition. For more serious or active treatment, there are support groups for anxiety sufferers which can help people understand and deal with the disorder.

A systematic analysis of trials testing this kind of self-help found that websites, books, and other materials based on cognitive-behavioral therapy could help some people. The best-studied conditions are panic disorder and social phobia.

Interceptive exposure (The patient is given exercises to do that mimic the feelings of a panic attack. For example, they might be instructed to breath quickly to induce hyperventilation, put their head between their legs and then sit up quickly to produce a head rush, or spin around in a chair to create dizziness.) Is sometimes used for panic disorder. People's interceptive triggers of anxiety are evaluated one-by-one before conducting interceptive exposures, such as addressing palpitation sensitivity via light exercise.

Despite evidence of its clinical efficacy, this practice is reportedly used by only 12–20% of psychotherapists. Potential reasons for this underutilization include "lack of training sites, logistical hurdles (e.g., occasional need for exposure durations longer than a standard therapy session), policies against conducting exposures outside of the workplace setting, and perhaps most tellingly, negative therapist beliefs (e.g., that interceptive exposures are unethical, intolerable, or even harmful).

PSYCHOTHERAPY

Psychotherapy for panic disorder can include several different approaches.

Cognitive behavioral therapy (CBT) can help people with panic disorder learn new ways of thinking and reacting to anxiety-provoking situations. As part of the CBT process, therapists help clients identify and challenge negative or unhelpful patterns of thinking and replace these thoughts with more realistic and helpful ways of thinking.

Cognitive behavioral therapy encourages patients to confront the triggers that induce their anxiety. By facing the very cause of the anxiety, it is thought to help diminish the irrational fears that are causing the issues to begin with. The therapy begins with calming breathing exercises, followed by noting the changes in physical sensations felt as soon as anxiety begins to enter the body. Many clients are encouraged to keep journals. In other cases, therapists may try and induce feelings of anxiety so that the root of the fear can be identified.

Comorbid clinical depression, personality disorders and alcohol abuse are known risk factors for treatment failure. In addition to medication and psychotherapy, Interceptive exposure, another form of psychotherapy that has shown effectiveness in controlled clinical trials is panic-focused psychodynamic psychotherapy, which focuses on the role of dependency, separation anxiety, and anger in causing panic disorder.

There are some lifestyle habits that have been found to help people better cope with the symptoms of panic disorder.

Get Moving -Not only can regular exercise help reduce stress, anxiety, and tightness throughout the body, but it's been found to lessen the frequency of panic attacks as well.
Prioritize Sleep - Sleep disturbances and panic disorder can be a vicious cycle. People with panic disorder often have trouble sleeping and the resulting sleep deprivation can result in greater panic disorder symptoms.
Watch Your Diet - While there's no magic diet to cure your panic disorder, there are certain foods and substances that might increase your anxiety or trigger a panic attack, including: Alcohol, Caffeine, Monosodium glutamate (MSG), and refined sugar.
Keep a Journal - In addition to tracking your triggers, a panic attack journal can be used to record your symptoms (physical and emotional) as well as any coping strategies that helped you cope with those symptoms.
Practice Relaxation - Relaxation techniques can help you slow down your thoughts, ease stress and anxiety, and counteract many of the cognitive and physical symptoms of panic disorder. Here are a few relaxation techniques you can try on your own or with the help of a mental health professional. Deep breathing, Mindfulness meditation, Progressive muscle relaxation, Visualization, Yoga
Seek Help - For many people, the stigma associated with panic disorder can prevent them from seeking support and treatment. However, getting a proper diagnosis and treatment and having a solid support system of friends and family can help you manage your symptoms and feel your best.
Exposure therapy involves progressively exposing people with panic disorder to the object and situations that trigger a fear response while teaching and practicing new relaxation strategies.
Panic-focused psychodynamic psychotherapy (PFPP) aims to uncover underlying conflicts and experiences that may have influenced the person's development of panic and anxiety.

MEDITATION

Medications for panic disorder fall into one of two categories: antidepressants and anti-anxiety drugs. Selective serotonin reuptake inhibitors (SSRIs) are the most commonly prescribed class of antidepressants used for panic disorder. Benzodiazepines are commonly prescribed classes of anti-anxiety medication that can help reduce the severity of panic attacks acutely.

REFERENCES

https://www.mayoclinic.org/diseases-conditions/panic-attacks/symptoms-causes/syc-20376021

https://en.wikipedia.org/wiki/Panic_disorder

https://www.bbrfoundation.org/blog/advice-parents-diagnosing-and-treating-anxiety-disorders-young-people

https://www.verywellmind.com/what-is-a-panic-disorder-2795468

Lesson 8: Obsessive Compulsive Disorder

INTRODUCTION

Behavioral disorders involve a pattern of disruptive behaviors in children that last for at least 6 months and cause problems in school, at home and in social situations. Nearly everyone shows some of these behaviors at times, but behavior disorders are more serious.

Behavioral disorders may involve, Inattention, Hyperactivity, Impulsivity, Defiant behavior, drug use, criminal activity

What is Obsessive Compulsive Disorder?

Obsessive-Compulsive Disorder (OCD) is clinical classification but we're often asked if we consider OCD a mental health problem, so we thought it might be helpful to try and summarize how we classify and refer to OCD and the language that we use.

OCD is considered an **anxiety disorder**, and technically anxiety disorders are considered **mental health problems**, however many users struggle with both of these labels. Use the phrase a person 'suffers with OCD' rather than 'a person is OCD', this is because a person can't be a disorder, but they can suffer with the disorder. For a similar reason we will also never use the term 'OCDers', because people can't be a disorder.

The person involved in OCD might be having **Inflated responsibility** – belief that they are responsible for preventing harm coming to themselves, a loved one or others, **Overestimation of threat** – belief that things are riskier than they are.

OCD is driven by the fear of consequences, no matter how unlikely they are. For someone with OCD, the perceived level of risk is turned on its head, a 0.01% risk feels as likely to happen as a 99.9% risk. Emotions play a big part in OCD becoming stuck and how someone with OCD responds to thoughts helps to explain where these emotions come from. In a situation an event can make people feel completely different emotions (angry, happy, anxious), and result in them behaving in very different ways, due to their different beliefs about the event.

Obsessive-Compulsive Disorder, compared with other anxiety related disorders is associated with more marked social and work related occupational impairment

So for someone with OCD, anxiety provoking situations and thoughts cause negative interpretations about what might or could happen. Even when nothing bad happens, anxiety remains high until a person carries out a safety seeking behavior – the compulsion. Because these negative interpretations still remain, the same anxiety provoking thoughts continue to necessitate further safety seeking behaviors, so instead of digging themselves out of a hole, they are digging that hole deeper.

The problem is that the person with OCD will become besieged by the obsessive thoughts. In fact the word '**obsession**' comes from the Latin 'obsidere' which means 'to besiege'.

Doubt is another characteristic of OCD – the French once called OCD 'folie du doute', which

translates to 'madness of doubt'. Anxiety is proportional to a person's perception of danger and risk. The worse the perceived consequences the greater is the fear of something bad happening and the more certain someone will want to be that they have done everything they can to prevent it.

Obsessive-Compulsive Disorder?

Obsessive and Compulsive disorder is a frequently found mental and behavioral disorder, in which obsessive thoughts and compulsive actions are involved. A disorder could be defined as a set of problems, which result in causing significant difficulty, distress, impairment and/or suffering in a person's daily life.

Equally, a disorder may be persistent, relapsing and remitting, it is not unusual for symptoms to wax and wane over time and become a little like a rollercoaster, with the severity increasing during times of stress, perhaps at work, university or within relationships for example.

So when people misuse OCD and make reference to being 'a little OCD', in addition to failing to understand that OCD is a disorder, they also fail to realize the impact it has on those that suffer. OCD can be so severe that it can seriously impact on some or all areas of a person's life, sometimes disrupting or completely ruining:

- Education
- Employment
- Career development
- Relationships with partners, parents, siblings and friends
- Starting a family
- Access to own children
- Quality of life (because of social interaction)

Also, some of the behavior that people do to cope with OCD (including compulsions) can also have devastating effects, including:

- Physical damage from compulsions (red and raw bleeding skin. Eye damage)
- Substance abuse (self-medicating with alcohol or other substances)
- Terminations (some women have felt they had no choice but to have abortions because of OCD)

OCD can affect people in different ways. Some people may spend much of their day carrying out various compulsions and be unable to get out of the house or manage normal activities. Others may appear to be coping with day-to-day life while still suffering a huge amount of distress from obsessive thoughts. Some people with OCD may carry out their rituals and compulsions in secret or make excuses to avoid social interaction so they can complete compulsions.

The severity of OCD differs markedly from one person to another. Some individuals may be able to hide their OCD from their own family. However, the disorder may have a major negative impact on social relationships leading to frequent family and marital discord or dissatisfaction, separation or divorce. It also interferes with leisure activities and with a person's ability to study or work, leading to diminished educational and/or occupational attainment and unemployment.

It can be particularly difficult for families when the person with OCD has poor insight into the disorder. In these cases the person will have difficulty recognizing that their concerns are excessive, that they may have OCD, or indeed that they may need help.

There is also frequent reports of a financial burden on the family.

The impact on family members should also not be underestimated. Loved ones, often unwittingly become entwined in OCD compulsions:

- Offering reassurance
- Avoiding objects or places for fear of triggering their loved one's OCD
- Carrying out actions (compulsions) for their loved one with OCD, i.e. looking after their baby, taking rubbish out, stripping naked at the door to not spread 'contamination'.

Said OCD was the fifth leading causes of disease burden for women aged 15-44 in the developed world.

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Finally, in some rare cases, the symptoms of a parent with OCD may directly impact on the well-being of family members, for example, when concerns about contamination lead to extreme hygiene measures.

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2. Avoiding objects or places for fear of triggering their loved one's OCD

3. Carrying out actions (compulsions) for their loved one with OCD, i.e. looking after their baby, taking rubbish out, stripping naked at the door to not spread 'contamination'.

Whilst we must not dismiss what a devastating impact OCD has, it's worth noting that with successful treatment, people don't just improve their quality of life, many move on to recovery.

DEFINITION OF OBSESSIVE COMPULSIVE DISORDER

Obsessive and Compulsive disorder is a frequently found mental and behavioral disorder, in which obsessive thoughts and compulsive actions are involved. A disorder could be defined as a set of problems, which result in causing significant difficulty, distress, impairment and/or suffering in a person's daily life. As the quote above shows, the Oxford English Dictionary define a disorder as an illness that disrupts normal physical or mental function. Looking at disorders in a little more detail, they are physical or mental conditions that disturb the regular or normal functions of everyday activities and day to day life. They can take up a lot of time and complicate the normal functioning of an individual.
The phrase obsessive–compulsive is sometimes used in an informal manner unrelated to OCD to describe someone as being excessively meticulous, perfectionist, absorbed, or otherwise fixated.

Due to the nature of disorders being flexible, they may not always be evident in every single situation and equally what may affect one individual may not be as troublesome to another individual in the same situation. Therefore, a disorder is a very flexible and individual term.
Equally, a disorder may be persistent, relapsing and remitting, it is not unusual for symptoms to wax and wane over time and become a little like a rollercoaster, with the severity increasing during times of stress, perhaps at work, university or within relationships for example.

NATURE OF OCD

Often referred to as OCD, obsessive-compulsive disorder is actually considered an anxiety disorder (which was discussed earlier in this fact sheet). OCD is characterized by recurrent, unwanted thoughts (obsessions) and/or repetitive behaviors (compulsions). Repetitive behaviors (hand washing, counting, checking, or cleaning) are often performed with the hope of preventing obsessive thoughts or making them go away. Performing these so-called "rituals," however, provides only temporary relief, and not performing them markedly increases anxiety.

CAUSES

The cause for OCD is unknown but research in the area found genetic components as responsible, in identical twin studies. The risk factors include child abuse, or other stress inducing event. Infections, drug and medical causes were also have close correlation with OCD.

However, there are plenty of theories surrounding the potential causes of OCD, involving one of or a combination of; neurobiological, genetic, learned behaviors, pregnancy, environmental factors or specific events that trigger the disorder in a specific individual at a particular point in time. Others have said that life events can cause it. Others have suggested that it's caused by a chemical imbalance in the brain. Different people, different researchers find different explanations.

Brain imaging studies have consistently demonstrated differing blood flow patterns among people with OCD compared with controls, and the cortical and basal ganglia regions are most strongly implicated. However, subsequent meta-analysis studies found that differences between people with OCD and healthy controls were found consistently only in the orbital gyrus and the

head of the caudate nucleus.

A 1998 finding implicated the basal ganglia as a key brain region in OCD with the discovery that in a sub-group of children with OCD the disorder may have been triggered by infections. Streptococcal infections trigger an immune response, which in some individuals generates antibodies that cross-react with the basal ganglia. It is thought that the body's natural response to infection, the production of certain antibodies, when directed to parts of the brain might be linked in some way to Pediatric Autoimmune Neuropsychiatric Disorders associated with Streptococcal Infection (PANDAS). So it could be that PANDAS whilst not a cause for OCD, triggers symptoms in children who are already predisposed to the disorder, perhaps through genetics or other causal explanations.

Overall, genetic studies indicate some tendency towards anxiety that runs in families, although this is probably only slight. Some research points to the likelihood that OCD sufferers will have a family member with OCD or with one of the other disorders in the OCD 'spectrum'. . In 2001, a meta-analytic review reported that a person with OCD is 4 times more likely to have another family member with OCD than a person who does not have the disorder. What this suggests is that genetics may not be the only cause of OCD (if at all), and that family prevalence of OCD could be learned behaviors in some cases. So although we cannot rule genetics out, it's clear that it's not the whole story and learned or environment factors may play a more significant part.

It's common to see and hear mental health professionals describing the cause of OCD in terms of a 'biochemical imbalance'. These approaches have focused on one particular neurotransmitter, serotonin. Serotonin is the chemical in the brain that sends messages between brain cells and it is thought to be involved in regulating everything from anxiety, to memory, to sleep. In more recent years some researchers have argued that the most robust evidence for the serotonin hypothesis is the specificity of serotonin reuptake inhibitors (SRI) and selective serotonin reuptake inhibitor (SSRI) medication.

