TOPIC 1: PERSONALITY DEVELOPMENT, ATTACHMENT THEORIES

1. Psychoanalytic theories

a.) Theory of Sigmund Freud

- main ideas: role of unconscious mind, childhood experiences
- development occurs in psychosexual stages
- concept of libido (a fundamental pleasure-seeking drive which unconsciously motivates us from the moment of our birth)
- psychosexual stages:
    - oral (birt-y1) – libido is gratified from stimulation of mucus membrane (e.g. sucking)
    - anal (y2-3) – libido is gratified from anus by the experience of excretion or retention
    - phallic (y3-4) - libido is gratified from erotic pleasures from genitals
    - latency/forgetful (y5-puberty) – psychosexual desires are inactive
    - genital – development of normal sexual behaviour
- concept of Oedipus complex (male child), castration anxiety
- concept of Electra complex (female child), penis envy
- critics of Freud's theory: focuses on male development, hard to test scientifically, future predictions are too vague, based on case studies not on empirical researches

b.) Theory of Eric H. Erickson

- accepts most of Freud's ideas, but proposes psychosocial development
    - trust vs mistrust (birth-y1)
    - autonomy vs doubt (y1-y3)
    - industry vs inferiority (y3-y6)
    - identity vs role confusion (puberty)
    - intimacy vs isolation (young adulthood)
    - generativity vs stagnation (middle aged adults)
    - integrity vs despair (elderly people)

2. Learning theories

- environmental impact on behaviour
- main concepts:
    - classical conditioning (Pavlov's experiment - biologically potent stimulus e.g. food, is paired with a neutral stimulus e.g. voice of bell)
    - operant conditioning (Skinner's experiment, skinner boxes-rats - voluntary behaviours are modified by association with the addition or removal of reward or aversive stimuli)
    - social learning (Albert Bandura, Bobo doll experiment - people learn by watching other people)

a.) Jean Piaget – stages of cognitive development

- sensory motory (birth-y2) – recognizes self as agent of action->act intentionally, achieves object permanence
- pre-operational (y2-y7) – learns to use language, thinking is still egocentric, classifies objects by single features

    - concrete operational (y7-y11) – logical thinking, conservation of numbers, classifies object by several features
    - formal operation (11) – can think logically about abstract propositions and test hypothesis, becomes concerned with the future and ideological problems
- criticism: basis of his theory his observation of his own 3 children, small research sample (not representative, researches show formal operation stage is influenced by environmental factors too), most children possesses many abilities earlier
- legacy: generated interest in child development, basis of later researches in education and developmental psychology

3. Attachment theories – John Bowlby, Mary Ainsworth

- role of attachment: a young child needs to develop a relationship with at least one primary caregiver for social and emotional development to occur normally
- J. Bowlby:
    - infant needs attachment of survival
    - concept of hospitalization (=leaving infants in the hospital, „attachment deprivation", results in deficits of emotional and motor development, intellectual impairment, apathy in behaviour)
- M. Ainsworth: Strange situation test
    - secure attachment
    - avoidant insecure attachment
    - ambivalent insecure attachment
    - disorganized insecure attachment

	Secure attachment	Ambivalent attachment	Avoidant attachment	Disorganized attachment
Separation	Distressed when mother leaves	Intense distress when mother leaves	No signs of distress when mother leaves	Overt displays of fear; contradictory behaviors or affects; stereotypic, asymmetric, misdirected or jerky movements; freezing and apparent dissociation. Wide range of odd and out of context behaviors
Behavior with stranger	Avoidant of stranger when alone but friendly when mother is present	Avoids the stranger	Okay with the stranger, plays normally when they are present	
Reunion	Easily soothable when mother returns	Approaches mother but resists contact and very difficult to comfort	Infant shows little interest when mother returns	
Other	Able to use mother as a safe base to explore	Cries more, explores less than the secure and avoidant children	Mother and stranger are able to comfort equally well	Associated with severe trauma/ abuse/neglect
Prevalence	65-70% of middle class children	15-20% of middle class children	10-15% of middle class children	<5% of middle class children but potentially 50-75% of high risk children

- early attachment matters, because:
    - affects later personality

- has a close connection to childhood behaviour (social competencies, aggression management)
- and psychopathology (adolescent onset antisocial disorder, depression, anxiety disorders, PTSD, dissociation, personality disorders)
- adulthood psychiatric disorders (PTSD, personality disorders, eating disorders, depression, anxiety, schizophrenia)

TOPIC 2: PERSONALITY THEORIES

1. Basics

- definition of personality:
  - dynamic, but relatively stable and organized pattern of one's characteristics, thoughts, feelings and behaviours that distinguishes the person from another, and persists over time and situations
  - Strongly influences one's perceptions, cognitions, expectations, motivations, values, attitudes as well as concepts of the self and others throughout the life span
- two ways to study it (Allport)
  - nomothetic (common traits)
  - idiographic (individual differences)
- healthy vs unhealthy personality

healthy	*unhealthy – 4D*
○ Adequate perception of reality	○ Deviance
○ Self-knowledge, reflective skills	○ Dysfunction
○ Intentional control of behaviour	○ Distress
○ Self-esteem and acceptance	○ Danger
○ Ability to form emotional relationships	
○ Creativity / motivation	

- relevance of personality in medical practice
  - coping with stress
  - maladaptive risk behaviours
  - development of psychosomatic and mental disorders
  - perception of physical symptoms
  - doctor-patient relationship such as difficult patients etc.
  - sickness behaviour e.g. acceptance of the patient status

2. Major personality theories

a. Biological
   - neuropsychological researches

b. Type approaches
   - Hippocrates & Galen, BC 400: choleric, melancholic, sanguine, phlegmatic
   - W. Sheldon, somatotypes: endomorph, mesomorph, ectomorph
   - Type A personality (scientifically proven)

c. Trait approaches (~dimensions)
    - Eyesenck: extraversion, neuroticism (=emotional instability), psychoticism
    - BIG5: OCEAN (openness to experience, conscienciousness, extraversion, agreeableness, neuroticism)
    - criticism: too descriptive, oversimplified
d. Psychoanalytic of psychodynamic (Freud)
    - foundation of modern psychology
    - topographical model: conscious, preconscious, unconscious (iceberg model)
    - structural model: ID, Ego, Superego -> in healthy personality, these are balanced
    - anxiety: Ego is threatened by ID or Superego impulses (anxiety can be realistic, moral, neurotic, traumatic)
    - defense mechanisms: Ego is defending itself from anxiety (unconscious); examples: repression, denial, projection, displacement, regression, sublimation, etc.
e. Behaviourism – or learning theories, social learning perspective
    - Watson, 1920: patterns of behaviour are shaped by experience (Stimulus – Organism – Response)
    - classical conditioning (pairing stimuli), habituation (getting used to a stimuli), generalization (according to one or a few examples, a more universal behaviour develop), discrimination (differentiation between similar stimuli)
    - Bandura: Social learning theory (learning by observing others, Bobo doll experiment)
f. Cognitive theories (e.g. Beck)
    - schemas (information organised into patterns, about the world and about ourselves), dysfunctional attitudes, negative automatic thoughts, cognitive distortions (10 types)
    - cognitive restructuring: evaluate & modify thoughts
g. Humanistic approach (e.g. Rogers, Maslow)
    - emphasis: personal worth and growth of the individual with human values
    - self-actualization (all people have a constant tendency toward growth) – there is a gap between ideal self and actual self, self-actualization helps to become our ideal self (=being congruent)
    - therapist should have: self-congruence (~harmony in personality) + empathy + acceptance
    - Maslow: hierarchy/pyramid of needs
h. Evolutionary, etc.

3. Personality assessment:

- Observation
- Physiological examinations
- Experiments
- Interviews
    - can be structured, semi-structured, unstructured
    - can be admission, first interview, anamnestic, hetero-anamnestic, etc.
    - Argelander's first interview (unstructured), 3 types of information:
        - Objective information: data, biographical details, etc.

        - Subjective: meaning attached by the patient
        - Scenic / situational: what the patient does during the examination
    - Tests
        - standardized instrument designed to reveal aspects of an individual's character or psychological makeup
        - types of psychological tests:
            - personality tests (questionnaires like mmpi1 or projective methods like rorschach)
            - achievement or iq tests (e.g. wais, mawi)
            - tests for symptom assessment (e.g. BDI, BAI, STAI, etc.)

TOPIC 3: HUMAN SEXUALITY

1. Basics

- patients and professionals often find it difficult to talk about sexual problems
    - anamnesis: name, contact info, marital status, occupation (of the couple), description of the problem, therapies so far, motivation, erection/masturbation, background question about sexuality, medical anamnesis, other questions (sexual orientation, extramarital relationships)
- chronic diseases can have an impact on sexual life (e.g. arthritis, diabetes, cancer, obesity, etc.)
- sexuality with chronic diseases/disabilities is possible

2. Sexual dysfunctions (DSM 5)

Category of Disfunction	*Diagnosed in Women*	*Diagnosed in Men*
Sexual interest, desire or arousal	Female interest / arousal disorder	Male hypoactive sexual desire disorder
Intercourse	Genitopelvic pain / penetration disorder	Erectile disorder
Orgasm	Female orgasmic disorder	Premature (early) ejaculation Delayed ejaculation

- possible causes:
    - organic illnesses (genital infection, peripheric neuropathy, arteriosclerosis, diabetes, hormonal disorders, etc.)
    - mental illnesses (depression, anxiety disorders, psychosomatic disorders, psychosis, posttraumatic stress disorder, etc.)
    - side effect of medication (antidepressants, anti-hypertensive medication, hormonal medications, diuretics, etc.)
    - relationship problems (communication issues, alienation, etc.)

- other psychological problems (performance anxiety, inadequate expectations about your own or others' performance, guilt, past negative experiences, negative self-image, etc.)