It's worth noting that relapse is frequently associated with the withdrawal of SSRI medications in OCD, more so than in other conditions, especially where no behavioral therapy is in place, which is yet to be fully understood. This could mean that serotonin is an important neurotransmitter involved in the maintenance of OCD, if not a specific cause.

Overall, there is a place for SSRIs in the treatment of OCD, especially where co-morbidity is present, provided that medication remains part of informed patient choice, and combined with psychological therapy like CBT.

Other research has revealed that there may be a number of other factors that could play a role in the onset of OCD, including behavioral, cognitive, and environmental factors. According to the Learning Theory, OCD symptoms are a result of a person developing learned negative thoughts and behavior patterns, towards previously neutral situations which can result from life experiences.

Stress and parenting styles are environmental factors that have been blamed for causing OCD, but no evidence is yet to show that. Stress does not actually cause OCD, but major stresses or traumatic life events may precipitate the onset of OCD. However, these are not thought to cause OCD, but rather trigger it in someone already predisposed to the disorder.

If left untreated, everyday anxiety and stress in a person's life will worsen symptoms in OCD. Problems at school or work, university exam pressures and normal everyday problems that

relationships can bring are all contributory factors to increasing the frequency and severity of a person's OCD. Depression is also sometimes thought to cause OCD, although without question depression will make OCD symptoms worse, the majority of experts believe that depression is often a consequence of OCD rather than a cause.

Whilst the cause is currently still being debated, sometimes vigorously by the scientists, what is not in contention is the fact that Obsessive-Compulsive Disorder is indeed a chronic (at times), but equally very treatable medical condition.

It's also important that we don't become fixated on what causes our OCD at the expense of fighting and tackling it. Even if we think we have identified a cause, it won't necessarily help us overcome OCD, so our focus must remain on tackling the problem we have right now, today, in the here and now.

HISTORY OF OCD

The incidence of Obsessive-Compulsive Disorder (OCD) or Obsessive Compulsive Neurosis as it was once known, is a relatively common disorder and can be traced historically, cross-culturally and across a broad social spectrum and does not appear to restrict itself to any specific group of individuals. On the contrary, evidence shows numerous examples of OCD type symptoms in the lives of figures throughout the ages.

People experiencing problems with obsessions and compulsions (what we now call OCD) will have probably been around since people have been around. Finding early historical descriptions of OCD does exist, with some clear detailed likely cases dating back to the 14th century.

Of course the name OCD did not come into being until the 20th century, but prior to that earlier references to symptoms we would now call Obsessive-Compulsive Disorder were surprisingly called scrupulosity.

Much of the earlier historical record of OCD descriptions are in the religious, rather than the medical literature, and what is clear from the cases we have found, is that from the in the 14th and 18th century, obsessional fears around religion were commonplace. So around this time, a new word for obsessions and compulsions came into usage, scrupulosity. Later in the seventeenth century, obsessions and compulsions were also described as symptoms of melancholy.

Scrupulosity is a modern-day psychological problem that echoes the traditional use of the term 'scruples' in a religious context, to mean obsessive concern with one's own sins and compulsive performance of religious devotion, where in earlier centuries it encompassed all types of obsessions and compulsions. The term is actually derived from the Latin 'scrupulum', a sharp stone, implying a stabbing pain on the conscience. The use of the term dates back centuries, with several historical and religious figures suffering from doubts of sin, and expressing their obsessional suffering. Running through some of those historical and religious figures in from 1363 to 1700 chronological order. Some are having fear of sins, scrupulosity, and pure confessions, wild, baseless fears that one has not prayed or otherwise acted according to God's wishes, which can be caused by either the devil or physical illness. Antoninus's belief (conviction of the existence of a divine power and government was founded on his perception of the order of the universe) that scrupulosity sometimes had a physical cause, and not necessarily a satanic one, was one of the earliest documented realizations that maladies of thought and behavior were illnesses necessitating "medicine or other physical remedies" as he put it. He

recommended that those trying to escape religious compulsions receive God's grace, study sacred Scripture, pray constantly, and put up a spirited resistance to the urge to pray or confess excessively.

John Locke (1632–1704) was a philosopher and physician who widely regarded as one of the most influential of enlightenment thinkers and in 1678 it's reported that he drafted a letter on the subject of scrupulosity. In one of his letters he wrote, "I cannot imagine that God, who has compassion upon our weakness and knows how we are made, would put poor men, nay, the best of men, those that seek him with sincerity and truth, under almost an absolute necessity of sinning perpetually against him, which will almost inevitably follow if there be no latitude at all allowed as in the occurrences of our lives."

One of the first known public presentations of what we now call OCD happened in 1691 when John Moore (1646–1714), the bishop of Norwich (later Bishop of Ely) preached before Queen Mary II on "religious melancholy" describing good moral worshippers who are tormented by "naughty and sometimes blasphemous thoughts" despite all their efforts to stifle and suppress them.

As time moved on, physicians of the 1700s and 1800s described more types of behaviors including washing, checking, obsessive fear of syphilis, aggressive and sexual obsessions, but fewer religious obsessions were reported than in earlier centuries.

Modern concepts of OCD began to evolve in the nineteenth century, when theories like faculty psychology, phrenology and mesmerism were popular and when 'neurosis' implied a neuropathological condition. Back then when physicians were struggling to understand the mentally ill, they were influenced by intellectual currents coursing through philosophy, physiology and political thought.

Obsessions, in which insight was preserved, were gradually distinguished from delusions, in which it was not. Compulsions were distinguished from impulsions which included various forms of paroxysmal, stereotyped and irresistible behavior. Influential physicians disagreed about whether the source of OCD lay in disorders of the will, the emotions or the intellect.

In his 1838 psychiatric textbook, the famous French psychiatrist Jean Etienne Dominique Esquirol (1772–1840) described OCD as a form of monomania, or partial insanity. Monomania is a term used to describe psychiatric conditions where the focus of pathology is in one specific area of dysfunction but the rest of the personality and intellect remain intact.

Another French psychiatrist, Henri Dagonet (1823–1902) considered compulsions to be a kind of impulsion and OCD a form of 'folie impulsive' (impulsive insanity). In this illness, violent, irresistible impulses overcame the will and manifested in obsessions or compulsions. He described the phenomenon as follows: "the more one tries to discard an idea, the more it becomes imposed upon the mind, the more one tries to get rid of an emotion or tendency, the more energetic it becomes." Although Dagonet considered OCD as an impulse control disorder, he saw it as a disorder and failure of the will to control these impulses; this concept is different from the irresistible impulses that occur under conditions of organic pathology, such as the epilepsies or damage to the frontal lobes.

Writing in 1850, the French psychiatrist, Jean-Pierre Falret (1794–1870) used the term folie du doute, which translates to 'madness of doubt', and in 1875 another French psychiatrist, Henri Le Grand du Saulle (1830–1886) published a book called La folie du doute avec délire du toucher, which translates to 'The madness of doubt with delirium (delusions) of touch'.

In the UK, Zwang, which would be translated usually to 'forced' was instead translated as 'obsession', but in the United Stated it was translated as 'compulsion', so Obsessive-Compulsive Disorder emerged as the eventual compromise at some time in the mid-20th century.

Interestingly, although today health professionals emphasize the dual nature of the illness, obsessive thoughts trigger anxiety, leading to a compulsive action, those earlier health professionals saw it as a single entity.

In 1877, the German psychiatrist, Karl Friedrich Otto Westphal (1833–1890) ascribed obsessions to disordered intellectual function. His description of a "compelled idea" captures both the cognitive and compulsive aspects of the disorder.

In 1895, the term obsessive neurosis "zwangsneurose" was first mentioned in Freud's paper about "anxiety neurosis", the term obsessive neurosis was still used by psychiatrists well into the 1990s and a disorder or failure of will was seen as part of the obsessive clinical picture, the argument could be made that OCD is a degenerative disorder of the brain and (based on the family studies), of hereditary origin. This concept of neurodegeneration did little to reduce the stigma associated with mental illness in general, but to those already secretive and hypersensitive because of their obsessive and compulsive behaviours, this was an additional reason to hide their disease, and perhaps why into the end of the 20th century OCD was still considered 'the secret illness'.

A great proportion of Freud's thinking about obsessive neurosis was formulated in 1909 with his famous description of the case of "The rat man" in which Freud described the psychoanalytical treatment of a 29-year old man who developed certain impulses (Zwangshandlung) against aggressive and sexual obsessions since his early childhood. Later in his life, the patient came across a senior military officer who conveyed a particularly sadistic method of punishment that involved confining rats and placing them in the victim's anus. At this moment, Freud's patient reportedly started obsessing that his dead father and a young lady he liked could have suffered this type of torture. Although the patient expressed horror as he mentioned it in his analysis, Freud interpreted it as one of "horror at pleasure of his own desires, of which he himself was unaware." The precipitating cause of this man's obsessions was never clearly identified by Freud or by the patient himself, but Freud correlated them to the patient's ambivalent feelings (hate—love) about his father and his doubts concerning sexual orientation.

Sigmund Freud, the Austrian founder of psychoanalysis, gradually evolved a conceptualization of OCD that influenced and then drew upon his ideas of mental structure, mental energies, and defense mechanisms. In Freud's view, the patient's mind responded maladaptive to conflicts between unacceptable, unconscious sexual or aggressive id impulses and the demands of conscience and reality. He believed obsessive-compulsive behavior is linked to unconscious conflicts manifested as symptoms of the illness. Conflict develops between the desires and subsequent actions of the conscious and unconscious minds. OCD sufferers, frequently "compelled" to carry out actions giving only temporary relief from anxiety, still "know" it is ridiculous or embarrassing to do so.

Freud's theories about such matters continued to be fairly well-accepted up to the 1960 and 1970s. In the 1970s behavioral psychology and later cognitive psychology began to overcome the Freudian theory and other ideas still floating around at that time, to become the main models for understanding OCD that remain so to this day.

TYPES OF OCD

OCD will fall into one of these five main categories, with themes often overlapping between categories too. 1. Checking, 2. Contamination / Mental Contamination, 3. Symmetry and ordering, 4. Ruminations / Intrusive Thoughts, 5.Hoarding

There are infinite types of OCD, it can impact on any thought, on any subject, on any person, on any fear, and frequently fixates on what's important in a person's life. For example, if religion is important to someone, OCD fixates on unwanted intrusive thoughts around religion, perhaps making the sufferer believe their actions/thoughts will offend their god. Another example is if someone begins a new relationship, OCD can make a person question that relationship, their feelings, their sexuality resulting in almost constant rumination, perhaps with the sufferer worrying that they may be misleading their partner.

The brain is a powerful organ, and in many types of OCD, especially those focused on themes around sexuality it can cause parts of our body to react when we focus on our thoughts, even if we desperately don't want it to.

SYMPTOMS OF OCD

The OCD person reports that inability to control either thoughts or activities for more than a short period of time. Common compulsions occur in such a degree that the persons daily life is negatively affected, often consuming patients valuable time. Most of the adults realize that the behaviors do not make sense. The condition associated with tics, anxiety disorder and risk of suicide.

The mothers or to be mothers develop worries and related obsessive thoughts of wellbeing of children and which lead to compulsive behaviors or actions. So it is anxiety management to check children frequently, taking excessive care of food they take, following some culture bound activities for wellbeing of children. These acts may take lot of her time and child's pleasure. Again as with other forms of OCD, women with such concerns may seek excessive reassurance from their partner or family and friends that the baby is developing satisfactorily and that her behavior is 'safe'. They may then avoid contact with their baby or take special measures to stay 'safe' around them such as hiding knives and sharp objects in the home. Offers an insight into some of the common compulsions seen in the prenatal or postnatal period. The OCD is the power of a single unwanted intrusive thought (obsession) to cause such distress and secondly how such thoughts can lead to seemingly nonsensical compulsions (i.e. ripping the piece of paper into many shreds).

Overt and Covert Compulsions can be differentiated by observing the acts of the individual suffering and by conducting clinical interviews. The overt compulsion (i.e. observable by others), such as checking that a door is locked or, covert (an unobservant mental act) is repeating a

specific phrase in the mind.

Reassurance is also most suffered compulsive behavior. The sufferers will be more than two persons, one being the patient and others are who live with them either in the home or work place. The actions can be mental or physical. When someone is affected by Obsessive-Compulsive Disorder their natural response is to fight their unwanted and anxiety provoking intrusive thoughts with purposeful behaviors and deliberate actions (this includes both mental and physical actions, seeking reassurance and avoidance of people, places and objects), these behaviors are called compulsions.

The most compulsive behaviors include Checking (e.g. gas taps), Cleaning, washing, Mental compulsions (e.g. special words or prayers repeated in a set manner), Ordering, symmetry or exactness, Hoarding/collecting, Counting, Checking of switches, cars, doors, taps, locks, body reactions.

When clinical interviews were conducted it was found that the obsessive thoughts might be to prevent danger from fire/ breaks-in or signs of arousal. The rituals done, like counting or checking to neutralize as obsessional thought. Hoarding is done with an obsessive thought that something bad may happen, if dangerous items are discarded, the obsessive thought behind might be that something important or harm happening, the compulsive act of avoidance of kitchen knives and such instruments (locking them in drawer) may have an

Other examples of common obsessions include:

- Worrying that something/someone/somewhere is contaminated.
- Worrying about catching HIV/AIDS or other media publicized illnesses such as Bird Flu or Swine Flu.
- Worrying that everything must look and feel arranged at a specific position (sometimes symmetrically) so everything feels 'just right'.
- Worrying about causing physical or sexual harm to others.
- Unwanted and unpleasant sexual thoughts and feelings about sexuality or the fear of acting inappropriately towards children.
- Worrying that something terrible will happen.
- Unwanted and intrusive thoughts about violence.
- Fear of something bad happening unless checked (i.e. property will be broken into/burn down).
- Worrying that have caused an accident whilst driving.
- Having the unpleasant feeling that are about to shout out obscenities in public.