3. Paraphilias (DSM 5)

- Exhibitionistic disorder ("Flashing" genitals is leading to sexual arousal)
- Voyeuristic disorder ("Peeping Tom", secretly watching others during sexual intercourse is leading to sexual arousal)
- Fetishistic disorder (fetish object, e.g. shoes)
- Transvestic disorder (dressing up in clothes of opposite gender leading to sexual arousal)
- Frotteuristic disorder (rubbing genitals to others e.g. on public transport is leading to sexual arousal)
- Pedophilic disorder
- Sexual masochism disorder
- Sexual sadism disorder

TOPIC 4: DEPRESSION

1. Depressive disorders in DSM 5 (depressed/low mood phases only)

- Disruptive Mood Disregulation Disorder
- Major Depressive Disorder*
  - single
  - recurrent
- Persistent depressive Disorder (dysthimia)
- Premenstrual Dysphoric Disorder
- Depressive Disorder due to another Medical Condition
- Other Specified Depressive Disorder
- Unspecified Depressive Disorder

a.) Unipolar depression* (= Major depressive disorder)

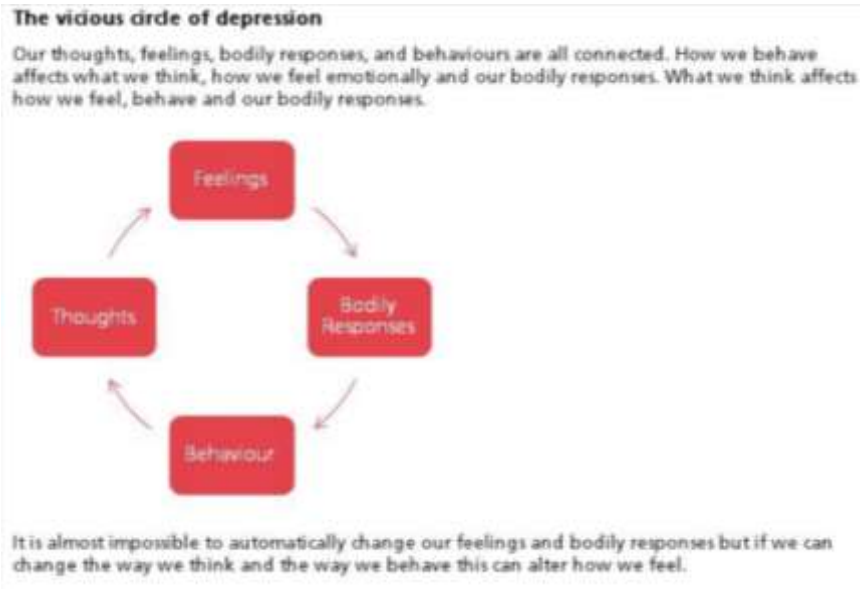
- prevalence: 5%, women:men 2:1
- underdiagnosed: low awareness in medical practice
- comorbid disorders can be: substance abuse, medical illness, other psychiatric disorder, abnormal grief
- Symptoms of depression (five or more of the following symptoms at least one of which is either depressed mood/loss of interest or pleasure)
  - Affective: sadness/depressed mood, loss of interest in activities that were enjoyed before
  - Cognitive: thinking that oneself is worthless/low self-esteem/excess guilty, thoughts about death/suicide, poor memory and concentration
  - Behavioural: social withdrawal (don’t want to mix with/see other people), psychomotor changes (e.g. moving slowly)

- Physical functioning: changes in appetite (both over & under eating can happen), sleep disturbances (both difficulty falling asleep or problems getting out of bed), low energy levels/fatigue, psychomotor agitation/retardation

+ symptoms must be distressing and stop the person from functioning normally

+ symptoms are not because of other mental/somatic illness or substance abuse

- vicious circle of depression:



2. Bipolar and related disorders in DSM 5 (depressed/low mood phases and manic/hypomanic phases also)

- Bipolar I Disorder (mania** and depression)
- Bipolar II Disorder (hypomania and depression)
- Cyclothymic Disorder (hypomania and mild depression)
- Substance/Medication-Induced Bipolar and Related Disorder
- Bipolar and Related Disorder Due to Another Medical Condition
- Other Specified Bipolar and Related Disorder
- Unspecified Bipolar and Related Disorder

a.) Manic episode**

- prevalence of bipolar disorder: 1%, women:men 1:1
- symptoms of mania (five or more of the following symptoms at least one of which is either elevated/irritable mood)
- Affective: elevated/irritable mood
- Cognitive: Inflated self-esteem (e.g. belief that one has special talents, powers and abilities); distractibility (attention easily diverted); Flight of ideas/subjective impression that thoughts are racing
- Behavioural: Unusual talkativeness, rapid speech; Increase in activity level: at work, socially or sexually or agitation; Excessive involvement in activities that have a high potential for painful consequences (e.g.: buying sprees, foolish businesses)
- Physiological: Less than usual amount of sleep needed

+ The symptoms must be distressing and stop the person from functioning normally

+ Not because of other mental/somatic illness or substance abuse

3. Treatment

- Pharmacotherapy (antidepressants and mood stabilizers)
- Psychotherapy (Cognitive behavioural therapy and Interpersonal Therapy with best evidence base)
    - Seligman: learned helplessness (main point: people suffering from depression because they learnt that they are not in control of their lives)
    - Aaron Beck: cognitive triad (negative view about the world, the future, oneself), cognitive distortions (10 types)
    - Albert Ellis: ABC model (underlying irrational beliefs, A (action) is affected by B (beliefs) resulting in C (consequence)
    - low intensity psychological interventions based on these approaches:
        - behaviour activation
        - focusing on positive experiences
        - regular exercises
        - successive problem solving methods
        - identification of negative automatic thoughts + restructuring with „standard questions
- Additional treatment options (if needed)
    - light therapy (seasonal affective disorders)
    - sleep deprivation
    - ECT (electroconvulsive therapy in cases of treatment resistant depression)
- Background causes, triggers, conditions – help us defining the treatment)

	Psychosocial aspects	Neurobiological aspects
Vulnerability	e.g. negative life experience, personality	e.g. genetical factors
Triggers	e.g. acute psychosocial burden, stress	e.g. hyperactivity of the axis of stress hormones
Depressive condition	depressive symptoms (experience and conduct)	e.g. neurochemical dysfunctions, hyperactivity of the axis of stress hormones
Therapy	psychotherapy	pharmacotherapy

TOPIC 5: ANXIETY

1. Basics

- fear vs anxiety: fear is momentary reaction to a perceived threat vs anxiety is a more general fear occurring without a specific and immediate threat
- Pros of anxiety:
    - facilitates coping with adverse or unexpected situations
    - At the optimal level, it enhances achievement (Yerkes-Dodson law: performance improves up to a threshold, and then falls off)
- Anxiety is a problem, when:
    - it occurs in the absence of identifiable danger or out of proportion to the actual danger
    - chronic, irrational and interferes with normal life
    - causes avoidant behaviour, incessant worry and difficulties in concentration and memory
    - specific manifestations of this are called anxiety disorders
- risk factors: biological (genetics, changes in brain biochem. etc.) and psychological (poor coping, impulsivity, etc.)
- prevalence: 6-10% approx.

2. Anxiety disorders in DSM 5

- Selective mutism: failure to speak in certain social situations, not because lack of language skills)
- Separation anxiety: separated from attachment figure, to an extent that is inappropriate for the person's stage of development; starts in childhood, extend to adulthood
- Specific phobia: fear or anxiety about, or avoiding particular objects or situations
    - evolutionary origin sometimes, but mostly learnt
    - good treatment option: exposure therapy (CBT method, teaching patients relaxation techniques + exposure gradually; e.g. snake phobia: pictures, videos, imagination, real life snake)
- Social anxiety: causes avoidance of social situations, not because of fear of being humiliated/rejected
- Panic disorder: recurrent panic attacks, persistent concern about future panic attacks + significant maladaptive change in behaviour
    - symptoms of a panic attack (at least four):
        - palpitations, pounding heart, or accelerated heart rate
        - sweating
        - trembling or shaking
        - sensations of shortness of breath or smothering
        - feeling of choking
        - chest pain or discomfort
        - nausea or abdominal distress
        - feeling dizzy, unsteady, lightheaded, or faint
        - chills or heat sensations
        - paresthesias (numbness or tingling sensations)

        - derealization (feelings of unreality) or depersonalization (being detached from oneself)
        - fear of losing control or going crazy
        - fear of dying
    - panic thinking: catastrophization, enhanced self-observation, attaching importance to insignificant symptoms
    - treatment: CBT (realistic meaning of symptoms=beating catastrophization + overcome avoidance), antidepressants, self-help
- Agoraphobia: anxiety in certain public spaces, e.g. public transport, open spaces, etc. + avoidance
    - treatment: very similar as for panic disorder
- Generalized anxiety disorder: excessive and persistent worry, mostly about everyday things, disrupting normal functioning and causing physical symptoms
    - for diagnosis, at least three of these: restlessness or feeling keyed up or on edge
        - being easily fatigued
        - difficulty concentrating or mind going blank
        - irritability
        - muscle tension
        - sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)
    - treatment:
        - relaxation
        - psychotherapy
        - drug treatment
        - long-term support
- Substance/medication induced anxiety disorder
- Anxiety disorder due to another medical condition (certain endocrine, cardiovascular, respiratory, metabolic, B12 df, neurological illnesses)

3. OCD – obsessive compulsive disorder (no longer classified as anxiety disorder in DSM-5)

- Obsessions: recurring intrusive thoughts that cause anxiety (can be repeated doubts e.g. worrying about whether one has done something – locked the door, turned off the TV; worries about becoming dirty or contaminated; fears that one may injure someone; fear of blasphemous, inappropriate thoughts; magical thinking e.g. terrible consequences of stepping on a crack)
- Compulsions: repetitive behaviours or rituals to neutralise the anxiety caused by obsessive thoughts (cleaning, checking, repeating, slowness, being excessively careful and methodical, hoarding)
- Therapy:
    - cognitive behavioural therapy
        - exposure and response prevention
        - deliberate exposure to the source of the obsession, while avoiding the compulsive behaviour
        - finding more effective responses to obsessive thoughts other than the usual compulsive behaviour
    - family therapy
    - group therapy
    - drug treatment