All of these are the 'worry/fear' which is the obsession, rather than the behavior which would be the compulsion.

PREVALENCE

The OCD experience will be there for everyone at any point of time in their lives. Obsessive–compulsive disorder affects about 2.3% of people at some point in their lives. While rates during any given year are about 1.2%. It is unusual for symptoms to begin after the age of 35, and half of people develop problems before 20. Males and females are affected about equally, and OCD occurs worldwide.

Based on current estimates for the UK population, there are around three quarters of a million people living with OCD at any one time. What we know about OCD is that the condition affects

as many as 12 in every 1,000 people (1.2% of the population) from young children to adults, regardless of gender, social or cultural background.

The book *Obsessive-Compulsive Disorder: The Facts* reports that a disproportionately high number of those, about 50% of all these cases, will fall into the severe category with less than a quarter being classed as mild cases. The American DSM also reports the 12-month prevalence of OCD is also 1.2%, with a similar prevalence internationally of between 1.1%—1.8%.

However, it's worth noting that these figures could potentially be doubled if we assume that the majority of people living with OCD will involve a loved one in their OCD compulsions. (I.e. seeking reassurance, asking them to complete tasks, like taking the rubbish out).

OCD starts to become problematic and impacting on a person's life on average during late adolescence for men and during their early twenties for women, although the age of onset covers a wide range of ages, with development of the disorder for some children as young as six and 25% of cases starting by age 14. Onset after the age of 35 years is unusual, but does occur.

The onset of symptoms is typically gradual, however, acute onset has also been reported.

Recent research suggests that OCD is slightly more prevalent in women than in men, although our own service-user stats show that most of our user contact comes from women, at a ratio of about 75%. We believe this is because women find talking about feelings and emotions more comfortable than men. This may also be a barrier which prevents men seeking professional help for their problem, so it's highly likely that men and women are affected equally.

We are frequently asked by journalists if more people now suffer with OCD. We don't think that is the case, going back 20-years, the estimates of OCD were reported to be 2-3% of the population, however more recent research suggests that figure was exaggerated, hence the 1.2% figures now used. The reason people have the misconception that OCD is more common now is because of traditional media and social media now making much more references to OCD, sadly often inaccurately. So whilst more people talk about having OCD quirks, many don't actually have the disorder.

In summary, we don't think OCD is more common today than it used to be, it is just talked about more (which can be counterproductive).

DIAGNOSIS AND TREATMENT

There are some methods which the professional use in diagnosing the obsessive compulsive disorder. The patient himself may complain about the problem or someone who live with him either in workplace or home environment might bring the problem to the professional seeking help.

Whatever may be the situation, the psychiatrist may observe the conditions and start medications. The psychologist initially observes by doing mental status examination. The severity of the problem will be discussed by taking time, longevity of the problem along with the dangers involved in it.

The person's anxiety levels will be taken in to consideration in treatment by talking to him. The

fears and worries of the individual will be addressed for to bring him out of problem, as relapses will be very less. If the thoughts and actions of obsessive and compulsive behaviors are directly taken, the problem will be reduced for time being but the inner fears and worries may result in relapse of the problem.

What this research shows us is that many, many people without any obsessional problem have exactly the same types of unwanted thoughts as people with OCD. The main difference is that people with OCD report obsessions which are more intense, frequent and difficult to control.

There are many standardizes questionnaires developed to understand the problem from its roots. So medications will be used based on symptoms and requires ruling out other drug related or medical causes. Yale-Brown Obsessive compulsive scale (Y-BOCS) can be used for severity.

The medication when used among pregnant ladies may affect the new born baby, so it has to be taken care, if medication has to be withdrawn for pregnant ladies, it should be done gradually, with dosage changes. So any medicine for OCD during prenatal and postnatal period must be done carefully by observing the medical reaction on the patient. The risk of the new-born child will have some withdrawal symptoms was found.

Psychotherapy, Psych-education, Meditation, Yoga, Breathing exercises, Mindfulness, relaxation techniques, fact finding are few of the techniques for treatment.

Lesson 9: General Anxiety Disorder (GAD)

UNDERSTANDING GAD

The people with generalized anxiety disorder usually worry for everything in day to day life. They imagine problems related to present and future events related to money, health work, dependents on them (children or parents) family and other issues of life with persistent and excessive worry about a number of different things. They may expect the worst even when there is no apparent reason for concern.

The diagnosis of GAD can be done if persistent worry for longer periods, nearly or more than six months with three or more symptoms.

It was found that more of women affected by GAD than men. The disorder affects slowly and gradually, can begin across the life cycle, though the risk is highest between childhood and middle age. Although the exact cause of GAD is unknown, there is evidence that biological factors, family background, and life experiences, particularly stressful ones, play a role.

The people suffering from GAD don't know how to stop the worry cycle and feel it is beyond their control, even though they usually realize that their anxiety is more intense than the situation warrants.

The people with GAD can be normal in social activities and meaning lives when their anxiety level is mild to moderate or with treatment. Many with GAD may avoid situations because they have the disorder or they may not take advantage of opportunities due to their worry (social situations, Travel, profession etc.). Some people can have difficulty carrying out the simplest daily activities when their anxiety is severe. Daily life becomes a constant state of worry, fear, and dread. Eventually, anxiety can even dominate a person's thinking so much that they find it hard to do routine things at work or school, socially, and in their relationships.

GENERALIZED ANXIETY DISORDER SYMPTOMS

The way persons thinks is different from normal thinking in GAD, it can lead to physical symptoms. The symptoms include Excessive, ongoing worry and tension, Unrealistic view of problems, Restlessness or a feeling of being "edgy", Feeling of doom, Crankiness, Muscle tension, faster heart rate, breathing faster, Headaches, Sweating, Trouble concentrating, Nausea, A need to go to the bathroom frequently, feeling tired or weak, Trouble falling or staying asleep, trembling, being easily startled, trouble swallowing, People with generalized anxiety disorder often also have other anxiety disorders such as panic disorder or phobias, obsessive compulsive disorder, clinical depression, or problems with drug or alcohol misuse. The professionals and Experts don't know the exact causes of generalized anxiety disorder. But the Causes and Risk Factors for Generalized Anxiety Disorder include several things -- including genetics, brain chemistry, and environmental stresses -- appear to contribute to its development.

Genetics:

Family history play vital role in making a person have GAD.

GAD may be passed on in families. But no anxiety genes have been identified, and families may also pass down the tendency through lifestyle or environment.

Brain chemistry:

The brain part involved in thinking and emotion, Brain cell pathways transmit send information through neurotransmitters one nerve cell to the next. The particular GAD thinking affect the type of neurotransmitter and affects the health conditions of the individual. . If the pathways that connect particular brain regions don't work well, problems related to mood or anxiety may result.

Medicines, psychotherapies, or other treatments that are thought to work on these neurotransmitters may improve the signaling between circuits and help to improve symptoms related to anxiety or depression.

Environmental factors:

Abuse, death of loved ones, Divorce, Change of job, unpredictable situations in life situations, feeling of not having control on something in their life, use of and withdrawal from addictive substances (including alcohol, caffeine, and nicotine) can also worsen anxiety and other changes contribute to GAD.

DIAGNOSING GENERALIZED ANXIETY DISORDER

Physical examination, lab tests may not help in diagnosis of GAD. They help only to identify underlying physical illness. The diagnosis is done by knowing how intense and long-lasting (six months) the symptoms are, including any problems with daily life caused by the symptoms. The doctor then determines whether the person has a specific anxiety disorder or generalized anxiety disorder.

TREATMENT AND HOME REMEDIES FOR GENERALIZED ANXIETY DISORDER

It is very important to get the treatment done to the GAD patient. The professional to be referred if no medical conditions are not found are psychiatrist or psychologist, treatment for GAD most often includes a combination of medication and cognitive behavioral therapy. By taking daily habits in to consideration and that can make a difference.

Cognitive behavioral therapy:

The therapist first identifies distorted thoughts and behaviors that lead to anxious feelings. They help GAD patient to identify, recognize and change thought patterns and behaviors that lead to anxious feelings.

Medications:

(Have side effects, can get information from the doctor) are used by certified Psychiatrist are not cure, but they can help ease symptoms. The drugs most often used to treat GAD in the short term (since they can be addictive, are sedating, and can interfere with memory and attention) are from a group of drugs called benzodiazepines. They work by curbing the physical symptoms of anxiety, such as muscle tension and restlessness. These medications are sometimes called "sedative-hypnotics" or "minor tranquilizers" because they can temporarily remove intense feelings of sudden (acute) anxiety. These drugs can exaggerate sedation effects when combined with many other medicines, and they are also dangerous if mixed with alcohol.

Life style changes: (Don't have negative side effects)

Exercise, Yoga, A healthy diet, Getting enough sleep, Avoiding caffeine, Avoiding alcohol and other drugs, Meditation, Biofeedback, Relaxation techniques such as deep breathing.

GENERALIZED ANXIETY DISORDER PREVENTION

Anxiety disorders like GAD can't always be prevented. But there are some things that you can do to control or lessen symptoms, including:

Seek counseling and support after a traumatic or disturbing experience, or if noticed that feeling more anxious than usual. It's better to address a problem, not avoid it, leading a healthy, active lifestyle, and Stay connected to others. Don't get isolated, Take breaks when you start to worry. Stick to treatment plan, use correct dosage as directed by doctor as many contain chemicals that can increase anxiety symptoms, Practice stress management techniques.

Lesson 10: Personality Disorders

LEARNING OBJECTIVES

Of studying this course to the students are
1.To understand what is personality
2.To understand what are personality disorders
3.Maladaptive behaviors which are usually found in personality disorders

STRUCTURE

1. Introduction
2. History of personality disorders
3. Epidemiology of personality Disorders
4. Other factors associated with personality disorders
5. Classification of personality disorders
6. Diagnosis and treatment for personality disorders
7. Summary
8. Model question Paper
9. Suggested Readings

INTRODUCTION

Maladaptive behaviors are mainly adopted by people who have trouble adjusting situations. The underlying maladaptive patterns of behavior are result of their experience and cognition. These mental disorders are inflexible and are associated with distress and disability.

Personality: A set of enduring behavioural and mental traits that distinguish individual humans is known as personality when defined psychologically.

Personality Disorders: Some behaviours and experiences deviate from social norms and expectations are called Personality disorders. Those diagnosed with a personality disorder may experience difficulties in cognition, emotiveness, interpersonal functioning, or impulse control. In general, personality disorders are diagnosed in 40–60% of psychiatric patients, making them the most frequent of psychiatric diagnoses.

The definition of personality disorders given by the International classification of diseases (ICD-10) states that 'personality disorders' comprise of deeply ingrained and enduring behavioural patterns, manifesting themselves as inflexible responses to a broad range of personal and social situations. They represent extreme or significant deviation from the manner in which an average

individual in the given culture perceives, thinks, feels, and particularly relates to others. They are frequently, though not always, associated with varying degrees of subjective distress and problems in social functioning and performance.

The Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV) definition is similar, although it is more explicit, and emphasizes the impulse control problems that many patients with personality disorders would have.

The deviated behaviours in personality disorders result in or associated with considerable personal, social, and occupational disruption. Ego-centric behaviours result in inflexibility; they lack insight into their condition and refrain from seeking treatment. Maladaptive coping skills lead to personal problems that induce extreme anxiety, distress or depression and result in impaired psycho social functioning. The pervasive maladaptive behaviour patterns are recognizable in childhood and adolescence and also in the beginning of adulthood and result negatively on quality of life.

Personality disorders are now recognised as important conditions, which are associated with morbidity, premature mortality, and great personal and social costs.

The International Pilot Study on Personality Disorders demonstrated that disorders, as presently defined, could be identified at all sites (multinational, multilingual, multicultural).

BEFORE THE 20TH CENTURY

Personality disorder is a term with a distinctly modern meaning, owing in part to its clinical usage and the institutional character of modern psychiatry. Although highly anachronistic, and ignoring radical differences in the character of subjectivity and social relations, some have suggested similarities to other concepts going back to at least the ancient Greeks.

Indian epics like Ramayana and Mahabharata are worth mentioning here as some characters in them are most probably oldest of all evidence for personality disorders.

Different in their personality style evolved from antiquity. [7]

Indian research in personality disorders description and classification of personality disorders has expanded dramatically. The research states that the proposition that human beings are different in their personality style evolved from antiquity. Charaka applied the Tri-guna theory to the clinical situation and postulated that man's prakriti (nature) was defined by the relative accentuation of any of the three gunas: Satvik (consciousness), rajsik (energy) or tamsik (inertia).

It is before Greece civilization. The Greek philosopher Theophrastus described 29 'character' types that he saw as deviations from the norm, and similar views have been found in Asian,

Arabic and Celtic cultures. A long-standing influence in the Western world was Galen's concept of personality types, which he linked to the four humours proposed by Hippocrates. From that period to the present the personality was focus for understanding human nature. Such views lasted into the eighteenth century, when experiments began to question the supposed biologically based humours and 'temperaments'. Psychological concepts of character and 'self' became widespread. In the nineteenth century, 'personality' referred to a person's conscious awareness of their behavior, a disorder of which could be linked to altered states such as disassociation. This sense of the term has been compared to the use of the term 'multiple personality disorder' in the first versions of the DSM.

In the early 20th century, another German psychiatrist, Emil Kraeplin, included a chapter on psychopathic inferiority in his influential work on clinical psychiatry for students and physicians. He suggested six types – excitable, unstable, eccentric, liar, swindler and quarrelsome.

The categories were essentially defined by the most disordered criminal offender's observed, distinguished between criminals by impulse, professional criminals, and morbid vagabonds who wandered through life. Kraepelin also described three paranoid (meaning then delusional) disorders, resembling later concepts of schizophrenia, delusional disorder and paranoid personality disorder. A diagnostic term for the latter concept would be included in the DSM from 1952, and from 1980 the DSM would also include schizoid, schizotypal; interpretations of earlier (1921) theories of Emst Kreschmer led to a distinction between these and another type later included in the DSM, avoidant personality disorder.

In this way there is lot of history for personality disorders, based on the understanding of personality by keeping norms of the society. We are not taking country wise of many facts available in the form of history of personality disorders as we are concerned with understand basic knowledge. Towards the mid-20th century, psychoanalytic theories were coming to the fore based on work from the turn of the century being popularized by Sigmund Freud and others. This included the concept of character disorders, which were seen as enduring problems linked not to specific symptoms but to pervasive internal conflicts or derailments of normal childhood development.

These were often understood as weaknesses of character or willful deviance, and were distinguished from neurosis and psychosis. The term 'borderline' stems from a belief some individuals were functioning on the edge of those two categories, and a number of the other personality disorder categories were also heavily influenced by this approach, including dependent, obsessive–compulsive and histrionic. International differences have been noted in

how attitudes have developed towards the diagnosis of personality disorder.

EPIDEMIOLOGY

The prevalence of individual personality disorders ranges from about 2% to 3% for the more common varieties, such as schizotypal, antisocial, borderline, and histrionic, to 0.5–1% for the least common, such as narcissistic and avoidant.

A screening survey across 13 countries by the world health organization using DSM- IV criteria, reported in 2009 a prevalence estimate of around 6% for personality disorders. The rate sometimes varied with demographic and socioeconomic factors, and functional impairment was partly explained by co-occurring mental disorders.

A recent narrative review reported relatively high rates of personality disorders (4.4–21.5%) in community populations across the Western world.

In 2010 that the majority of people show some personality difficulties in one way or another (short of threshold for diagnosis), while the prevalence of the most complex and severe cases (including meeting criteria for multiple diagnoses in different clusters) was estimated at 1.3%. Even low levels of personality symptoms were associated with functional problems, but the most severely in need of services was a much smaller group.

Personality disorders (especially cluster A) are also very common among homeless. The sex ratio was different for specific types of personality disorders, although the overall rate of prevalence was roughly equal for the two sexes. Personality disorder diagnosis was significantly associated with the male gender prevalence in community.

In the International Pilot Study of Personality Disorders (IPSPD), the following personality disorders were frequently diagnosed in the clinical sample at Bangalore: Schizotypal (19.1%) and borderline (14.7%) according to the DSM-III-R system; and emotionally unstable (8.6%) according to the ICD-I0 system. Banerjee and Mitra compared 50 teenage girl outpatients with academic difficulties with normal controls. About 30% of the index group had emotionally unstable personality disorder (impulsive type), 6% had dependent personality disorder, and 6% other personality disorders, according to the ICD-10.

CAUSES

There is no proven cause for personality disorder. The dependent causes and risk factors are found scientifically.

Genetic disposition and life experiences, such as trauma and abuse, play a key role in the

development of personality disorders.

Child abuse and neglect consistently show up as risk to the development of personality disorders in adulthood. Children who had experienced such verbal abuse were three times as likely as other children (who did not experience such verbal abuse) to have borderline, narcissistic, obsessive–compulsive or paranoid personality disorders in adulthood. The physical abuse, sexual abuse has extremely strong correlation with the development of antisocial and impulsive behavior.

Socio Economic Status or Socioeconomic cause is found to be potential for personality disorders. Low parental and neighborhood, women students who take frequent punishments for disciplinary actions are closely associated to low socio economic back ground. The higher socio income group students are less in personality disorder prone or with a low risk of developing personality disorders later on in life, more altruistic, less risk seeking and had overall higher intelligence quotient.

Parenting issues are found to be the major cause for personality disorders. Children pick up parental dependable behaviors, inability in reaching their higher goals, getting good job etc. the genetic or modelling the children take them from parents and pass on to the next generation. Other factors like low or not having maternal bonding, poor parenting, not having breast feeding are some of the variables highly correlated with personality disorders. When left not fostered, other attachment and interpersonal problems occur later in life ultimately leading to development of personality disorders but negative correlation was found with two attachment variables such as maternal availability and dependability.

The genetic causes were not much studied as less research was done on it, at present researchers are currently looking into genetic mechanisms for traits such as aggression, fear and anxiety, which are associated with diagnosed individuals with personality disorders.

The brain and neural causes found behind personality disorders are malfunctioning of inner brain parts like Hippocampus, its size, smaller amygdala, malfunctioning of striatum- nucleus accumbens and the Cingulum neural pathways are crucial in incoming information to the brain, having anti - social information from the multiple senses; so what comes out is anti-social - not according to what is the social norms, socially acceptable and appropriate.

REFERENCE

https://www.researchgate.net/publication/51566689_An_overview_of_Indian_research_in_personality_disorders

DIAGNOSIS AND TREATMENT

In India a number of assessment instruments for the diagnosis and measurement of personality disorders are now available for clinical and research use as it is in in the West. Some of these focus on individual personality disorders such as schizotypal, borderline or depressive, while others are comprehensive in their coverage. Among the latter, both self-rating instruments useful for screening purposes, such as, Personality Disorder Questionnaire (PDQ)] and Millon Clinical Multiaxial Inventory (MCMI)-III, and semi-structured interview-based instruments, and International Personality Disorder Examination (IPDE). Ethnocentric work is clearly needed before the universality of personality disorders is assumed.

The studies in diagnosis do not confirm the cross-cultural validity or usefulness of western diagnostic categories or personality dimensions, as these utilize western concepts in a non-western setting. Thus, they may have identified ethnic artefacts rather than culturally meaningful configurations. Personality disorders typically carry a strong connotation of immutability that may be directly at odds with the core belief of some of the major non-western cultural traditions, which lay emphasis on the perfectibility of human nature. At an even more fundamental level, cross-cultural analysis has challenged concepts such as 'person' and 'selfhood,' implicitly or explicitly used by theories of personality.

Diagnosis has taken up many forms like clinical interviews, questionnaires etc., but research in this area to identify personality disorders by identifying new criteria based is still going on. As the deeper identification helps the professionals to prepare people with personality disordered person to adjustment in life situations, also people living with them by Psycheducation.

TREATMENT OPTIONS

Psychotherapy, shadowing by a trained family member, are proven to be effective.

The treatment helps the individuals to gain insight of their behavior and thinking, a better understanding of disorder and it symptoms. Expression of their feeling, thoughts and meaning of their behavior is also part of treatment. Social awareness of how they think of behavior, what others are thinking of that behavior, this knowledge helps the adjust better to the situations. It helps them to further realize how their behavior affects others around them as they learn how to manage their symptoms and reduce the behaviors that may be causing problems in their ability to function.

TREATMENT AND MANAGEMENT

The treatment methods depend on disorder type and its expression. The modality of treatment also changes for personality disorder based on the type and severity.

Family therapy which includes couple and other family members, group therapy if common problem is found in more than two persons is now popularly used, psychological education for people living with the person with personality disorder, the usage of resource groups, self-help groups when need arises, psychotherapy as needed either for short or long term. The Milieu therapy also a kind of group therapy with residential approach, has history of use treating personality disorders, including therapeutic communities.

The practice of Yoga, meditation, mindfulness that encourages to regular practice of accepting unpleasant emotions appears to be a promising clinical tool for managing different types of personality disorders.

Other psychological counselling or therapy techniques like psychodynamic, cognitive, behavioral techniques. Finding common themes among personality disorders and giving suitable therapy is more successful approach. Eclectic approach also used by therapists as and when applicable.

Attributes of the therapist (e.g. trustworthiness, competence, caring), processes afforded to the client (e.g. ability to express and confide difficulties and emotions), and the match between the two (e.g. aiming for mutual respect, trust and boundaries).

The management and treatment of personality disorders can be challenging and controversial. This often involves interpersonal issues, with establishing and maintaining a specific therapeutic relationships and the disruptiveness that people with personality disorders can create in an organization are the most challenging conditions to manage.

There may be simple distinct or objective boundary between 'normal' and 'abnormal' personalities and maybe there is substantial social stigma and discrimination related to the diagnosis. So the individual with personality disorder may not consider their personality to be disordered or the cause of problems. the patient's ignorance or lack of insight into their own

condition, an ego-syntonic perception of the problems with their personality that prevents them from experiencing it as being in conflict with their goals and self-image.

Personality disorders can require fundamentally different approaches and understanding as

The term 'personality disorder' encompasses a wide range of issues, each with a different level of severity or disability. Some disorders or individuals are characterized by continual social withdrawal and the shunning of relationships, others may cause fluctuations in forwardness. The extremes are worse still: at one extreme lie self-harm and self-neglect, while at another extreme some individuals may commit violence and crime, with this it illustrates the scope.

Some will be in problematic substance use or dependency or behavioral addictions. A person may meet the criteria for Dissociative Identity Disorder (formerly "Multiple Personality Disorder") diagnoses and/or other mental disorders, either at particular times or continually, so making coordinated input from multiple services a potential requirement for treating the person. So any therapists in this area can become disheartened as there will be very little or no initial progress, or by apparent progress that then leads to setbacks. So therapists usually perceive the clients, as negative, rejecting, demanding, aggressive or manipulative.

Social Skills, Coping efforts, defense mechanisms, moral judgement strategies, thoughtful strategies like underlying motivations for specific behaviors or conflicts.

The client’s vulnerabilities or weaknesses of a client and indeed a therapist, may become lost behind actual or apparent strength and resilience. The need for maintenance of professional personal boundaries, by allowing emotional expression and therapeutic relationship.

The difficulty in acknowledging the different worlds and views that both the client and therapist may live with can affect the therapy. A therapist may assumptions that the kinds of relationships and ways of interacting that make them feel safe and comfortable to the client also.

It is just like people who may have been exposed to hostility, deceptiveness, rejection, aggression or abuse in their lives, may in some cases be made confused, intimidated or suspicious by presentations of warmth, intimacy or positivity. The therapists who provide

reassurance, openness and clear communication are usually helpful and needed. The therapist may have to take several months of sessions, and perhaps several stops and starts, to begin to develop a trusting relationship that can meaningfully address a client's issues

Lesson 11: Personality Classification of Disorders

CLASSIFICATION

The ICD-10 and DSM-V are different, but overlapping classification systems. Both have adopted a polythetic approach as against a monothetic approach, in which none of the listed criteria are essential to make a diagnosis, any combination of a required number of criteria would lead to the diagnosis.

The two relevant major systems of classification are

The International classification of diseases (11th revision, ICD-11) published by World Health Organization.

Diagnostic and Statistical Manual of Mental Disorders (DSM-5) by American Psychological Association.

The ICD system is a collection of numerical codes that have been assigned to all known clinical disease states, which provides uniform terminology for medical records, billing, and research purposes. The DSM defines psychiatric diagnoses based on research and expert consensus, and its content informs the ICD-10 classifications. Both have deliberately merged their diagnoses to some extent, but some differences remain. For example, ICD-10 does not include narcissistic personality disorder as a distinct category, while DSM-5 does not include enduring personality change after catastrophic experience or after psychiatric illness. ICD-10 classifies the DSM-5 schizotypal personality disorder as a form of Schizophrenia rather than as a personality disorder. There are accepted diagnostic issues and controversies with regard to distinguishing particular personality disorder categories from each other.

GENERAL CRITERIA

Both diagnostic systems provide a definition and six criteria for a general personality disorder. These criteria should be met by all personality disorder cases before a more specific diagnosis can be made.

The ICD-10 lists these general guideline criteria

- Markedly disharmonious attitudes and behavior, generally involving several areas of functioning, e.g. affectivity, arousal, impulse control, ways of perceiving and thinking, and style of relating to others;
- The abnormal behavior pattern is enduring, of long standing, and not limited to episodes of mental illness;

- The abnormal behavior pattern is pervasive and clearly maladaptive to a broad range of personal and social situations;
- The above manifestations always appear during childhood or adolescence and continue into adulthood;
- The disorder leads to considerable personal distress but this may only become apparent late in its course;
- The disorder is usually, but not invariably, associated with significant problems in occupational and social performance.

The ICD adds: "For different cultures it may be necessary to develop specific sets of criteria with regard to social norms, rules and obligations.

In DSM – 5, any personality disorder diagnosis must meet the following criteria.

- An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas:
  - Cognition (i.e., ways of perceiving and interpreting self, other people, and events).
  - Affectivity (i.e., the range, intensity, liability, and appropriateness of emotional response).
  - Interpersonal functioning.
  - Impulse control.
- The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.
- The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.
- The enduring pattern is not better explained as a manifestation or consequence of another mental disorder.
- The enduring pattern is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., head trauma).

The most recent fifth edition of the Diagnostic and Statistical Manual of Mental Disorders, stresses that a personality disorder is an enduring and inflexible pattern of long duration leading to significant distress or impairment and is not due to use of substances or another medical condition. The DSM-5 lists personality disorders in the same way as other

mental disorders, rather than on a separate 'axis', as previously.

DSM – 5 Lists ten specific personality Disorders.

PERSONALITY CLUSSTERS

The specific personality disorders are grouped in to three clusters based of descriptive similarities

CLUSTER A

The first of the three clusters, **Cluster A**, is described as the odd or eccentric cluster of personalities. Social awkwardness and social withdrawal are common features. Although people with Cluster A personality disorders may have a strong link to a relative who has been diagnosed with schizophrenia, these disorders are typically **less extensive and impact daily functioning less than schizophrenia.**

People with Cluster A (odd or eccentric disorders) personality disorders tend to have relationship issues because their behavior is seen **as peculiar, suspicious, or detached**. Three types of personality disorder are included in the first cluster. **1. Paranoid Personality Disorder, 2. Schizoid personality disorder, 3. Schizotypal personality disorder.** Cluster A personality disorders are often **associated with schizophrenia**: in particular, schizotypal personality disorder shares some of its hallmark symptoms with schizophrenia, **e.g., acute discomfort in close relationships, cognitive or perceptual distortions, and eccentricities of behavior.** However, people diagnosed with odd-eccentric personality disorders tend to have a greater grasp on reality than those with schizophrenia. Patients suffering from these disorders can be paranoid and have difficulty being understood by others, as they often have odd or eccentric modes of speaking and an unwillingness and inability to form and maintain close relationships. Though their perceptions may be unusual, these anomalies are distinguished from delusions or hallucinations as people suffering from these would be diagnosed with other conditions.