- in most severe cases, psycho-surgery

4. Post-traumatic stress disorder

- Re-experiencing a traumatic event that threatens the person's safety or makes him feel helpless
- Symptoms (for more than one month and are not due to a substance or other medical condition):
  - persistent re-experiencing of event (intrusive memories, flashbacks, nightmares, intense distress and physical reactions when reminded of event)
  - avoidance and numbing (avoiding event-associated places, thoughts, feelings, people; feeling detached and emotionally empty)
  - negative alterations in cognitions (not remembering important aspects of event; distorted ideas about the cause or consequences of the event)
  - alterations in arousal and reactivity – irritability, self-destructive behaviour
- Treatment:
  - trauma-focused cognitive behavioural therapy (gradual exposure to thoughts, feelings and situations that remind the person of the trauma; correcting distorted and irrational thoughts)
  - family therapy
  - medication (only to relieve secondary depression or anxiety)

TOPIC 6: EATING DISORDERS

1. Basics

- importance: high prevalence, high mortality (especially in anorexia), high comorbidity (both somatic and mental illnesses
- onset: anorexia at age 12-18, bulimia at age 17-25
- males:females – 1:9
- 9 truth about eating disorders:
  1. Many people with eating disorders can look healthy, yet may be extremely ill.
  2. Families are not to blame, and can be the patients' and providers' best allies in treatment.
  3. An eating disorder diagnosis is a health crisis that disrupts personal and family functioning
  4. Eating disorders are not choices, but serious biologically influenced illnesses
  5. Eating disorders affect people of all genders, ages, races, ethnicities, body shapes and weights, sexual orientations, and socioeconomic status
  6. Eating disorders carry an increased risk for both suicide and medical complications
  7. Genes and environment both play important role in the development of eating disorders
  8. Genes alone do not predict who will develop eating disorders.
  9. Full recovery from an eating disorder is possible. Early detection and intervention are important

2. Diagnoses of eating disorders according to DSM 5

a.) Anorexia nervosa

- symptoms
    - significantly low body weight, BMI<18,5
    - fear of gaining weight or becoming fat, even though underweight
    - body image disorder
- subtypes (we should specify)
    - restricting type: no binge-eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)
    - binge-eating/purging type: regularly engaged in binge-eating or purging behaviour
- health complications
    - amenorrhea (not a diagnostic criteria any more)
      abnormally slow and/or irregular heartbeat (if under 45/minute, hospital)
    - low blood pressure (if systolic under 85, hospital)
    - anaemia
    - poor circulation in hands and feet (if body temperature under 35.5 hospital)
    - muscle loss and weakness – fatigue
    - dehydration/kidney failure - send them for lab test
    - memory loss/disorientation
    - chronic constipation, symptoms that resemble IBS
    - dry skin, lanugo hair
    - bone density loss/Osteoporosis
- SCOFF questionnaire can be useful for measure the symptoms

b.) Bulimia nervosa

- Symptoms:
    - recurrent episodes of binge eating:
        - eating, in a discrete period of time, an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances
        - a sense of lack of control over eating during the episode
    - recurrent inappropriate compensatory behaviour in order to prevent weight gain
    - the binge eating and inappropriate compensatory behaviours both occur, on average, at least once a week for 3 months
    - body image disorder
    - the disturbance does not occur exclusively during episodes of anorexia nervosa
- former types of bulimia (from DSM 4)
    - purging type: self-induced vomiting or the misuse of laxatives, diuretics, or enemas
    - nonpurging type: the person has used other inappropriate compensatory behaviours, such as fasting or excessive exercise
    - multiimpulsive forms: bulimia + drog abuse, alcoholism, suicide, self-harm behaviour, promiscuity
- health complications
    - anaemia
    - irregular heartbeat
    - constipation / diarrhea
    - irregular period
    - depression
    - swelling cheeks
    - cavities

    - irritated throat
    - stomach ulcers or ruptures
    - abrasion on skin (Russell's sign)

c.) binge eating disorder

- 3,5% of women, 2% of men (most common ED in USA)
- symptoms
    - recurring episodes of eating significantly more food in a short period of time than most people would eat under similar circumstances
    - lacking control
    - no compensatory behaviour
    - causing distress
    - at least once a week over three months

c.) orthorexia

- obsession of healthy or righteous eating (may come from a number of sources such as family habits, society trends, economic problems, recent illness etc.) - the individual fixates on the "right" foods, that can be safely eaten they will spend too much time and energy with thinking about food and eating (OCD spectrum)
- often eat their own food, because they do not trust in the proper preparation of others' dishes
- can morph into anorexia

d.) feeding or eating disorders not elsewhere classified

- disturbances in eating behaviour that do not necessarily fall into the specific category of anorexia, bulimia, or binge eating disorder
- the most common eating disorder diagnosis: 4.7%
- atypical anorexia nervosa, Bulimia nervosa of low frequency and/or limited duration, Binge-eating disorder (of low frequency and/or limited duration)

e.) purging disorder (recurrent purging behaviour with no binge eating)

f.) laxative abuse (what the name suggests, to control weight)

g.) night eating disorder (recurrent episodes of night eating, as manifested by eating after awakening from sleep or by excessive food consumption after the evening meal; there is awareness and recall of the eating)

h.) body dysmorphic disorder

- preoccupied with 1 or more perceived defects or flaws in physical appearance that are not observable by or appear slight to others
- repetitive behaviours (e.g. mirror checking, excessive grooming, skin picking, or reassurance seeking) or mental acts (e.g. comparing his or her appearance with that of others) in response to the appearance concerns
- the preoccupation causes clinically significant distress or impairment in social, occupational functioning
- the appearance preoccupation cannot be better explained by concerns with body fat or weight in an individual whose symptoms meet diagnostic criteria for an eating disorder

A central symptom in most of eating disorders: body dissatisfaction/body image distortion (false perception only of their own body, perception of others is not disturbed, strong wish to alter the body shape or size)

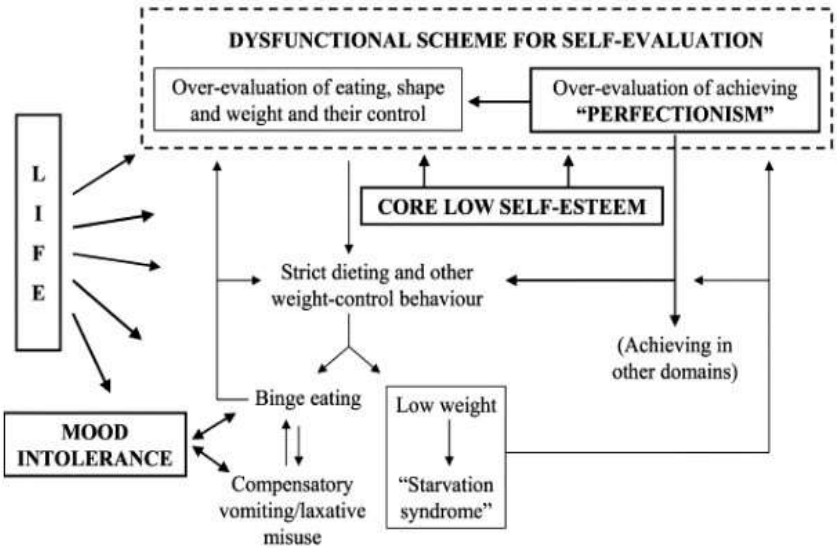
3. Etiopathogenesis of eating disorders

- Eating disorders are complex psychosomatic disorders: there are biological, psychological, and sociocultural components

+ Multidimensional models differentiate: predisposing, precipitating, and maintaining factors

	biological	*psychological*	*sociocultural*
predisposing	genetics, neurotransmitters, etc. , premorbid obesity	a.) individual risk factors: disorders of self perception, special personality characteristics, sexual or physical abuse b.) family risk factors: eating disorder / diet of family members, affective disorder or alcoholism in the family, special family relationships, magnification of cultural values	cultural norms, slimness ideal
precipitating		different stressors which cause dieting: life events	
maintaining	effects of malnutrition	cognitive and family reinforcements, lack of social skills, isolation, depression, change in the family structure etc.	cultural norms, slimness ideal

- transdiagnostic theory of the maintenance of eating disorders (infographic):



4. Treatment of eating disorders

- Pharmacotherapy
    - cannot be an exclusive treatment form - combination of pharmacotherapy and psychotherapy may be more effective
    - AN, BN: antidepressants (SSRIs) - drug dose may be higher as than depression (e.g. 60 mg fluoxetine)
    - short term abstinence rate in the pharmacotherapy of BN is about 30%, the symptom reduction is about 70%, but relapse rate is high (30-45%) + high drop-out rate
- Nutritive rehabilitation
    - secondary approach for stabilization: normalization of food intake, establishing healthier eating behaviours
    - components:
        - intake assessment (present and past dietary history, food records, dietary recalls, diet histories, food frequency questionnaires, biochemical indices + psychosocial data, sociological data, activity level)
        - dietary modification: may include supplemental nutrition, parenteral nutrition, and enteral nutrition)
        - patient education
        - aftercare: dietary guidance evaluated periodically to monitor effectiveness
- Psychotherapy options
    - Psychodynamic therapies
        - hidden, unconscious conflicts in the background e.g., fears from sexuality
        - sexual abuse in the history: about 25-30% of the patients (it is non-specific factor)
        - postponing of the adulthood (evolutionary theories)
    - Cognitive-behavioural therapies
        - researches proved the effectivity of CBT for EDs (particularly for BN and BED)
            - there are more types of CBT that can be applied, e.g. Dialectic Behaviour Therapy (DBT), rational emotive, multimodal, etc.
        - focuses on problematic thinking and behaviours that sustain ED symptoms
        - effective for comorbid disorders (e.g. addictions, mood disorders, personality disorders, anxiety) + educational components + meal plan
            - self-help recovery guidelines
            - food diary
            - normalization of daily meals
            - reducing dietary restraint
            - reducing over-evaluation of eating, shape and weight control
            - avoidance of body checking
            - modifying maladaptive thoughts related to eating
        - can help underlying psychological issues in EDs, e.g. anger issues, low self-esteem + in physical health problems linked to EDs, such as pain or fatigue
        - can be applied individually, in group settings, and can adapted for self-help
    - Interpersonal psychotherapy
    - Family therapy
        - researches proved the effectivity of family therapy for EDs
        - for teenagers it's the number 1 therapy method (especially for young patients with AN)