Significant evidence suggests a small proportion of people with Cluster A personality disorders, especially schizotypal personality disorder, have the potential to develop schizophrenia and other psychotic disorders. These disorders also have a higher probability of occurring among individuals whose first-degree relatives have either schizophrenia or a Cluster A personality disorder.

Paranoid personality disorder. Paranoid personality disorder symptoms include chronic, pervasive distrust of other people; suspicion of being deceived or exploited by others, including

friends, family, and partners; angry outbursts in response to deception; and cold, secretive, or jealous behavior. Characterized by a pattern of irrational suspicion and mistrust of others, interpreting motivations as malevolent.

Schizotypal personality disorder. Symptoms of schizotypal personality disorder include odd speech, behavior, and appearance, as well as strange beliefs and difficulty forming relationships. Lack of interest and detachment, from social relationships, apathy, and restricted emotional expression.

Schizoid personality disorder. Characterized by social isolation and indifference toward other people, schizoid personality disorder affects more men than women. People with this relatively rare disorder often are described as cold or withdrawn, rarely have close relationships with other people, and may be preoccupied with introspection and fantasy. Pattern of extreme discomfort interacting socially, and distorted cognition and perceptions.

CLUSTER B (DRAMATIC, EMOTIONAL OR ERRATIC DISORDER)

The second of the three clusters includes disorders have characteristics such as dramatic, emotional, erratic, impulse control and emotional regulation are problems for people with disorders categorized in cluster B. Healthy relationships are almost impossible for people in this cluster. They tend to experience very intense emotions or engage in extremely impulsive, theatrical, promiscuous or law-breaking. Four types of personality disorders included in this cluster B. The four personality disorders included in this cluster are 1. Antisocial personality disorder, 2. Borderline personality disorder, 3. Histrionic personality disorder, 4. Narcissistic personality disorder.

Antisocial personality disorder. Showing up earlier than most other personality disorders, antisocial personality disorder tends to show up in childhood. Symptoms include a disregard for rules and social norms and a lack of empathy for other people. Pervasive pattern of disregard for and violation, of the rights of others, lack of empathy, bloated self-image, manipulative and impulsive behavior.

Borderline personality disorder. Characterized by emotional instability, intense interpersonal relationships, and impulsive behaviors. Pervasive pattern of abrupt emotional outbursts, altered empathy, instability in relationships, self-image, identity, behavior and affect, often leading to self-harm and impulsivity.

Histrionic personality disorder. With a need to always be the center of attention that often leads to socially inappropriate behavior to get attention, people with histrionic personality disorder may have frequent mood swings as well. Pervasive pattern of attention seeking behavior, excessive emotions, and egocentrism.

Narcissistic personality disorder. Associated with self-centeredness, exaggerated self-image, and lack of empathy for others. Pervasive pattern of, superior grandiosity, need for admiration, and a perceived or real lack of empathy. In a more severe expression, narcissistic personality disorder may show evidence of paranoia, aggression, psychopathy, and sadistic personality disorder known as malignant narcissism

CLUSTER C (ANXIOUS OR FEARFUL DISORDERS)

The third of the three clusters is characterized as the anxious or fearful cluster. This group features an overlap of symptoms of anxiety and depressive disorders.

There are three personality disorders included in Cluster C.

- **Avoidant personality disorder.** Characterized by a disregard for rules and a lack of empathy and remorse, this disorder can show up during childhood. Pervasive feelings of social inhibition and inadequacy, extreme sensitivity to negative evaluation.

- **Dependent personality disorder**. Involves a fear of being alone and often causes those who have the disorder to do things to try to get other people to take care of them. Pervasive psychological need to be cared for by other people.

- **Obsessive-compulsive personality disorder**. Characterized by a preoccupation with orderliness, perfection, and control of relationships, this is not the same as obsessive-compulsive disorder (OCD). Characterized by rigid conformity to rules, perfectionism, and control to the point of satisfaction and exclusion of leisurely activities and friendships. (not obsessive compulsive behavior).

Lesson 12:Additional factors for Classification of Disorders

ADDITIONAL FACTORS

Severity, impact on social functioning and attribution are other factors than classifying personality factors by clusters or category.

SEVERITY

It is notion personality difficulty, as measure of sub threshold scores for personality disorder using standard interviews and evidence that those with the most sever personality disorders demonstrate. It is a kind of "ripple effect" of personality disturbance across whole range of personality disturbance across the whole range of mental disorders.

Personality difficulty – sub-threshold, simple personality disorder – single cluster, two or more clusters of personality disorder present – complex or diffuse personality disorder for those of greatest risk, are some of examples of classification based on severity.

The advantages of this classification based on severity are, advantage of tendency for personality disorder to be comorbid with each other is allowed, influence of personality disorder on clinical out come more satisfactorily than the simple dichotomous system of no personality disorder versus personality disorder is also allowed, and the system accommodates the new diagnosis of severe personality disorder, particularly "dangerous and severity personality disorder" (DSPD).

EFFECT ON SOCIAL FUNCTIONING

Mental functioning and personality affect social functioning. Social functioning occurs just due to personality abnormality, rather than any other clinical reasons. By assessing social functioning hierarchy among personality disordered or personal dysfunction people, greater social dysfunction is given primacy, while discussing personality disorders.

ATTRIBUTION

This group have been termed the Type R, or treatment-resisting personality disorders, as opposed to the Type S or treatment-seeking ones, who are keen on altering their personality disorders and sometimes clamour for treatment. Type R and Type S personality disorders with Cluster C personality disorders being significantly more likely to be Type S, and paranoid and schizoid (Cluster A) personality disorders significantly more likely to be Type R than others.

COMORBIDITY

Co-occurrence of personality disorders when there is a considerable personality disorders diagnosed. So it was found that personality disorder for one criteria in DSM-5 can occur for another criteria also.

Diagnostic criteria are very clear but they are explained with a group of maladaptive behaviors.

PPD – Paranoid Personality Disorder,

SzPD – Schizoid Personality Disorder,

StPD – Schizotypal Personality Disorder,

ASPD – Antisocial Personality Disorder,

BPD – Borderline Personality Disorder,

HPD – Histrionic Personality Disorder,

NPD – Narcissistic Personality Disorder,

AvPD – Avoidant Personality Disorder,

DPD – Dependent Personality Disorder,

OCPD – Obsessive–Compulsive Personality Disorder,

PAPD – Passive–Aggressive Personality Disorder.

Personality disorders are linked to impaired functioning and reduced quality of life applicable to some personality disorders only.

Higher disability and lower quality of life are predicted by avoidant, schizoid, dependent, and schizotypal, paranoid and anti-social personality disorder.

Compromised quality of life and dysfunction are not compulsory in obsessive – Compulsive personality disorder. But for the narcissistic and obsessive compulsive disorders all other personalities reported to have significant impairment 15 years later.

Study of “Life success” (status, wealth and successful intimate relationships) shoed less success rate for schizoid, antisocial, borderline and dependent personality disorders.

In these aspects, schizoid personality disordered people were at the low level, and paranoid, histrionic and avoidant personality disorders were average. Narcissistic and obsessive and compulsive personality disorders were had positive and high contribution to these life success aspects.

Quality of life and number of diagnostic criteria met by individual has connection, as if number of criteria increase the quality of life decreases.

THE PERSONALITY DISORDERS- RISK OF MENTAL DISORDERS

The three cluster A, B, and C of personality disorders share with each other underlying common vulnerability factors involving cognition, affect and impulse control, and behavioral maintenance or inhibition, respectively. But they may also have a spectrum relationship to certain syndrome mental disorders.

Paranoid, Schizoid or schizotypal personality disorders may be observed to be premorbid antecedents of – Delusional disorders or schizophrenia.

The borderline personality disorder is seen in association with – Mood and Anxiety Disorders. The impulse-control disorders, eating disorders, ADHD and substance abuse disorder.

Avoidant personality disorder is seen with societal anxiety disorder.

Openness to experience: helps us to understand personality disorders well. The related three factors are Cognitive distortions, Impulsivity, and Lack of insight.

High Openness related problems that can cause problems with social or professional functioning are excessive fantasizing, (peculiar thinking, diffuse identity, unstable goals and unconformity with the demands of the society.

High openness is a characteristic found in schizotypal personality disorder (odd and fragmented thinking), Narcissistic personality disorder (excessive self-evaluation) and paranoid personality disorder (sensitive to external hostility)

Lack of insight (shows low openness) is characteristic found among all personality disorders and persistence of maladaptive behaviour problems.

Low openness is associated to- difficulties adapting to change, low tolerance for different worldviews or life styles, and emotional flattening, alexithymia and narrow range of interests.

Rigidity is most obvious aspect and persistent of low openness among personality disorders. It is lack of knowledge of one's emotional experiences. It is again mostly related characteristic of obsessive- compulsive personality disorder.

Impulsivity is opposite to openness which results in behaving unusually and autistically. It is associated characteristic for schizotypal and border line personality disorders.

Lesson 13: Mood Disorders- Depression

STRUCTURE

1. Depression
2. Mood Disorders
3. Epidemiology
4. Demographic and psychosocial risk factors for depression
5. Subtypes of depression or course specifies
6. Physiological basis for Depression:
7. Electrophysiology
8. Endocrinology
9. Neurocognitive functioning
10. Genetics
11. Lipids
12. Diagnosis and Treatment

DEPRESSION

Depression is a mood disorder or affective disorder. This includes both mental and behavioral conditions. Any disturbance in the person's mood is the main criteria for classifying it in the DSM (Diagnostic and Statistical Manual of Mental Disorders) , and ICD (International Classification of diseases respectively).

MOOD DISORDERS

Mood disorders are divided in to seven groups. Abnormally elevated mood, such as mania or hypomania, (major depressive Disorder (MDD) (alternatively known as clinical depression, unipolar depression (Depression without periods of mania is sometimes referred to as *unipolar depression* because the mood remains at the bottom "pole" and does not climb to the higher, manic "pole" as in bipolar disorder), or major depression), and moods which cycle between mania and depression, known as bipolar (BD) (formerly known as manic depression). There are several sub-types of depressive disorders or psychiatric syndromes featuring less severe symptoms such as dysthymic disorder similar to but milder than MDD) and cyclothymic disorder (similar to but milder than BD). Mood disorders may also be substance induced or occur in response to a condition. It also referred as affective disorder initially (by

Henry Maudsley) but later named as mood disorder.

Depression classified as a mental and behavioral disorder. It is a state in which the person is in low mood and aversion to activity. So this low mood of depression affects a person's thoughts, behavior, motivation, feelings and sense of wellbeing.

Commonly found in depressive patients is anhedonia is currently used by researchers to refer to reduced motivation, reduced anticipatory pleasure (wanting), reduced consummators pleasure (liking), and deficits in reinforcement learning, which refers to loss of interest or a loss of feeling of pleasure in certain activities that usually bring joy to people.

Depressed mood is a symptom of some mood disorders. It is like major depressive disorder or dysthymia, it is a normal temporary reaction to life events, such as the loss of a loved one; and it is also a symptom of some physical diseases and a side effect of some drugs and medical treatments. It may feature sadness, difficulty in thinking and concentration and a significant increase or decrease in appetite and time spent sleeping. People experiencing depression may have feelings of dejection, hopelessness and, sometimes, suicidal thoughts. It can either be short term or long term.

Major Depressive Disorder (MDD), commonly called major depression, unipolar depression, or clinical depression, wherein a person has one or more major depressive episodes. After a single episode, Major Depressive Disorder (single episode) would be diagnosed. After more than one episode, the diagnosis becomes Major Depressive Disorder (Recurrent).

Individuals with a major depressive episode or major depressive disorder are at increased risk for suicide. Seeking help and treatment from a health professional dramatically reduces the individual's risk for suicide. Studies have demonstrated that asking if a depressed friend or family member has thought of committing suicide is an effective way of identifying those at risk, and it does not "plant" the idea or increase an individual's risk for suicide in any way.

Depressive disorder is frequent in primary care and general hospital practice but is often undetected. Unrecognized depressive disorder may slow recovery and worsen prognosis in physical illness, therefore it is important that all doctors be able to recognize the condition, treat the less severe cases, and identify those requiring specialist care.

EPIDEMIOLOGY

Many studies have estimated the prevalence of depression in community samples and the prevalence rates have varied from 1.7 to 74 per thousand population. The prevalence in urban population are in line with the findings of a survey done on the entire adult population of an

industrial township, which showed that the prevalence rate for depression to be 19.4 per thousand.

Studies done in hospitals have shown that 5 to 26.7% of cases attending the psychiatric outpatient clinics have depression. Studies on elderly show that old age people are more in depression.

Studies on the elderly population, either in the community, inpatient, outpatient and old age homes have shown that depression is the commonest mental illness in elderly subjects. There was significantly more morbidity in population in the age group 70-74 and 80+ as compared to normal population. The total mental morbidity rate was as high as 612/1000 population. Depression was the commonest illness of old age in this sample, the rate being 522/1000 population (101 cases out of 112 were diagnosed as cases of depression).

It was observed that women are more when compared to men among depression patients. Women had a higher rate of depression-704/1000 population. Another significant finding was the high rate of morbidity amongst the widowed persons.

With regard to epidemiology of depression in children and adolescents reported a prevalence of 0.1% in the 4-16 year age group and no child in the age group 0-3 was diagnosed to have depression. Another study from north India reported an annual incidence rate of 1.61/1000 children in a community based study on school children.

Clinic-based studies have reported a prevalence rate of 1.2 to 9.2% for the affective dis orders, amongst which unipolar depression was the commonest category in most of the studies.

However, in a recent study evaluating the trend of various diagnoses in clinic population, reported increase in prevalence of affective disorders from 2% to 13.49% in children (0-14 years) attending the psychiatric outpatient clinics. Studies done in women during and after pregnancy have reported incidence of post-natal depression to be 11%

DEMOGRAPHIC AND PSYCHOSOCIAL RISK FACTORS FOR DEPRESSION

In terms of socio-demographic variables studies have shown that depression is more common in women, younger subjects, in subjects from poor economic background and subjects with poor nutritional status. old age depression (first episode of depression at or after the age of 50) have also shown that depression is more common in low social class, widowed state unemployed condition, low educational level, in subjects living in nuclear family or in those living alone.

With regard to gender most of the studies have reported that it is more common in elderly females however, some clinic-based studies suggest that it is more common in elderly males. It is also seen that prevalence of depression increases with increasing age in elderly.

Studies have shown that compared to healthy controls and subjects with schizophrenia, depressed patients have significantly greater number of life events prior (6-12 months) to the onset of their illness.

In terms of type of life events, it is seen that depressed patients experience significantly higher proportion of life events related to death of a family member, personal health related events, bereavement, interpersonal and social events and lower number of life events in the form of illness of family members compared to patients with schizophrenia.

It is also seen that compared to patients with mild depression patients with moderate and severe depression tend to use avoidance as a coping strategies more frequently for the stressful life events, suggesting that it may be a maladaptive way to cope with the situation, which is responsible for development of depression. Studies have also reported that parental loss before the age of 18 years, parental disharmony and eldest birth order tend to be more common in subjects with depression.

Studies in elderly also suggest that life events, especially financial problems and death in the family are as important a precipitating event for depression as they are in young adult. It is also seen that stressful life events were specifically more in the elderly females and those with lower per capita income.

Found that depressed adolescent girls report life events in the form of death of a family member, change in residence, failure in examination, end of a relationship and serious illness.

poverty (low income and having difficulty in making ends meet), being married as compared with being single, use of tobacco, experiencing abnormal vaginal discharge and reporting a chronic physical illness were associated with risk of developing a common mental disorder.

Studies have also reported that economic and interpersonal relationship difficulties, partner violence, sexual coercion by the partner as the common causal factors related to development of depression in general and depression during antenatal and postnatal period.[34,55–58] It has been shown that gender of the newborn child is an important determinant of postnatal depression

Among the psychological factors, attribution style was proposed to predispose individuals to depression and maintain depressive symptoms once they develop. A study using the Attribution Style Questionnaire showed that depressed patients have a specific attribution style for their failures and successes in comparison to patients with schizophrenia and medical disorders. According to this study, patients with depression made more internal, stable and global attributions for bad events when compared to other disorders.

A study evaluating the cognitive model of depression as given by Beck failed to find support for

the causal role of cognitive errors in relapse of depressed subjects as a significant proportion of patients were free from cognitive distortions following remission.

However, it was also observed that those who had persistent cognitive distortions during remission ran the risk of early relapse

It has also been seen that patients with neurosis, including depression, have poor social interactions and reports of more interactions of unpleasant type and less of pleasant type of social interactions as compared with healthy controls.

With regard to personality factors, a study showed that higher scores on the hardiness, a personality trait, and correlates with lower scores on the depression scale suggesting that presence of hardiness doesn't allow depressive feelings to become more severe.

Subtypes of depression or course specifies

Atypical Depression: (AD)) is characterized by mood reactivity (paradoxical anhedonia) and positivity, significant weight gain or increased appetite ("comfort eating"), excessive sleep or somnolence (hypersomnia, a sensation of heaviness in limbs known as leaden paralysis, and significant social impairment as a consequence of hypersensitivity to perceived interpersonal rejection. Difficulties in measuring this subtype have led to questions of its validity and prevalence.

Melancholic Depression: is characterized by a loss of pleasure anhedonia in most or all activities, a failure of reactivity to pleasurable stimuli, a quality of depressed mood more pronounced than that of grief or loss, a worsening of symptoms in the morning hours, early-morning waking, psychomotor retardation, excessive weight loss (not to be confused with anorexia nervosa), or excessive guilt.

Psychotic Major Depression (PMD), or simply psychotic depression, is the term for a major depressive episode, in particular of melancholic nature, wherein the patient experiences psychotic symptoms such as delusions or, less commonly, hallucinations. These are most commonly mood-congruent (content coincident with depressive themes).

Catatonic Depression is a rare and severe form of major depression involving disturbances of motor behavior and other symptoms. Here, the person is mute and almost stuporose, and either is immobile or exhibits purposeless or even bizarre movements. Catatonic symptoms can also occur in schizophrenia or a manic episodic, or can be due to neuroleptic malignant syndrome.

Postpartum Depression (PPD) is listed as a course specifier in DSM-IV-TR; it refers to the intense, sustained and sometimes disabling depression experienced by women after giving birth. Postpartum depression, which affects 10–15% of women, typically sets in within three months of labor and lasts as long as three months.

It is quite common for women to experience a short-term feeling of tiredness and sadness in the first few weeks after giving birth; however, postpartum depression is different because it can cause significant hardship and impaired functioning at home, work, or school as well as, possibly, difficulty in relationships with family members, spouses, or friends, or even problems bonding with the newborn. In the treatment of postpartum major depressive disorders and other unipolar depressions in women who are breastfeeding, nortriptyline, paroxetine, (Paxil), and sertraline (Zoloft) are in general considered to be the preferred medications. Women with personal or family histories of mood disorders are at particularly high risk of developing postpartum depression.

Pre-menstrual dysphoric disorder (PMDD) is a severe and disabling form of premenstrual syndrome affecting 3–8% of menstruating women. The disorder consists of a "cluster of affective, behavioral and somatic symptoms" that recur monthly during the luteal phase of the menstrual cycle. PMDD was added to the list of depressive disorders in the Diagnostic and Statistical Disorders in 2013. The exact pathogenesis of the disorder is still unclear and is an active research topic. Treatment of PMDD relies largely on antidepressants that modulate serotonin levels in the brain via serotonin reuptake inhibitors as well as ovulation suppression using contraception.

Seasonal Affective Disorder (SAD), also known as "winter depression" or "winter blues", is a specifier. Some people have a seasonal pattern, with depressive episodes coming on in the autumn or winter, and resolving in spring. The diagnosis is made if at least two episodes have occurred in colder months with none at other times over a two-year period or longer. It is commonly hypothesized that people who live at higher latitudes tend to have less sunlight exposure in the winter and therefore experience higher rates of SAD, but the epidemiological support for this proposition is not strong (and latitude is not the only determinant of the amount of sunlight reaching the eyes in winter). It is said that this disorder can be treated by light therapy SAD is also more prevalent in people who are younger and typically affects more females than males.

Dysthymia is a condition related to unipolar depression, where the same physical and cognitive problems are evident, but they are not as severe and tend to last longer (usually at least 2 years). The treatment of dysthymia is largely the same as for major depression, including antidepressant medications and psychotherapy.

Double Depression: can be defined as a fairly depressed mood (dysthymia) that lasts for at least two years and is punctuated by periods of major depression.

Depressive Disorder not otherwise Specified (DD-NOS) is designated by the code 311 for

depressive disorders that are impairing but do not fit any of the officially specified diagnoses. According to the DSM-IV, DD-NOS encompasses "any depressive disorder that does not meet the criteria for a specific disorder." It includes the research diagnoses of recurrent brief depression, and minor depressive disorder listed below.

Depressive Personal disorder (DPD) is a controversial psychiatric diagnosis that denotes a personality disorder with depressive features. Originally included in the DSM-II, depressive personality disorder was removed from the DSM-III and DSM-III-R. Recently, it has been reconsidered for reinstatement as a diagnosis. Depressive personality disorder is currently described in Appendix B in the DSM-IV-TR as worthy of further study.

Recurrent brief depression (RBD), distinguished from major depressive disorder primarily by differences in duration. People with RBD have depressive episodes about once per month, with individual episodes lasting less than two weeks and typically less than 2–3 days. Diagnosis of RBD requires that the episodes occur over the span of at least one year and, in female patients, independently of the menstrual cycle. People with clinical depression can develop RBD, and vice versa, and both illnesses have similar risks.

Minor depression disorder, or simply minor depression which refers to a depression that does not meet full criteria for major depression but in which at least two symptoms are present for two weeks.

PHYSIOLOGICAL BASIS FOR DEPRESSION

The neurological studies on schizophrenia are more than depression in India. Studies on Neurobiology: Compared to schizophrenia, there is relatively less research on the neurobiology of depression from India. Studies have evaluated the levels of catecholamine metabolites in cerebrospinal fluid, urine and blood. Studies have showed that urinary 5-hydroxyindoleacetic acid (5HIAA), a metabolic end product of serotonin was significantly higher in depressed patients as compared to controls and these values decreased following successful treatment.

ELECTROPHYSIOLOGY

Many studies have evaluated the pre-treatment P300 amplitude and latency in depressed subjects and compared the same with healthy controls. All studies have consistently shown that P300 amplitude is smaller in depressed subjects and this normalizes with recovery.

ENDOCRINOLOGY

As a marker for melancholia, studies have shown that dexamethasone suppression test (DST) has low sensitivity but high specificity. Studies have also shown that, compared to DST suppressors, DST non-suppressors are significantly more depressed, attempt suicide more frequently, have

higher rates of past and family history of depression, more frequently require electroconvulsive therapy and show better response to treatment.

Adrenocorticotrophic Hormone (ACTH) measurements, both at baseline and post-DST in patients of major depression, have been found to be significantly high at baseline and post DST as compared to healthy controls. It was found that significantly higher number of patients with unipolar depression has subnormal T3 and T4 levels and a corresponding increase in thyroid stimulating hormone (TSH) levels compared with healthy controls.

Immunology: It has been shown that there is significant increase in total CSF protein levels in depressed subjects compared to subjects with neurological and surgical illnesses.

Extracellular fluid: it was found that the extracellular fluid (ECF) volume of patients with depression tends to be lower than normal controls and normalization of the same correlates with clinical improvement.

Melatonin: Studies have shown that urinary melatonin levels can help in distinguishing subjects of endogenous depression from those with neurotic depression. Nocturnal as well as 24 hours urinary melatonin levels are low in subjects with endogenous depression whereas subjects with neurotic depression have higher than normal levels. It was also seen that melatonin levels were related to suicide attempts, diurnal variation and psychomotor retardation.

NEUROCOGNITIVE FUNCTIONING

Studies from India suggest that definite cognitive impairments are present in the domains of intelligence and memory (Bhatia's Battery test or the Wechsler Adult Performance Intelligence Scale and PGI memory scale) in the depressed state but these don't persist following recovery. It is also reported that subjects with depression perform poorly on the Wisconsin Card Sorting Test (WCST) as compared to controls suggesting cognitive inflexibility and prefrontal dysfunction. Further, more severe illness is associated with greater impairment in the executive functioning on WCST. Other studies which have evaluated various cognitive domains have shown that when patients with depression are asked to discriminate the emotional tone in terms of intensity of facial expression while presented in pairs, it is seen that they are highly evaluative of sadness and less evaluative of happiness, in comparison to the normal.

GENETICS

A recent study, showed the importance of genetic factors in treatment response. Significantly better response to escitalopram was seen in patients homozygous for long allele of the serotonin

transporter gene compared to the patients who were homozygous for short allele or heterozygous for short and long allele. Another study showed that short variants of D7S1875 marker in LEP gene may be a risk factor for depression.

LIPIDS

A recent study evaluated the serum total cholesterol level in depressed subjects and showed that there is significant elevation of serum total cholesterol in depressed patients compared with normal controls and this persists even after controlling for the confounders. Another study suggested that measurement of serum cholesterol levels may actually indicate towards hypothyroidism in depressed subjects

DIAGNOSIS AND TREATMENT

A number of instruments have been developed to attempt to measure negative cognition in the three areas of the triad.

The Beck Depression Inventory (BDI) is a well-known questionnaire for scoring depression based on all three aspects of the triad. Other examples include the Beck hopelessness scale for measuring thoughts about the future and the Rosenberg Self Scale for measuring views of the self.

The Cognitive Traid Inventory (CTI) was developed by Beckham et al. To attempt to systematically measure the three aspects of Beck's triad. The CTI aims to quantify the relationship between "therapist behavior in a single treatment session to changes in the cognitive triad" and "patterns of changes to the triad to changes in overall depressive mood. This inventory has since been adapted for use with children and adolescents in the CTI-C.

The psychiatric symptoms develop in a prolonged depressed mood, especially in combination with other symptoms which needs medication and treatment for recovery. Antidepressants should not be routinely used for the initial treatment of mild depression, because the risk-benefit ratio is poor. Physical activity can have a protective effect against the emergence of depression.

Physical activity: Physical activity is found to be the best therapy as it can also decrease depressive symptoms due to the release of neurotropic proteins in the brain that can help to recover from inhibited activity of hippocampus. Yoga, regular breathing exercises, rhythmic exercises also help the depressive patients

Reminiscence of old and fond memories is another alternative form of treatment, especially for the elderly who have lived longer and have more experiences in life. It is a method that causes a person to recollect memories of their own life, leading to a process of self-recognition and identifying familiar stimuli. By maintaining one's personal past and identity, it is a technique that stimulates people to view their lives in a more objective and balanced way, causing them to pay attention to positive information in their life stories, which would successfully reduce depressive mood levels.[47]

Self-help books are a growing form of treatment for people's physiological distress. There may be a possible connection between consumers of unguided self-help books and higher levels of stress and depressive symptoms. The growth-oriented group has higher stress reactivity levels than the problem-focused group. However, the problem-focused group shows higher depressive

symptomatology. The empirical evidences of a connection between the type of stress management techniques and the level of daily depressive mood was found in research. On the other hand, emotion-focused coping promotes a depressed mood in stressful situations.

The Cognitive behavior therapy helps the depressive patient to identify the distorted thoughts and rectify them under the supervision of expert professional. Shadowing the depressive patients and helping them to be in daily activities by taking care by someone in the house and work environment is found working for good results. Practice of regular day to day activities along with physical exercises must be part of any treatment and psychotherapy.

Lesson 14:Mood Disorders- Bipolar

STRUCTURE

1. What is Bipolar Disorder?
2. Types of Bipolar Disorder
3. Symptoms of Bipolar Disorder
4. Risk Factors
5. Diagnosis
6. Brain and neurological base
7. Treatment and Management
8. Bipolar Disorder Outlook
9. Bipolar Disorder and Suicide

WHAT IS BIPOLAR DISORDER?