        - dysfunctional aspects of psychosomatic families (Minuchin, 1974) – families in which EDs are more frequent:
            - enmeshment
            - overprotection
            - rigidity
            - avoidance of conflicts
            - involvement of the child into parental conflicts
    - Group therapies
    - Body oriented therapy
    - Hypnotherapy
    - Integrative programmes (stepped care)
        - 1. step: generally self-help groups or psychoeducation
        - later: pharmacotherapy, outpatient group therapy
        - + outpatient psychotherapy, family therapy, intensive inpatient therapy
    - Psychoeducation and self-help
- treatment outcome
    - high mortality in an: about 8% after 10 years, 20% after 20 years
    - rough estimation at follow-up: 50% is symptom-free, 25% improves with remaining sypmtoms, 25% does not change

TOPIC 7: PSYCHOSOMATIC THEORIES AND DISORDERS

1. Basics

- definition of „psychosomatic": unity and interdependence of biological and psychosocial aspects of human existence
    - psychosomatic medicine: holistic, biopsychosocial approach in understanding and treating patients' individual symptomology
    - psychosomatic disorders: disorders that significantly incorporate psychological factors
- somatization: patient's tendency to experience and communicate psychological distress in form of somatic symptoms + to seek medical help for them
    - = the existence of physical/bodily complaints in the absence of a known medical condition
    - present in 25% of GP counselling
- two main fields in psychosomatics:
    - Behavioural medicine:
        - interdisciplinary science - integrates biomedical + behavioural knowledge + practice into prevention, diagnosis, rehabilitation
        - broad field of research, education, clinical practice - analyses the role of psychological regulation
        - biopsychosocial models of diseases, built on a circular causality of predisposing, precipitating, maintaining factors
    - Health psychology

        - psychology of promotion and maintenance of health, prevention, treatment of diseases
            - by highlighting psychological factors in health and diseases; and promoting adaptive behavioural patterns (conflict resolution, coping)
- 3 classic cluster of psychosomatic disorders
    - Conversions: motor or sensory symptoms (e.g. deficits, seizures), which cannot be explained by physical condition or psychoactive substance use
        - the psychological conflict is expressed in a somatic response, which has a symbolic meaning (e.g. Freud: case of Anna O.)
    - Functional disorders: complaints without organic alterations in their background, but the functioning of organs is altered, and is influenced by psychological factors, such as stress (e.g. IBS)
        - symptoms do not have a symbolic meaning, they are consequences of disturbed bodily functions
    - Psychosomatoses: organic alterations/tissue lesions and conflicting experiences can be detected behind their formation, onset and fluctuation of symptoms
        - psychosomatic disorders in their narrower sense

2. Related diagnoses – ICD 10 and DSM 5

a.) ICD 10 (=The International Statistical Classification of Diseases)

- category and central features of *somatization syndrome*:
    - multiple, recurrent, frequently changing physical symptoms of at least two-year duration
    - long and complicated history of contact with medical care services, during which many negative investigations or fruitless exploratory operations may have been carried out
    - symptoms may be referred to any part or system of the body
    - the disorder is chronic and fluctuating + often associated with disruption of social, interpersonal, and family
- diagnostic categories within the group of somatization syndromes include:
    - Undifferentiated somatoform disorder
    - Hypochondriasis
    - Somatoform autonomic dysfunction
    - Persistent somatoform pain disorder
    - Other somatoform disorders, such as dysmenorrhoea, dysphagia etc.
    - Somatoform disorder, unspecified

b.) DSM 5

- category and central features of *somatic symptom and related disorders* (broader category than the one in ICD 10)*:*
    - conditions with no medical explanation;
    - conditions where there is some underlying pathology but an exaggerated response
    - instead of the earlier negative criterion, namely that the symptoms should be medically unexplained, a positive criterion appears:

        - distressing somatic symptoms, abnormal thoughts, feelings, and behaviours in response to these symptoms can be observed
        - they cause substantially more severe distress and impairment than expected.
        - the emphasis is on the interpretation or reaction to symptoms (APA, 2013).
- Somatic Symptom disorder
    - one or more somatic symptoms that are distressing or result in significant disruption of daily life
    - excessive thoughts, feelings, or behaviour related to the somatic symptoms or associated health concerns as manifested by at least one of the following:
        - disproportionate and persistent thoughts about the seriousness of one's symptoms
        - persistently high level of anxiety about health or symptoms
        - excessive time and energy devoted to these symptoms or health concerns
    - although a somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months)
- Illness Anxiety Disorder (=hypochondria)
    - preoccupation with having or acquiring a serious illness
    - somatic symptoms are not present or if present, are only mild in intensity. If another medical condition is present or there is a risk for developing a medical, the preoccupation is clearly excessive or disproportionate
    - there is high level of anxiety about health, and the individual is easily alarmed about personal health status
    - the individual performs excessive health-related behaviours (e.g., repeatedly checks his or her body for signs of illness) or exhibits maladaptive avoidance (e.g, avoids doctor appointments and hospitals)
    - illness preoccupation has been present for at least 6 months, but the specific illness that is feared may change over that period of time
    - the illness-related preoccupation is not better explained by another mental disorder
    - two types:
        - care-seeking type: medical care, visits, tests, procedures are frequently used
        - care-avoidant type: Medical care is rarely used
- Conversion Disorder (=Functional Neurological Symptom Disorder)
    - one or more symptoms of altered voluntary motor or sensory function
    - clinical findings provide evidence of incompatibility between the symptom and recognized neurological or medical conditions
    - the symptom or deficit is not better explained by another medical or mental disorder
    - the symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation
    - can appear with or without a psychological stressor, it can be acute or chronic
- Psychological Factors Affecting Other Medical Conditions
    - a medical symptom or condition (other than a mental disorder) is present
    - psychological or behavioural factors adversely affect the medical condition in one of the following ways:
        - the factors have influenced the course of the medical condition as shown by a close temporal association between the psychological factors and the development or exacerbation of, or delayed recovery from, the medical condition.
        - the factors interfere with the treatment (e.g., poor adherence)

        - the factors constitute additional well-established health risks
        - the factors influence the underlying pathophysiology, precipitating or exacerbating symptoms or necessitating medical attention
    - the psychological and behavioural factors in Criterion B are not better explained by another mental disorder.
- Factitious Disorder
    - two types:

    1. Imposed on Self:

    - falsification of physical or psychological signs or symptoms, or induction of injury or disease, associated with identified deception
    - the individual presents himself or herself to others as ill, impaired, or injured
    - the deceptive behaviour is evident even in the absence of obvious external rewards
    - the behaviour is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder
    - can be single episode or recurrent

    2. Imposed on Another (By proxy form)

    - falsification of physical or psychological signs or symptoms, or induction of injury or disease, in another, associated with identified deception
    - the individual presents another individual (victim) to others as ill, impaired, or injured
    - the deceptive behaviour is evident even in the absence of obvious external rewards
    - the behaviour is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder
    - the perpetrator, not the victim, receives this diagnosis
    - can be single episode or recurrent
- Other Specified Somatic Symptom and Related Disorder
    - This category applies to cases in which symptoms cause clinically significant distress or impairment, but do not meet the full criteria for any of the disorders in the somatic symptom and related disorders, e.g.
        - Brief somatic symptom disorder: duration of symptoms is less than 6 months
        - Brief illness anxiety disorder: duration of symptoms is less than 6 months
        - Illness anxiety disorder without excessive health-related behaviours: criterion D for illness anxiety disorder is not met.
        - Pseudocyesis: a false belief of being pregnant that is associated with objective signs and reported symptoms of pregnancy

3. Theories on the causes of somatization

- one of the oldest explanations for somatization: this is a result of the body's attempt to cope with emotional and psychological stress
    - the body has a finite capacity to cope with psychological, emotional, and social distress - beyond a certain point, symptoms are experienced as physical, principally affecting the digestive, nervous, and reproductive systems

    - there are many different feedback systems where the mind affects the body: especially, long term stress and the hormone cortisol have a negative impact on immune functions
    - somatizing patients are more likely to have a mood or anxiety disorders, and history of abuse
- another hypothesis for somatization: these people have heightened sensitivity to internal physical sensations and pain
    - perception of our organs is called interoception (reminder from medical communication: sensitiser and repressor patients)
    - biological sensitivity to somatic feelings could predispose a person to developing somatization disorder
    - the person's body might develop increased sensitivity of nerves associated with pain and pain perception, as a result of chronic exposure to stressors
- neuroimaging evidence
    - a recent review of the cognitive–affective neuroscience of somatization suggested that catastrophization in patients with somatization disorders tends to present a greater vulnerability to pain
    - the relevant brain regions include the dorsolateral prefrontal, insular, rostral anterior cingulate, premotor, and parietal cortices
- The vicious circle of somatisation (Kirmayer and Young, 1998)
    - a somatizing patient has higher emotional arousal
    - he/she has increased attention on bodily phenomenon
    - makes distorted attributions about physical symptoms
    - classifies his/her symptoms as harmful
    - it intensifies the perception and experience of the symptoms
    - it will become a part of the broader social functioning
    - and leads to sickness behaviour and sick role
- Main approaches in psychosomatic medicine
    - Psychophysiological approach:
        - physiological and emotional processes correlate with our behaviour (Pavlov: affects are conditioned with unconditional reflexes, e.g. guinea pig study: sound stimuli was conditioned with histamine and antigen intake -> asthma attack induced)
        - stress theory by Hans Selye:
            - physiological or biological stress is the organism's response to a threatening internal or external condition or stimulus - sympathetic nervous system's activation - body cannot keep this state for long time -parasympathetic system returns the body's physiological conditions to normal homeostasis
            - constant stress leads to exhaustion -> immune-suppression through cortizol hormone -> increase the possibility for physical diseases -> may serve as the central psychosomatic pathway
        - General adaptation syndrome (3 phases):
            - alarm
            - resistance
            - exhaustion
    - Psychodinamic theories
        - Freud's conversion model - psychic forces behind the somatic symptoms