Bipolar disorder, also known as manic depression, is a mental illness that brings severe high and low moods and changes in sleep, energy, thinking, and behavior. Other names to Bipolar Disorder include, Bipolar Affective disorder (BPAD), Bipolar Illness, Depressive Disorder, Manic-Depressive Illness (historical), Manic Depressive Psychosis, Circular Insanity, (historical) Bipolar Disease.

People who have bipolar disorder can have periods in which they feel overly happy and energized and other periods of feeling very sad, hopeless, and sluggish. In between those periods, they usually feel normal. One can think of the highs and the lows as two "poles" of mood, which is why it's called "bipolar" disorder.

The word "manic" describes the times when someone with bipolar disorder feels overly excited and confident. These feelings can also involve irritability and impulsive or reckless decision-making. About half of people during mania can also have delusions (believing things that aren't true and that they can't be talked out of) or hallucinations (seeing or hearing things that aren't there).

Hypomania describes milder symptoms of mania, in which someone does not have delusions or

hallucinations, and their high symptoms do not interfere with their everyday life.

The word "depressive" describes the times when the person feels very sad or depressed. Those symptoms are the same as those described in major depressive disorder or "clinical depression," a condition in which someone never has manic or hypomanic episodes.

Most people with bipolar disorder spend more time with depressive symptoms than manic or hypomanic symptoms. The bipolar sufferers have suicidal and self-harm tendencies. The risk factor is for 25years old and above people. The cause of disorder is **both genetic and environmental.** Risk factors are found to be the exposure to family history of abuse, childhood abuse and long term stress. Differential diagnosis shows attention deficit hyperactivity disorder, personality disorders, Schizophrenia and substance use disorder. The frequency of disorder is 1-3%.

TYPES OF BIPOLAR DISORDER

There are a few types of bipolar disorder, including:

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

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

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

With any type of bipolar disorder, misuse of drugs and alcohol use can lead to more episodes. Having bipolar disorder and alcohol use disorder, known as “dual diagnosis,” requires help from a specialist who can address both issues.

SYMPTOMS OF BIPOLAR DISORDER

In bipolar disorder, the dramatic episodes of high and low moods do not follow a set pattern. Someone may feel the same mood state (depressed or manic) several times before switching to the opposite mood. These episodes can happen over a period of weeks, months, and sometimes even years.

How severe it gets differs from person to person and can also change over time, becoming more or less severe.

Symptoms of mania ("the highs"): Excessive happiness, hopefulness, and excitement, Sudden

changes from being joyful to being irritable, angry, and hostile, Restlessness, Rapid speech and poor concentration, Increased energy and less need for sleep, Unusually high sex drive, Making grand and unrealistic plans, Showing poor judgment, Drug and alcohol abuse, Becoming more impulsive, Less need for sleep, Less of an appetite, Larger sense of self-confidence and well-being, Being easily distracted

During depressive periods ("the lows"), a person with bipolar disorder may have: Sadness, Loss of energy, Feelings of hopelessness or worthlessness, Not enjoying things they once liked, Trouble concentrating, Forgetfulness, Talking slowly, Less of a sex drive, Inability to feel pleasure, Uncontrollable crying, Trouble making decisions, Irritability, Needing more sleep, Insomnia, Appetite changes that make you lose or gain weight, Thoughts of death or suicide, Attempting suicide,

Bipolar Disorder Causes

There is no single cause of bipolar disorder. Researchers are studying how a few factors may lead to it in some people. For example, sometimes it can simply be a matter of genetics, meaning they have it because it runs in their family. The way ones brain develops may also play a role, but scientists aren't exactly sure how or why.

RISK FACTORS

When someone develops bipolar disorder, it usually starts when they're in late adolescence or young adulthood. Rarely, it can happen earlier in childhood. Bipolar disorder can run in families.
Men and women are equally likely to get it. Women are somewhat more likely than men to go through "rapid cycling," which is having four or more distinct mood episodes within a year. Women also tend to spend more time depressed than men with bipolar disorder.
Bipolar disorder usually develops later in life for women, and they're more likely to have bipolar disorder II and be affected by seasonal mood changes.
A combination of medical and mental issues is also more common in women. Those medical issues can include thyroid disease, migraine, and anxiety disorders.
Some things that make you more likely to have bipolar disorder include:
Having a family member with bipolar disorder
Going through a time of high stress or trauma
Drug or alcohol abuse
Certain health conditions
Many people with the condition abuse alcohol or other drugs when manic or depressed. People with bipolar disorder are more likely to have seasonal depression, co-existing anxiety disorders, posttraumatic stress disorder, and obsessive-compulsive disorder.

Bipolar Disorder Diagnosis

In order to diagnosis purpose or to know about the symptoms of the problem, to take a wise

decision to decide the symptoms are due to result of any other problem, the mental health professionals like psychiatrist, Psychotherapist they take information by conducting mental status examination. In which the professional can get to know the condition of mood, changes in sleep, energy, and behavior.

The close family members, friends, children, siblings of the patient help the doctor to distinguish bipolar disorder from thyroid problem, major depressive disorder or any psychiatric disorder which can involve changes in mood, thinking and behavior.

Diagnosing bipolar disorder can be trickier for children and teenagers. Their symptoms may be the same as adults but might be confused for attention deficit hyperactivity disorder (ADHD) or even just bad behavior.

DSM- 5 (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition) and ICD-10 (International Statistical Classification of Related Health Problems, 10th edition), are widely used criteria diagnosing Bipolar disorder. Several rating scales for the screening and evaluation of bipolar disorder are used for evaluation, but they cannot substitute the full clinical interview, but systemize the collection of symptoms. The Bipolar disorder instruments tend to have lower sensitivity.

We can mention many standard screening and evaluation rating scales. The bipolar spectrum diagnostic scale, mood disorder questionnaire, the general behavior inventory and hypomania check list. Bipolar disorder is classified as a mental and behavioral disorder.

The differential diagnosis (the process of differentiating between more than two conditions which share same or different symptoms). tests also are used as same symptoms may be found due to neurological problems, side effects of medicines already in use by the patient, EEG to find any lesions or tumors, blood tests, endocrine tests, infection tests, tests of vitamin deficiency,

The Prognosis shows that the bipolar disorder is lifelong condition with full or partial recovery, and incidents of relapse. This is considered as major health problem worldwide because of the increased rates of disability premature mortality.

BRAIN AND NEUROLOGICAL BASE

Brain and neurological base of bipolar disorder patients is having difference when compared to people without this disorder. Studies found that the area responsible is related to emotions and behavior.

The precise mechanisms that cause bipolar disorder are not well understood. Bipolar disorder is thought to be associated with abnormalities in the structure and function of certain brain areas responsible for cognitive tasks and the processing of emotions.

A neurologic model for bipolar disorder proposes that the emotional circuitry of the brain can be divided into two main parts.

The ventral system (regulates emotional perception) includes brain structures such as the amygdala, insula, ventral striatum, ventral anterior cingulate cortex and prefrontal cortex.

The dorsal system (responsible for emotional regulation) includes the hippocampus, parts of the prefrontal cortex and dorsal anterior cingulate cortex.

The model hypothesizes that bipolar disorder may occur when the ventral system is over activated and the dorsal system is under activated. Other models suggest the ability to regulate emotions is disrupted in people with bipolar disorder and that dysfunction of the ventricular prefrontal cortex (vPFC) is crucial to this disruption.

Bipolar Disorder Management and Treatments

The aim of management is to treat acute episodes safely with the help of medication, help patient to have long term management of further episodes, with the help of medication and psychosocial therapies. The hospitalization may also be used periodically for manic episodes.

Psychotherapy includes assisting bipolar patients acceptance of problem diagnosed, coping with various types of stress, improving interpersonal relationships and recognizing prodromal symptoms to take necessary care.

Cognitive behavioral therapy, Family – focused therapy, and Psychoeducation help a lot in prevention and relapse. Social rhythm and interpersonal therapy along with cognitive therapy found to be effective with depression symptoms.

"Talk therapy," is often recommended, too. There are several different types. Options can include:

Interpersonal and social rhythm therapy (ISPRT). This is based on the idea that having a daily routine for everything, from sleeping to eating, can help keep your mood stable.

Cognitive behavioral therapy (CBT). This helps you replace bad habits and actions with more positive alternatives. It also can help you learn to manage stress and other negative triggers.

Psychoeducation. Learning more and teaching family members about bipolar disorder can help give you support when episodes happen.

Family-focused therapy. This sets up a support system to help with treatment and helps your loved ones recognize the beginning of an episode.

Other treatment options for bipolar disorder can include:

Electroconvulsive therapy (ECT). Small doses of electricity shock the brain and set off a small seizure to kind of reboot it and change the balance of certain chemicals. While it's still a last-

resort treatment when medications and therapy haven't worked, it is much better controlled and safer, with fewer risks and side effects, than in the early days of this procedure.

Acupuncture. There's some evidence that this complementary therapy may help with the depression caused by bipolar disorder.

Supplements. While some people take certain vitamin supplements to help with the symptoms of bipolar disorder, there are many possible issues with using them. For example, their ingredients aren't regulated, they can have side effects, and some can affect how prescribed medications work. Be sure to tell your doctor about any supplements you take.

Lifestyle changes may also help: Regular exercise, Stay on a schedule for eating and sleeping, Learning to recognize mood swings, getting support from friends or groups. Maintaining a symptom dairy or chat, learning to manage stress, development of healthy hobbies or sports, not using alcoholic and recreational drugs.

Bipolar Disorder Outlook

For most people, a good treatment program can stabilize their moods and help ease symptoms. Those who also have a substance abuse problem may need more specialized treatment.

Ongoing treatment is more effective than dealing with problems as they come up.

The more you know about your condition, the better you can manage your episodes. And support groups, where you can talk with people who are going through the same things you are, can also help.

Bipolar Disorder and Suicide

Some people who have bipolar disorder may become suicidal.

Recognizing warning signs such as depression, Isolating one's self, acting recklessly, talking and thinking about suicide, hopelessness , helplessness, taking risks in life, starting of alcohol, crying more giving away possessions, and taking necessary care is very much necessary to avoid suicide.

Medication by psychiatrists is based on episode, Lithium is used for reducing relapse, self-harm, suicide rate. Lithium along with some other medicines will help as mood stabilizers.

Medication is the main treatment, usually involving the following:

Mood stabilizers, such as carbamazepine (Tigerton)), Lamotrigine lamictal or valproate Depakote

Antipsychotic drugs, such as careprazine, lurasidone, olanzapine, and quetiapine.

Antidepressant-antipsychotic drugs, a combination of an antidepressant and a mood stabilizer

Anti-anxiety medications or sleep medicines, such as sedatives like benzodiazepines

Women who are pregnant or breastfeeding should talk with their doctors about medications that are safe to take.

Lesson 15: MOOD Disorder-Suicide

STRUCTURE

1. Some Facts about Suicide
2. Definitions
3. Risk Factors
4. The History of Previous Attempts of Suicide
5. Psychosocial factors
6. Religion:
7. Substance misuse
8. Medical conditions
9. Prevention:
10. Psychophysiology
11. Treatments Available for Suicide
12. Summary
13. Model Questions
14. Suggested Readings

SUICIDE

Suicide is the act of intentionally causing one's own death

SOME FACTS ABOUT SUICIDE

Suicide is more committed by people from15 to 30 years of age and also people above 70 years of age. The risk is more among people with Depression, bipolar disorder, autism spectrum disorders, schizophrenia, personality disorders, anxiety disorders, alcohol use disorder, substance use disorder, nihilistic beliefs. physical disorders (such as chronic fatigue syndrome) and substance use disorders (including alcohol use disorder and the use of and withdrawal from benzodiazepines) are risk factors.

DEFINITION

Suicide is "An act of taking ones' own life" Self-injury is not suicide but it is also known as Non-fatal suicide behavior or self-injury. The thought of ending one's life but not taking any active

efforts do so, not involve exact planning or intent is called Suicidal Ideation.

RISK FACTORS

Usually now a days more suicides are seen in students, who cannot reach the expectations of parents and society. Some love failures, financial problems among farmers are also are also found to be risk factors.

The ready availability of means to commit suicide, having attempted suicide previously, family history of suicide, brain injury, availability of firearms in house hold also showing high risk for suicide.

The risk has increased due to the Corona Virus Pandemic situation. But in general the studies show that the mental disorders, Drug abuse or misuse, some psychological states, the cultural issues, family and social situations, genetics, and the experience of trauma or loss, and negative thinking or nihilism. It is more frequent with mental disorders and substance abuse.

The risk factors which are mostly found in studies on suicide victims' families are unemployment, homelessness, discrimination etc. under the common heading socioeconomic problems. Families with mental illness, war veterans, post-traumatic stress disorder, physical health problems related to war are also at high risk of suicide. The thought of suicide and attempts to suicide show that the high levels of pain in those persons. They also may have reduced risk of death. Genetics appears to account for between 38% and 55% of suicidal behavior's. Suicides may also occur as a local cluster of cases.

Mental illness: in 27% to more than 90% of the time, mental illness was found in people who committed or attempted suicide.

Half of all people who die by suicide have mental disorders such as major depressive disorder, mood disorders (Bipolar disorder). 20 fold of risk increases with these mental disorders. The suicide risk for other mental illness are, Schizophrenia (14%), personality disorders (8%), obsessive compulsive disorders, post-traumatic stress disorder and autism spectrum disorders.

Personality Disorders, like Border line personality disorder have more cases of complete suicides.

People with Schizophrenia (5%) and eating disorders are another high risk condition for suicide.

Most of the suicide cases have history of visiting physiologist for some problems. Such cases are 80% among total cases taken for suicidal deaths. 45% visited physician prior month, 25-40% cases in a year time visit to mental health professionals.

Medicated people who committed suicide are mostly found to be using Antidepressants of the SSRI class (Selective serotonin reuptake inhibitors) among children and adults to same extent. The risk of suicide increased with non-willingness to take professional help.

THE HISTORY OF PREVIOUS ATTEMPTS OF SUICIDE

A previous history of suicide attempts is the most accurate predictor of completed suicide. The rate of suicide is more within one year, and suicide is seen even after 10 years. Self-harm people not at the risk of suicide, but however, do still end their life by suicide, and risk for self-harm and suicide may overlap.

PSYCHOLOGICAL FACTORS

Psychological Factors which increase the risk of suicide are hopelessness, loss of pleasure in life, depression, anxiousness, agitation, rigid thinking, rumination, thought suppression and poor coping skills.

Poor ability to solve problems, poor impulse control, perception of burden to others, people who never married, recent life stressors are contributors for suicidal risk.

Personality factors such as neuroticism, introvertedness having associated with stress and suicide. People who were isolated, distressed, having few reasons for living, feeling of trapped in stressful situations, the stress responses of the body change also found to be behind the committing suicide. Social Isolation, lack of social support, Poverty, poverty when compared with others financial status increase the risk of suicide. In India farmers, in china also financial difficulties found drive people towards suicide

RELIGION

Religiousness reduces the risk for suicide. The rate is low during Christmas time, increase during spring and summer, male suicides are more during their birthdays. These facts show that time and period has influence on suicide rate.

The drug abuse can lead to suicide, poverty and crime. Depression and bipolar disorder are first major cause for suicide but the second major cause is substance misuse. The substance misuse if combined with any other factors as mental illness, personal grief, such as personal bereavement, the suicide risk increases.

The rate of high intake of different types of drugs and density of bars are also reported to have high suicidal rates. The misuse of cocaine and methamphetamine, sedative-hypnotic drugs (such as alcohol or benzodiazepines), those who use heroin, Smoking cigarettes has greatly shown to have higher rate of suicide risk. Cannabis, however, does not appear to independently increase the risk.

People suffering from chronic medical issues, chronic pain, traumatic brain injury, cancer, chronic fatigue syndrome, kidney failure (requiring hemodialysis), HIV, and systemic lupus erythematosus, and among people with more than one medical condition the frequency was particularly high. In Japan, health problems are listed as the primary justification for suicide

Sleep problems like insomnia, sleep apnea are risk factors for depression and suicide. Mood disorders and the suicide are found among people with mood disorders, including hypothyroidism, Alzheimer's, brain tumors, systemic lupus erythematosus, and adverse effects from a number of medications (such as beta blockers and steroids)

Media has vast influence on suicidal rate. Certain depictions of suicide may increase its occurrence, with high-volume, prominent, repetitive coverage glorifying or romanticizing suicide having the most impact. When detailed descriptions of how to kill oneself by a specific means are portrayed, this method of suicide can be imitated in vulnerable people.

This risk is greater in adolescents who may romanticize death.

Other factors

Trauma is a risk factor for suicidality in both children and adolescents, who try suicide to escape from bullying or prejudice. A history of childhood sexual abuse, and time spent in foster care are also risk factors. Sexual abuse is believed to contribute to approximately 20% of the overall risk. Significant adversity early in life has a negative effect on problem-solving skills and memory, both of which are implicated in suicidality. Problem gambling is associated with increased suicidal ideation and attempts compared to the general population Between 12 and 24% pathological gamblers attempt suicide. The rate of suicide among their spouses is three times greater than that of the general population. Other factors that increase the risk in problem gamblers include concomitant mental illness, alcohol, and drug misuse. Genetics might influence rates of completed suicides. A family history of suicide, especially in the mother, affects children more than adolescents or adults. Adoption studies have shown that this is the case for biological relatives, but not adopted relatives. This makes familial risk factors unlikely to be due to imitation.

There appears to be a link between air pollution and depression and suicide, Suicide might be rarer in societies with high social cohesion and moral objections against suicide. About 15–40% of people leave a suicide note. Infection by the parasite Toxoplasma gondii, more commonly known as toxoplasmosis, has been linked with suicide risk. One explanation states that this is caused by altered neurotransmitter activity due to the immunological response.

PREVENTION

Limiting access to methods of suicide, treating mental disorders and substance misuse, careful media reporting about suicide, improving social and economic conditions.
Preventive measures include support and access to therapy. Low perceived need and wanting to deal with problem alone are found to be the reasons behind.

PSYCHOPHYSIOLOGY

Knowledge of psychophysiology is very much necessary for professional working in suicide prevention as counsellors or in medical field. Eventhouh there is no known psychophysiological evidence, it is observed that depression, and withdrawal tendencies of individuals are having roots in psychophysiology, which in turn are found to be strongly related to increase of suicidal rate.

The suicides are result of social, economic and psychological interplay. Low levels of brain-derives neurotropic factor (BDNF) are both directly associated with suicide and indirectly associated in major post-traumatic stress disorder, schizophrenia, and obsessive-compulsive disorder. lower levels of BNDF was found in Post mortem studies found that BNDF low levels in Hippocampus and prefrontal cortex, among patients with mental illness or without mental illness is cause of suicides.

The scientists found that Epigenetics, the study of changes in genetic expression in response to environmental factor in response to environmental factors which does not alter underlying DNA, (Deoxyribonucleic acid, more commonly known as DNA, is a complex molecule that contains all of the information necessary to build and maintain an organism. All living things have DNA within their cells. In fact, nearly every cell in a multicellular organism possesses the full set of DNA required for that organism) is also believed to play a role in deciding suicide risk.

Serotonin, which is a neurotransmitter, is believed to be low in those who die by suicide, it is partly based on evidence of increased levels of 5-HT2A receptors found after death, and reduction levels of a breakdown product of serotonin, 5-hydroxyindoleacetic acid in the cerebral spinal fluid.

TREATMENTS AVAILABLE FOR SUICIDE

Some psychometric tests help professionals to identify suicidal thoughts. Psychometric tests

such as Becks Depression Inventory, Depression scale for older people are being used to identify depression. Such professional help to identify depression also help in recognizing the suicidal thoughts, reduction of suicidal rate.

Availability of some dangerous tablets in the medical shops without doctor's prescription, availability of firearms or toxins such as opioids and pesticides, can be restricted. The suicidal impulsive decision will be immediate and non-availability reduces the risk. 70% of near-fatal suicide attempts made after less than one hour of deliberation—thus, reducing access to easily-accessible methods of suicide may make impulsive attempts less likely to succeed. adding barriers on bridges and subway platforms, Treatment of drug and alcohol addiction, depression, and those who have attempted suicide in the past, may also be effective, Some have proposed reducing access to alcohol as a preventive strategy (such as reducing the number of bars).

Psychotherapy, De-addiction programs, improving mental health of school going children, poverty reduction and economic developmental strategies by training family income increasing sources play very effective role in treating the suicidal thoughts and changing conditions.

The cognitive behavior therapy, which focuses on change of thought process, will be very useful for adolescents, and college going students, as their ability to take decision in real life situation improves and suicidal tendencies get reduced. Training in social connections, inter relations among elderly males, also be effective in reducing the suicidal thoughts. Involving all who attempted in suicide in social development will be helpful to make them feel socially responsible and realize the purpose of life.

Follow up of attempted suicide care center members, creating crises hot lines, preventing childhood trauma, to take people aware of suicide related issues by conducting programs on world suicide day on September 10thh also helps in preventing suicide rate. Same way supporting WHO and International Association for suicide prevention also a proactive step that can be taken ahead the reduction of suicides worldwide.

SUMMARY

Psychotherapy is established as a major treatment option for the whole spectrum of

mood disorders. The treatment of major depression is the area that has received the most research attention, while a growing body of studies deals with chronic depression and bipolar disorder. A variety of psychotherapeutic approaches are backed by robust empirical support, and other approaches are receiving increasing research interest.

For instance, there is preliminary evidence that eye movement desensitization and reprocessing therapy and mindfulness-based cognitive therapy are beneficial in bipolar patients with a history

of traumatic events and unipolar patients with three or more prior depressive episodes respectively.

Psychotherapy has many attractive features; it may provide lasting gains, and adverse effects are rare, though not completely absent. However, it has also some limitations. Acute symptoms of mood elevation are poorly responsive, if at all, to psychological treatment alone. The effects of psychotherapy on depressive symptoms, while often long-lasting, usually require at least a few weeks to develop, which may increase the risk of premature termination of treatment, especially in patients who are highly symptomatic or looking for rapid improvement. With such patients, a careful explanation of the rationale and expected time course of therapeutic effects is of paramount importance. Also, the judicious short-term use of psychotropic medication to relieve acute symptoms may help engage severely depressed or anxious patients in therapy, and may allow them to benefit from a psychological treatment that would not have been possible otherwise.

Another limitation is that the patients who have low psychological mindedness, fear the development of psychological dependence, are poorly motivated, or show a marked preference for medication over psychotherapy might be difficult to engage and retain in treatment. With such challenging patients, the careful building of a strong therapeutic alliance is even more important than usual and may help deliver effective psychological treatment to the largest possible number of patients.

MOOD DISORDERS

A mood disorder is a mental health class that health professionals use to broadly describe all types of depression and bipolar disorders.

The most common types of mood disorders are major depression, dysthymia (dysthymic disorder), bipolar disorder, mood disorder due to a general medical condition, and substance-induced mood disorder.

There is no clear cause of mood disorders. Healthcare providers think they are a result of chemical imbalances in the brain. Some types of mood disorders seem to run in families, but no genes have yet been linked to them.

n general, nearly everyone with a mood disorder has ongoing feelings of sadness, and may feel helpless, hopeless, and irritable. Without treatment, symptoms can last for weeks, months, or years, and can impact quality of life.

Depression is most often treated with medicine, psychotherapy or cognitive behavioral therapy, family therapy, or a combination of medicine and therapy. In some cases, other therapies, such

as electroconvulsive therapy and transcranial stimulation may be used.

DIFFERENT MOOD DISORDERS

- Major depression. Having less interest in usual activities, feeling sad or hopeless, and other symptoms for at least 2 weeks may indicate depression.
- Dysthymia.
- Bipolar disorder.
- Mood disorder related to another health condition.
- Substance-induced mood disorder.

DEPRESSION

Depressive disorders are characterized by the patient's dysfunctional negative views. The views of themselves, their life experience (and the world in general), and their future – the cognitive triad. People with depression often view themselves as unlovable, helpless, doomed or deficient. They tend to attribute their unpleasant experiences to their presumed physical, mental, and/or moral deficits. They tend to feel excessively guilty, believing that they are worthless, blameworthy, and rejected by self and others.

They may have a very difficult time viewing themselves as people who could ever succeed, be accepted, or feel good about themselves and this may lead to withdrawal and isolation, which further worsens the mood.

BIPOLAR

Some bipolar disorders include:

Bipolar 1. This type of bipolar disorder is characterized by manic episodes, with or without depression symptoms.

Bipolar 2. Bipolar 2 disorder is characterized by having both manic and depressive episodes

Cyclothymic disorder

Other types.

SUICIDE

The media, including the Internet, plays an important role Certain depictions of suicide may increase its occurrence, with high-volume, prominent, repetitive coverage glorifying or romanticizing suicide having the most impact When detailed descriptions of how to kill oneself

by a specific means are portrayed, this method of suicide can be imitated in vulnerable people. This phenomenon has been observed in several cases after press coverage. In a bid to reduce the adverse effect of media portrayals concerning suicide report, one of the effective methods is to educate journalists on how to report suicide news in a manner that might reduce that possibility of imitation and encourage those at risk to seek for help.

When journalists follow certain reporting guidelines the risk of suicides can be decreased. Getting buy-in from the media industry, however, can be difficult, especially in the long term.

MODEL QUESTIONS

1	Answer ( )	Question	One of the following is not mood disorder. What is it?		
Choice for answer		A. ipolar	b. Depression	c. Major Depression	d. Paranoid disorder
2	Answer ( )	Individuals with bipolar disorder often show this very often			
Choice for answer		A. loss of	b. re	c. substan	d. fulre

		insight	sulting in resistance to treatment,	ce abuse	co very fr om Bi po lar dis or de r
3	Answer ( )	Other names to Bipolar Disorder include Bipolar Illness, Depressive Disorder, Manic Depressive Psychosis, (historical) Bipolar Disease and others mentioned given below, except one. What is it?			
Choice for answer		A. Suicide	B. Bipolar Aff	C Manic-Depressive Illness (histo	D. Circular Insanity

			ective disorder (BPAD),	ric al),	
4	Answer ( )	Choose the wrong answer from the causes of bipolar disorder.			
Choice for answer		a. Genetic and environmental.	b. History of abuse, child	c. Long term stress.	d. if spouse is with bipolar disorder

			hood abuse.		
5	Answer ( )	Commonly found in depressive patients is anhedonia is currently used by researchers to refer to the following. Find out which is not related to it?			
Choice for answer		A reduced motivation,	b. reduced anticipatory pleasure (wa	c. reduced consummatory pleasure (liking),	d. reinforcement learning,

		n ti n g),		

SUGGESTED READINGS

1. Amber Rain: Mood Disorders: 4 Mood Disorders Books-Symptoms And Treatment of Depressed or Bipolar People and How to Cope With Them (Mood Disorders, Depression Signs, Anxiety Symptoms, Bipolar People Book 5), Ambar Rain, Kindle version.

2. Sheila Reid, 2018, Mood Disorders, Foster Academics, 978-1632425577.

3. Dan J. Stein, 2005, The American Psychiatric Publishing Textbook of Mood Disorders, 978-1585621514

Links:

https://www.google.com/search?q=dna&rlz=1C1CYCH_enIN780IN781&oq=dna&aqs=chrome..69i57j0i433i512l2j0i512l2j0i433i512j0i131i433i512j0i5

https://en.wikipedia.org/wiki/Suicide

https://www.hopkinsmedicine.org/health/conditions-and-diseases/mood-disorders

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3146226/

https://en.wikipedia.org/wiki/Depression_(mood)

Beck Depression Inventory - https://en.wikipedia.org/wiki/Beck_Depression_Inventory

https://en.wikipedia.org/wiki/Treatment_of_Negative_Automatic_Thoughts

https://en.wikipedia.org/wiki/Beck_Anxiety_Inventory

https://en.wikipedia.org/wiki/Beck_Hopelessness_Scale

https://en.wikipedia.org/wiki/Bipolar_disorder

https://www.mayoclinic.org/diseases-conditions/bipolar-disorder/diagnosis-treatment/drc-20355961