        - psychological conflicts behind diseases, physical symptoms have symbolic meanings (somatization)
        - hydraulic principle: unlabored/unrealeased psychic tension (e.g. anxiety, aggression) causes somatic symptoms
        - primary and secondary advances of the disease (can be subconscious)
    - The psychodynamic psychosomatic theory of Franz Alexander
        - every healthy and pathological human functions are psychosomatic
        - emotions implicate an activation pattern, expressed by the nervous system and the organ, that is innerved by the nervous system
        - specific emotions are accompanied by specific vegetative reactions
        - the unexpressed, repressed emotions cause chronic tension and increase the vegetative innervation
        - this leads to functional disturbances, which can cause organic and morphologic changes
        - „the holy seven psychosomatic diseases": peptic ulcer, bronchial asthma, rheumatoid arthritis, ulcerative colitis, essential hypertension, neurodermatitis, thyrotoxicosis
- Psychosomatic personality concepts:
    - Type „A" behaviour:
        - three major symptoms: free-floating hostility, which can be triggered by even minor incidents; time urgency/impatience -> causes irritation; strong competitive drive -> stress and an achievement-driven mentality
        - relatively constant sympathetic over-activation -> risk for cardiovascular disorders
    - Alexithymia = deficit of emotion identification and expression – can lead to bodily expression, instead of verbal expression of emotions
- System approach and attachment theories: the role of close relationships and family dynamics
    - Dysfunctions of psychosomatic families (Minuchin, 1974): enmeshment, overprotection, rigidity, avoidance of conflicts, involvement of the child into parental conflicts
    - Communication: no sender or no reciever, sender speaks in someone else's name, indirect / obscure / hidden messages, double bind (underlying message is the opposite than the expressed message)
    - Attachment problems:
        - causes disturbances in arousal and recovery within physiological systems that respond to stress
        - physiological links between the mediators of social relationships, stress, and immunity
        - influences health and sickness behaviour
        - influences psychological well-being + the „psychological immune system" (sense of control, coherence, resilience, optimism, positive self-image etc.)
- Sociopsychosomatics: The role of social circumstances and effects in the susceptibility to disease (e.g. SES and hierarchie, learned helplessness)

4. Treatment options

- integrative therapeutical approach needed
    - psychoeducation,
    - regularly scheduled outpatient visits,
    - psychosocial interventions (joint meetings with family members),
    - treatment of prominent comorbid symptoms of anxiety or depression, including their psychoterapy, or the use of antidepressants.
- therapy should be patient centered not illness centered: compliance is a basic component
- mind placebo and nocebo effects
- the following psychosocial variables affecting illness vulnerability:
    - temporal relationship between life events and symptom, onset or relapse, e.g. presence of grief
    - perception by a person of an environment as exceeding his/her resources (i.e. allostatic load/overload (often patients deny a relationship between their allostatic load and symptomatology since they are unaware of the latency between stress accumulation and symptom onset)
    - buffering role: interpersonal relationships, psychological assets and well-being
- Levels of intervention may range from reassurance and effective communication to the integration of specific psychotherapeutic and psychopharmacological treatments.
- Nonspecific therapeutic ingredients include:

Full availability of the therapist for specific times	Attention
Opportunity for the patient to ventilate thoughts and feelings	Disclosure
An emotionally charged, confiding relationship with a helping person	High arousal
A plausible explanation of the symptoms	Interpretation
The active participation of patient and therapist in a ritual or procedure that is believed by both to be the means of restoring patient health	Rituals

- Options for psychotherapy:
    - stress management procedures
    - brief dynamic therapy
    - cognitive-behavioural therapy
        - best established treatment for a variety of somatoform disorders including somatization disorder, it helps in:
            - learn to reduce stress and preoccupation with symptom, cope with physical symptoms, deal with depression and other psychological issues, improve quality of life
        - methods:
            - identifying the processes by which behaviour has been learned via association, reward or observation
            - modifying behaviour using methods such as systematic desensitization, selective reinforcement and positive modelling
            - incorrect symptom attributions (over- or under-playing their significance) giving rise to suboptimal medication use
            - identification and constructive management of damaging thoughts
            - perceptions of helplessness or inappropriate fear of somatic symptoms that can trigger episodes
            - behavioural techniques to change negative thoughts mediating health behaviour
            - systematic relaxation techniques to extinguish fear responses associated with psychosocial triggers
    - interpersonal therapy

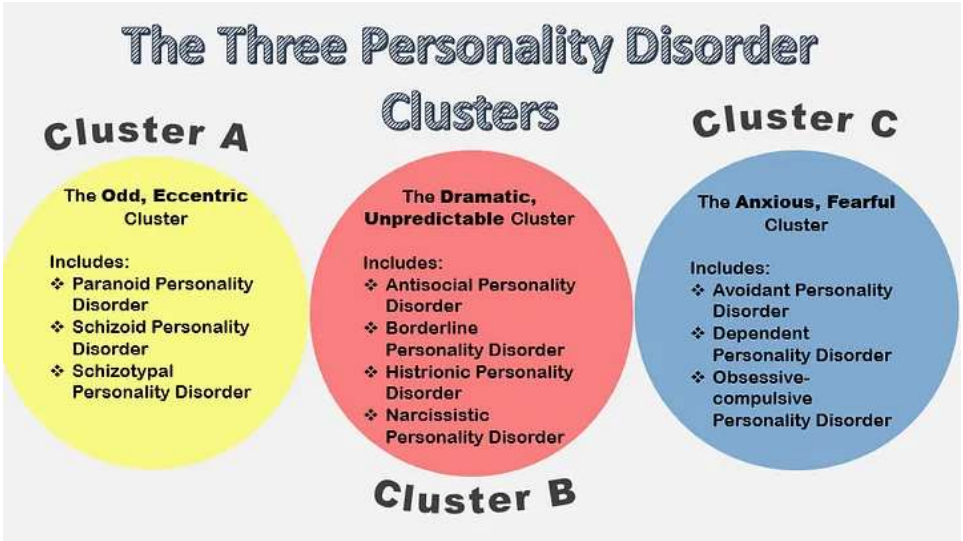
- family therapy
- relaxation and biofeedback
    - designed to control stress & anxiety - e.g. in asthma, may reduce panic or fear & improve breathing and respiratory function
    - techniques (examples):
        - progressive relaxation (systematically creating tension and release in different parts of the body and/or via guided mental imagery);
        - autogenic training (focuses on attending to bodily feelings and mentally controlling them);
        - and biofeedback (feedback of biological indicators, such as tracheal noise, which the subject must control via relaxation
- hypnotherapy
- group interventions

TOPIC 8: PERSONALITY DISORDERS

1. Basics

- Personality = an enduring pattern of thinking (=ways of looking at self, others, the world), feeling, relating, behaving, across many situations
- personality traits/types are not the same as personality disorders!
- in personality disorders, personality is:
    - deviates markedly from the expectations of the culture (in cognition, affect, interpersonal functioning, impulse control)
    - are inflexible, maladaptive, and pervasive across many situations
    - cause serious problems, distress and impairment of functioning in personal, social, and/or occupational situations
    - stable of long duration/traced back to adolescence
    - not better accounted by another mental disorder, substance use, medical condition

2. Criteria of personality disorders



- paranoid personality disorder: pervasive distrust and suspiciousness of others
    - suspects exploitation or deception of others
    - jealous and envious
    - hypersensitive (reads hidden demeaning or threatening meanings into benign remarks or events)
    - rigidity
    - persistently bears grudges (i.e. unforgiving of insults, injuries, or slights)
- schizoid personality disorder: pattern of detachment from social relationships and a restricted range of expressions of emotions (cool, aloof, doesn't react)
    - neither desires nor enjoys close relationships (including being part of a family)
    - almost always chooses solitary activities
    - has little interest in sexual encounters
    - takes pleasure in few, if any activities
    - appears indifferent to praise or criticism of others
    - shows emotional coldness and detachment
- schizotypal personality disorder: demonstrates many symptoms related to those of schizophrenia but of less severe nature, eccentric/odd behaviour
    - tends to be a loner; excessive social anxiety
    - appearance is odd, eccentric, or peculiar
    - unusual pattern of talking that is vague and abstract
    - usually demonstrates "emotional poverty" (lack of emotions), but when emotions are shown, they often do not match content of a discussion and seem inappropriate for the circumstance (ex. laughs upon hearing serious information)
    - preoccupied by thoughts of a magical nature (superstitious, belief in clairvoyance, telepathy, or "sixth sense", bizarre fantasies)
- antisocial personality disorder: disregard for and violation of rights of others
    - unlawful behaviour despite potential for arrest
    - deceitfulness (repeated lying, use of aliases, conning others for personal profit or pleasure)
    - repeated physical fights or assaults
    - reckless disregard for safety of self or others
    - irresponsible
    - lack of remorse
    - criteria for diagnosis includes: evidence of this behaviour before 15 years of age
    - (abnormal amygdala and prefrontal cortex function)
- borderline personality disorder: demonstrates unpredictability of self-image in relationships and emotions
    - frantic efforts to avoid real or imagined abandonment
    - pattern of intense and unstable interpersonal relationships (idealization and devaluation)
    - persistently unstable self-image and sense of self
    - impulsivity that is potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating)
    - recurrent suicidal behaviour, gestures, threats, or self-mutilating behaviour
    - chronic feelings of emptiness
    - difficulty controlling anger, frequent displays of temper
- histrionic personality disorder: excessive but shallow emotions and attention seeking

    - always wants to be center of attention
    - inappropriate sexually seductive or provocative behaviour
    - rapidly shifting and shallow expression of emotions
    - uses physical appearance to draw attention to self
    - speech is dramatic and exaggerated with emotion
    - is easily influenced by others or circumstances
    - considers relationships to be more intimate than they actually are
- narcissistic personality disorder: attitude that the world exists to meet his/her needs, lack of empathy
    - sense of self-importance (e.g. exaggerates achievements and talents, expects to be recognized as superior)
    - preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love
    - believes he/she is "special"
    - requires excessive admiration
    - has sense of entitlement
    - takes advantage of others to achieve own ends (manipulation)
    - lacks empathy
    - often envious of others or believes that others are envious of him/her
    - arrogant, haughty behaviour or attitude
    - there are covert and grandiose type (in covert type, introversion, lack of empathy, passive-aggression, high sensitivity to criticism, manipulation of others are present)
- avoidant personality disorder: demonstrates pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative situations
    - avoids occupational and social activities that involve interpersonal contact (fears of criticism, disapproval, or rejection)
    - unwilling to get involved with people unless certain of being liked
    - shows restraint within intimate relationships because of fear of being ridiculed
    - inhibited in new interpersonal situations
    - views self as socially inept, personally unappealing, or inferior
    - reluctant to take personal risks or engage in new activities
- dependent personality disorder: excessive need to be taken care of that leads to submissive and clinging behaviour and fears of separation
    - difficulty making decisions without advice and reassurance
    - needs others to assume responsibility for most major areas of life
    - difficulty expressing disagreement with others (fear of loss of support or approval)
    - difficulty initiating projects or doing things on own
    - goes to excessive lengths to obtain nurturance and support (volunteers to do things that are unpleasant)
    - feels uncomfortable or helpless when alone
- obsessive-compulsive personality disorder: preoccupation with orderliness and perfectionism
    - preoccupied with details, rules, lists, order, organization, or schedules to extent that major point of activity is lost
    - shows perfectionism that interferes with task completion
    - excessively devoted to work to exclusion of leisure activities and friendships
    - reluctant to delegate tasks
    - over conscientious, scrupulous, inflexible about matters f morality, ethics, or values

- unable to discard worn-out worthless objects
- adopts miserly spending style
- rigid and stubborn

3. Risk factors and treatment options

- risk factors:
  - a history of childhood verbal, physical or sexual abuse
  - a family history of schizophrenia
  - a family history of personality disorders
  - a childhood head injury
  - an unstable family life
- treatment: combination of psychotherapy and medications
  - psychotherapy options:
    - Psychodynamic psychotherapy: can help recognize how they are responsible for the turmoil in their lives, learn healthier ways of reacting (can be individual, group and family therapy)
    - Cognitive behaviour therapy: involves actively retraining the way they think about problems, which in turn improves your emotions and behaviours
  - medications: antidepressants, anticonvulsants, antipsychotics, etc.

TOPIC 9: SLEEPING DISORDERS

1. Basics

- sleep = a particular state of consciousness:
  - very active biological process
  - consists of processes with widely differing functions and mechanisms
  - has restorative effects on all aspects of functioning
  - is essential to life
- 5 stages of sleeping:

Stage	*EEG*	*Physiological response*
Alpha stage	alpha waves	feelings of being relaxed and drowsy
Non-REM 1 (1-7 min)	theta waves	transition from wakefulness to sleep: easy to wake
Non-REM 2	high-frequency bursts of activity known as “sleep spindles”	first stage of real sleep: muscle tension, heart rate and body temperature gradually decrease and the person becomes more difficult to wake
Non-REM 3 & 4 (starts after 30-40 min, last for few hours)	delta rythm	stage 4 is the deepest

		heart rate, respiration, temperature and blood flow to the brain decrease, growth hormone is released, physical growth and brain development controlling levels of metabolism hard to wake
REM stage	Brain activity is very similar to that when you are awake	The main dreaming stage About 90% of people awakened report long, complex dreams (only 10% in case of non-REM sleep) Physiological responses increase, but movement is paralysed in neck and limbs (this prevents accidents during violent dreams)

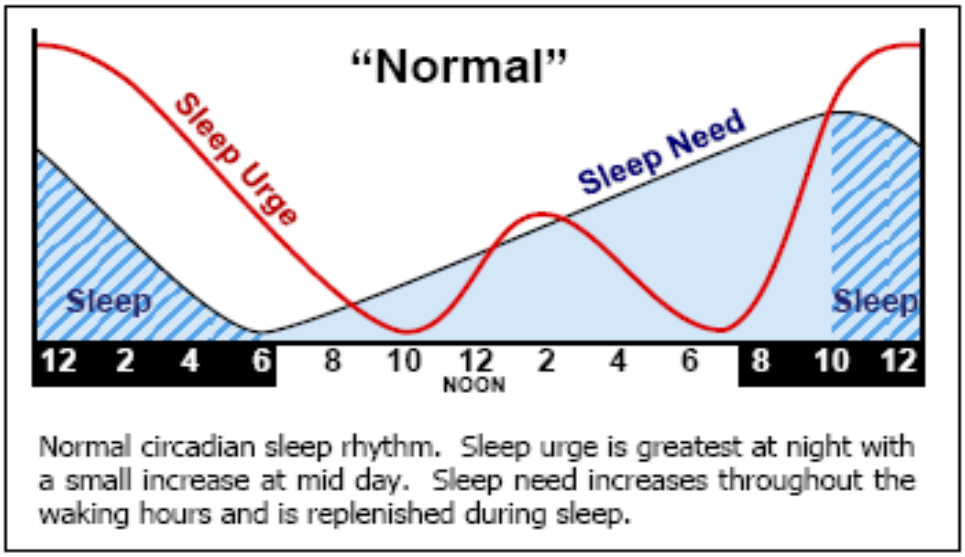
NREM and REM occur in alternating cycles, each lasting approx. 90-100 minutes, with a total of 4-6 cycles

- functions of sleep stages

Non REM	*REM*
○ Development ○ Reconstruction ○ Energy production (ATP) ○ Immune regulation ○ Memory consolidation	○ Memory consolidation and learning ○ Psychological wellbeing ○ Emotional learning ○ Motivation ○ Coping with stress ○ Mood regulation

- two factor model of sleep regulation: process S (homeostatic) & process C (circadian clock)

process S (homeostatic)	*process C (circadian clock)*
○ Controlled by hypothalamus ○ Pressure builds up during wakefulness ○ Determined by lack of sleep in previous period ○ Sleep-deprived period compensated by better or longer “catch-up” sleep	○ Controlled by suprachiasmatic nucleus (SCN) ○ Internal clock system ○ Operates even without environmental cues (e.g. in cave) ○ Natural period of 24 hours 18 minutes, reset by environmental cues (light and dark) ○ Not affected by previous day’s sleep quality or quantity ○ early birds & night owls (behavioural differences) ○ things that can influence circadian rhythm: ▪ light and dark through melatonin ▪ Exercise ▪ Social activity ▪ Eating and drinking ○ Psychoactive agents



Normal circadian sleep rhythm. Sleep urge is greatest at night with a small increase at mid day. Sleep need increases throughout the waking hours and is replenished during sleep.

- sleep requirements:
  - New born children: 17 hours
  - 4-year-olds: 10 hours
  - Adolescents: about 9 hours, but tend to go to bed later
  - Adults (over 20): 7-8 hours
  - Not true that older people need less sleep
- sleep deprivation:
  - awake for more than 18 hours: impaired reaction speed, memory, decision-making capacity, cognitive speed, spatial orientation (1/5 of road accidents in USA caused by sleepy drivers)
  - sleep deficit (sleeping less than 8 hours for more days):
    - hormonal changes → increased appetite, blood sugar irregularities
    - after four or five days of 4 hours a night, a person is in a state equivalent to drunkenness, and one beer is equivalent to six
    - In those with restricted sleep, numerous genes, including some related to metabolism, became less active - the effects may be long lasting
- role of melatonin (sleep hormone):
  - light and dark affects the secretion (produced by the pineal gland, controlled by the suprachiasmatic nucleus)
    - even a short period of light at night can suppress melatonin secretion use red night light!
  - also an antioxidant and affects the immune system
    - strong cancer prevention effect
    - large proportion of breast and prostate cancer cannot be explained by usual risk factors, and these may be linked to decreased melatonin level
  - secretion is adversely affected by caffeine

2. Sleeping disorders

- There are more than a hundred different types
- Three main categories:

- Dyssomnias – the true sleep disorders
  - Insomnia (most common sleep disorders, 30% of population is affected)
    - inability to fall or remain asleep, waking up early, and sleep that is non-restorative
    - causes can be psychiatric (e.g. depression), medical, psychophysiological (e.g. inappropriate lifestyle, lack of exercise, alcohol, caffeine, nicotine, jetlag, stress)
    - acute version: caused by immediate trauma or other factors, resolves quickly
    - chronic version: can be idiopathic=no apparent precipitating factor (genetic); or psychophysiological=caused by e.g. depression, stress, pain or shift work
    - treatment options:
      - treatment for underlying organic cause;
      - lifestyle counselling (regularity, exercise, control of substance use, stress management);
      - cognitive-behavioural therapy (cognitive techniques, sleep hygiene education, sleep restriction, relaxation, mindfulness-based stress reduction)
      - medication (sleeping pills, antidepressants, melatonin)
  - Sleep apnoea (stopping breathing for 10 seconds or longer during sleep, may repeatedly wake up and be tired the next day, associated with snoring, obesity, alcohol or sedatives – can be treated with CPAP and CBT for compliance)
  - Narcolepsy (sleepiness during the day - "sleep attacks" - brief periods of REM and occasional cataplexy, loss of muscle control; linked to neurons in the brain responsible for secretion of hypocretin; treated with medication)
  - Restless legs syndrome (discomfort in limbs causing restless movement, at rest and when in bed; cause unknown, but probably related to dopamine system, often genetic)
  - May be treated by long-term pharmacological therapies, including dopamine agonists
  - Circadian rhythm disorders
    - Jet lag (can be treated with light therapy or melatonine)
    - Shift work
    - Delayed/advanced sleep phase syndrome
- Parasomnias – sleep abnormalities (e.g. sleepwalking, nightmares)
  - Sleepwalking (occurs in stage 3 or 4; sleepwalkers have poor coordination but can get through obstacles like doors; have no memory of the event; does not always require treatment)
  - Sleep terrors (affects about 3-7% of young children: they wake up from deep sleep -stages 3 or 4- and scream in fright, but have no later memory of the experience; does not require treatment for children)
  - Nightmares (experienced by about 25-70% of children aged 3-6 and 47% of college students; occur during REM sleep; can be treated by anxiety-reduction techniques)

        - REM sleep behaviour disorder (mainly in older people; absence of muscle atonic during REM can mean that people "act out" their dreams; treated with medication)
    - Medical-psychiatric sleep disorders
        - Associated with mental disorders, e.g. psychoses, mood disorders, anxiety disorders, alcoholism
        - Associated with neurological disorders, e.g. dementia, Parkinsonism
        - Associated with other medical disorders, e.g. asthma, acid reflux, peptic ulcers

TOPIC 10: Addictions - Substance and behavioural addictions

1. Basics

- Concepts of addiction
    - Addiction = compulsive engagement in a rewarding behaviour (typically with adverse consequences)
        - biological reasons: inherited susceptibility of the brain, altered individual physiology, altered functioning of cerebral reward systems, increased incidence in certain families, genetic regulation
        - sociological factors: addictive behaviour in the family, addiction subculture, ambivalent relationship with social norms, underdeveloped social structure (poorly functioning families, schools, social institutions) cultural and historic traditions
    - Dependence (physical and psychological) = withdrawal symptoms if a substance/behaviour is removed
        - Criteria of dependence - at least three of the following, over the course of one year:
            - tolerance (increased dosage is needed for the same effect)
            - withdrawal symptoms
            - craving (inability to quit)
            - limited life goals (all activity is centered around getting the substance)
            - isolation (giving up goals, habits and relationships to engage more in substance use and/or drug subculture)
            - self-harm (continued use despite negative consequences)
        -
    - Tolerance = an increased quantity of the object of addiction is required for the same effect
    - Abuse = the addictive behaviour leads to significant damage over the course of one year in at least one of the following areas:
        - employment (reduced productivity or loss of the job, failure to appear to work)
        - physical health (adverse effects on health or repeated engagement in risky behaviour from which only luck saved the patient, e.g. being saved from a drug overdose)
        - conflict with the law (arrests, convictions or committing crimes)

- social relationships (alienation from friends, harming relatives)

2. Specific substances, legal and illegal

- Some addictive substances
  - Legal: alcohol, nicotine, caffeine, prescription medications, organic solvents, designer drugs (legal because the law can't follow the ever changing molecules fast enough)
  - Illegal: opioids, cocaine, LSD, amphetamine, hash, marijuana PCP (phencyclidin)
- Addictive behaviours:
  - gambling
  - obsessive-compulsive disorders (OCD, OCPD)
  - eating disorders (anorexia nervosa, bulimia etc.)
  - impulse control disorders (cleptomania, pyromania)
  - paraphilias (sexual aberrations)
  - „workaholism" (obsession with work performance)
  - internet addiction
- Cannabis
  - very common: 20% European adults
  - effects: euphoric, socialiser, "laughmaker"
  - side effects: memory deficits, decline of social ambitions and other secondary damages to social life
  - low addictive potential but risk of criminalisation
- Synthetic drugs: stimulants and hallucinogenic drugs
  - amphetamine: pure stimulant; extreme motoric drive, awake, active, superficial mind
  - ecstasy: content varies, tablets, mostly MDMA (somewhat hallucinogenic)
  - recreational, party culture, relative safety
  - LSD: low prevalence
  - Other hallucinogenic drugs: magic (psyiocybin-containing) mushrooms, peyote cactuses, ayahuasca
  - In rare instances: plants (belladonna, datura) or medicine (Tylenol) containing tropane alkaloids (very unpleasant and dangerous)
  - risk of criminalization
- Cocaine
  - coca plant – South America
  - euphoric, stimulant, aggression increases, sexual effects
  - high addictive potential, particularly 'crack'
- Opioids
  - poppy plant - alcaloid
  - morphine (medical drug), opium, heroine
  - strong physical and psychological dependency - massive withdrawal syndromes
  - solitary use or small groups, hidden
  - variety of somatic complications - medical involvement
  - criminalisation
  - rehabilitation centres
- Designer drugs
  - psychoactive substances (white powder) with a novel chemical composition - composition is designed/changed to avoid banning laws
  - increasingly common, „bath salts"
  - cheap and often legal
  - extreme effects, high toxicity, bad sideeffects

- Ethyl alcohol (simple, organic, often found in nature)
    - third highest mortality rate after cardiovascular disorders and cancer
    - C_2H_5OH (from $C_6H_{12}O_6$ and CO_2) – metabolism: CH_3-COH with alcohol-dehydrogenase (liver), then further
    - prime effect on GABA system
    - cultural attitudes to ethyl alcohol varies (prohibition, ambivalent, permissive Mediterranean type, permissive Eastern European type)
    - problematic use: frequent, excessive quantity but not dependent – background: impulse control disorder, social anxiety sometimes
    - alcohol related direct health problems: dependency, abuse, intoxication, alcohol related acquired brain deficiencies, alcohol induced and alcohol connected mental disorders, connection to other substance abuse and behavioural addictions, alcohol related somatic medical diseases
    - alcohol addiction: result of long term daily use - withdrawal syndrome: delirium tremens (dangerous)
    - criteria of withdrawal syndrome (after several hours or few days without alcohol in case of alcohol dependent individuals):
        - autonomic hyperactivity (e.g. sweating, high pulse)
        - hand tremor
        - insomnia
        - nausea or vomiting
        - hallucinations or illusions
        - psychomotor agitation
        - anxiety
        - generalized clonic-tonic seizures
    - alcohol intoxication: emergency services - seriously drunk state: about 0.3-0.4 % blood alcohol, respiratoric paralysis between 0.4-0.8% b. a.
    - alcohol related acquired brain deficiencies: brain damage, Korsakoff's syndrome, Wernicke's encephalopathy, dementia
    - alcohol induced and alcohol connected mental disorders: mood disorders, anxiety disorders, sleep disorders, psychotic disorders
    - alcohol related somatic diseases: cirrhosis, fatty liver, hepatitis, cancer, gastric bleeding, other gastrointestinal conditions, cardiomiopathia, infections, dermato-, endocrino-, and many other problems

3. Treatment options

- Basic concepts of modern addictology - intervention guidelines
    - in substance users, substance use is not the only problem, just the tip of the iceberg - the true reasons for using are complex: intrapersonal and external reasons
    - basis of intervention: individual responsibility+ external support
    - strategic goal: constructively altering the behaviour
    - tactical goal: restoring physical and mental health, mending work and family relationships, ensuring abstinence by professional means
- Treatment of alcohol problems
    - adjusted to the problem in question
    - role of a physician: early detecting, prevention, defining competence
    - demedicalisation = assistance other professionals and services (psychologists, social workers, etc.) + special group rehabilitation programmes like Anonym Alcoholics

4. DMS 5 categories and criteria (these are criteria ***in general***, specific ones can be found in the slides)

- 'X' use disorders, where 'X' can be any substance with addictive potential (e.g. alcohol, cannabis, etc.) = problematic pattern of X use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-months period:
    - taken in larger amounts or over a longer period than was intended
    - persistent desire or unsuccessful efforts to cut down or control usage
    - lot of time spent in activities necessary to obtain X, use it, or recover from its effects
    - craving or a strong desire or urge
    - resulting in a failure to fulfil major role obligations at work, school, or home
    - recurrent use in situation when it is physically hazardous
    - usage is continued despite knowledge of having persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by it
    - tolerance, as defined by either of these:
        - need for markedly increased amounts of X to achieve intoxication or desired effect
        - markedly diminished effect with continued use of the same amount of it
    - withdrawal, as manifested by either of the following:
        - characteristics of withdrawal syndrome for X
        - X or closely related substance
- 'X' intoxication disorder, where 'X' can be any substance with addictive potential (e.g. alcohol, cannabis, etc.)
    - recent ingestion of X
    - problematic behavioural or psychological changes that developed during or shortly after ingestion
    - one or more of substance specific signs (specific ones can be found in the slides)
    - symptoms are not the result of another medical condition, mental disorder, or other substance
- 'X' withdrawal, where 'X' can be any substance with addictive potential (e.g. alcohol, cannabis, etc.)
    - reduction in X use that has been heavy and prolonged
    - two or more of withdrawal symptoms (specific ones can be found in the slides, and I put criteria of alcohol withdrawal in the 'ethyl alcohol' chapter – topic10, point 2, ethyl alcohol)
    - withdrawal symptoms cause clinically significant distress or impairment in important areas of life
    - symptoms are not the result of another medical condition, mental disorder, or other substance

TOPIC 11: SUICIDE, CRISIS INTERVENTION

1. Basics

- definition: suicide is an action of killing oneself intentionally
    - attempted suicide is a potentially self-injurious act committed with at least some intent to die as a result of the act.

- prevalence: 1.000.000 suicides/ year in the world, 150.000 suicide/year in Europe, 10-20 x more attempts
    - gender paradox: lethal suicides: 2-3 times more frequent by males, but attempts: 3 times more common by females
- main methods of lethal suicides: self-strangulation, self-poisoning, jumping from a high place, jumping or lying before moving object, handgun, sharp object, drowning
- risk factors:
    - Primary, psychiatric risk factors:
        - psychiatric disorder (90%): major depression (45-87%), schizophrenia, substance dependence and/or abuse, personality disorder, anxiety disorders
        - previous suicide attempt
        - communication of suicidal intent („cry for help"),
        - family history of suicide,
        - decreased serotonin activity.
    - Secondary, psychosocial risk factors*:*
        - childhood trauma / losses
        - aggression, impulsivity
        - isolation,
        - negative life events
        - smoking
    - Tertiary, demografic risk factors*:*
        - male gender
        - adolescence, midlife and older age (65+)
        - vulnerable periods: Spring and early summer, birthday, premenstrual period, morning hours, Mondays
- protective factors:
    - good family/social/medical support
    - children
    - pregnancy
    - religiosity
    - lack of lethal means
    - regular physical activity
    - hypersomnia
- precipitating factors
    - interpersonal conflicts (>50%) (break up, divorce, disappointment, bullying)
    - financial difficulties
    - bereavement
    - job loss
    - physical illness, enduring pain
    - loneliness
    - shame
- suicide originates from a crisis:
    - overwhelming situation (cannot be avoided)
    - individual feels that he/she is not able to cope with the situation
    - coping mechanisms from everyday life are not effective
    - extreme solutions occur
    - behaviour is disorganized
- cry for help - there are warning sign in almost all cases:

    - communication of suicide intent: „It would be better to die". „There is no sense in my life".
    - indirect signs are also common (suicidal notes, collecting pills, risk taking behaviour)
    - represents the ambivalence of the suicidal patient
    - if there is no appropriate help from the environment, presucide syndrom can evoke.
    - take it seriously
- presuicidal syndrome - Ringel
    - situative and affective narrowing (focus only on the actual problem)
    - aggression directed „backwards", towards the self
    - suicidal thoughts, intense phantasies about one's death, funeral
    - ambivalence!
- types of suicide
    - active: individual takes concrete actions
    - passive: refuse those actions that would be necessary for living (refuse eating or life-saving treatment)
    - ambivalent: the intention of suicide is not obvious (overdose of drogs, …)
- types of suicide attempt
    - deliberate self-harm – release psychological pain
    - parasuicide pause/ temporary rest
    - parasuicide gesture (manipulation)
    - serious suicide attempt (intent to die)
- youth specific risk factors
    - divorce or separation of parents
    - sexual identity crisis
    - easy access to lethal methods, especially guns
    - school or family crisis
    - isolation, disappointment
    - genetic predisposition (serotonin depletion)
    - feelings of isolation or being cut off from others
    - ineffective coping mechanisms, problem solving skills
    - cultural and/or religious beliefs (e.g., belief that suicide is a noble or acceptable solution to a personal dilemma)
    - exposure to suicide and/or family history of suicide
- warning signs for youth suicide
    - suicide threats
    - suicide plan/method/access
    - sudden changes in physical habits and appearance
    - preoccupation with death and suicide themes
    - increased inability to concentrate or think clearly
    - loss of interest in previously pleasurable activities
    - symptoms of depression
    - alcohol and/or drugs
    - hopelessness
    - rage, anger
    - reckless behaviour or activities
    - anxiety and agitation
    - sleep difficulties, especially insomnia
    - dramatic changes in mood

- no reason for living
- no sense of purpose in life
- sense of being a burden
- profound sense of loneliness, alienation and isolation
- sense of fearlessness

2. Intervention options

- what to do:
  - increase receptiveness for help!
  - supportive, empathetic behaviour
  - keep distance - don't be involved (helps avoid getting overwhelmed)
  - clarify what is going on in the client (confused)
  - try to stay neutral - irrealistic, impulsive plans, fantasies can be hard to hear (anger, confusion on the therapist side is quite common, be aware of those emotions)
  - do not increase their guilt!
  - refer to adequate therapy
- crisis intervention
  - try to widen the patient's perspective
  - recall:
    - supportive relationships, friends, relatives
    - job, creative tasks
    - previous successful problem solving
    - personal strengths
    - positive traits
  - crisis plan is useful
- intervention: 3 basic step
  - 1. Show you care
    - take ALL talk of suicide seriously
    - if you are concerned that someone may take their life, trust your judgment.
    - listen carefully
    - reflect what you hear
    - use language appropriate for the age of the person involved
    - be genuine
    - ask about treatment: "Do you have a therapist/doctor? / Are you seeing him/her? / Are you taking your medications?"
  - 2. Ask about suicide
  - 3. Get help
    - do not leave the person alone
    - know referral resources
    - reassure the person
    - encourage the person to participate in the helping process
    - encourage the suicidal person to identify other people in their lives who can also help

3. Other useful information

Myth	*Fact*
People who talk about suicide don't die by suicide.	Many people who die by suicide have given definite warnings to family and friends of their intentions. Always take any comment about suicide seriously
Suicide happens without warning	Most suicidal people give many clues and warning signs regarding their suicidal intention.
People who are suicidal are fully intent on dying.	Most suicidal people are undecided about living or dying – which is called suicidal ambivalence.
Males are more likely to be suicidal.	Men die by suicide more often than women. However, women attempt suicide three times more often than men.
Asking a depressed person about suicide will push him/her to kill themselves.	Studies have shown that patients with depression have these ideas and talking about them does not increase the risk of them taking their own life.
Improvement following a suicide attempt or crisis means that the risk is over.	Most suicides occur within days or weeks of "improvement" when the individual has the energy and motivation to actually follow through with his/her suicidal thoughts.
Once a person attempts suicide the pain and shame will keep them from trying again.	The most common psychiatric illness that ends in suicide is major depression, a recurring illness. Every time a patient gets depressed, the risk of suicide returns.

- 10 most common errors during a suicide intervention

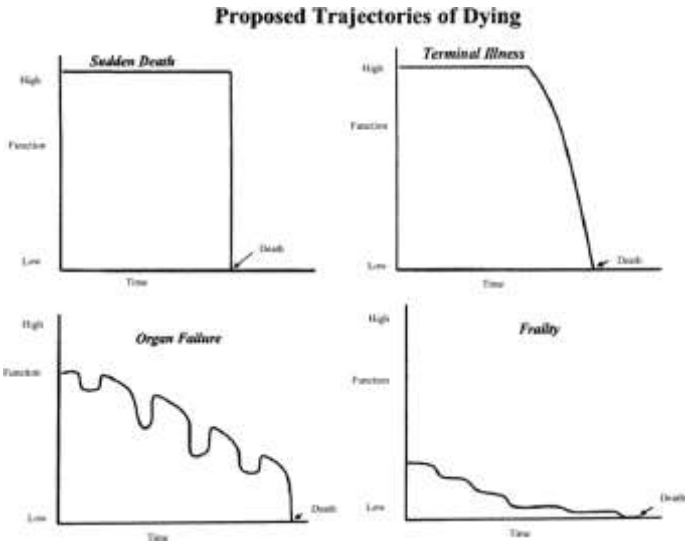
Error	*Example*
#1: Superficial Reassurance	"Come on now. Things can't be that bad."
#2: Avoidance of Strong Feelings	When faced with intense depression, grief, or fear don't retreat into professionalism, advice giving, or passivity
#3: Professionalism	„You can tell me. I've been trained to be objective."
#4: Inadequate Assessment of Suicidal Intent	"You say you're suicidal, but what's really bothering you?"
#5: Failure to Identify the Precipitating Event	"It sounds like everything collapsed when your brother died three years ago, but what has happened recently to make you feel even worse? That dying is the only way out?"
#6: Passivity	"Go on. I'm here to listen."
#7: Insufficient Directness	„If you keep feeling suicidal remember you can call back."
#8: Advice Giving	"Try not to worry about it." "Remember, focus on the positive."

#9: Stereotypic Response	"She's a borderline, attention seeking female."
#10: Defensiveness	If a patient says "How could you ever help me, have you ever tried to kill yourself?" and the doctors goes like „Do you want help, or not?"
instead of these errors, use genuine reassurance, empathy skills, ask about key incidents, be active and encouraging, treat every patient as an individual, and try to stay calm and understanding even if the patient is hostile/aggressive	

TOPIC 12: DEATH, DYING, GRIEF

1. Basics

- Criteria for establishing death
  - Unreceptivity and unresponsiveness even to intensely painful stimuli
  - No movement or spontaneous respiration for 3 minutes after being removed from respirator
  - Complete absence of reflexes, both deep tendon and central
  - A flat electroencephalogram (EEG) for at least 10 minutes of technically adequate recording, without response to noise or painful stimuli
  - All of above tests repeated in 24 hours with no change
  - No history of hypothermia or use of central nervous system depressants before onset of coma
- Nowadays, people are dying in one of these (the importance of humane way of treatment when the end is near)



2. Mourning and grief

- mourning: psychological process that leads to eventual resolution of bereavement – restore ability to enjoy life after any serious loss (stages: grief, protest, despair, detachment)

- grief: normal vs pathological

normal:	pathological:
○ somatic distress ○ preoccupation with deceased ○ guilt ○ hostility ○ loss of conduct ○ within 4-6 weeks	• the absence of grief (rituals!!) • dysfunctional denial • manic escape („merry widow") • dysfunctional hostility • clinical depression

- Kübler-Ross model (phases of grief) - the dying process (stages of dying)
  - denial
  - anger
  - bargaining
  - depression
  - acceptance
- Bronnie Ware experience for many years of palliative care taking – main things people regret before dying:
  - *I wish I'd had the courage to live a life true to myself, not the life others expected of me.*
  - *I wish I hadn't worked so hard*
  - *I wish I'd had the courage to express my feelings.*
  - *I wish I had stayed in touch with my friends.*
  - *I wish that I had let myself be happier.*

TOPIC 13: BEHAVIOURAL CHANGE AND PSYCHOTHERAPIES

- Behavioral Therapy:
  - Fundamental aspects of BT in ancient philosophical tradition - Stoicism
  - Based upon the principles of classical conditioning (I. Pavlov) and operant conditioning (B.F. Skinner)
  - Classical conditioning:
    - Aversion (e.g. placing unpleasant-tasting substances on the fingernails to discourage nail-chewing)
    - Flooding (actual exposure to the feared stimulus)
    - Systematic desensitization (overcoming fear by confronting the hierarchy of fears)
  - Operant conditioning:
    - Reinforcement
    - Punishment
    - Extinction
  - focuses on behaviour changing unwanted behaviours through rewards, reinforcements, desensitization
  - Desensitization: process of confronting something that arouses anxiety, discomfort or fear and overcoming the unwanted responses.
  - behavioural therapy often involves the cooperation of others, especially family and close friends, to reinforce a desired behaviour.
- Cognitive therapy (Beck):

    - aims to identify and correct distorted thinking patterns that can lead to feelings and behaviours
    - the therapy leads to more fulfilling and productive behaviour.
    - Cognitive behavioural therapy: combination of cognitive and behavioural therapies, this approach helps people change negative thought patterns
- Rational Emotive Therapy (Albert Ellis):
    - individual's capacity for creating emotions;
    - ability to change and overcome the past by focusing on the present;
    - power to choose and implement satisfying alternatives to current patterns
    - one form of CBT
    - Humanistic, action oriented approach to emotional growth
- Psychoanalysis
    - this approach focuses on past conflicts as the underpinnings to current emotional and behavioural problems.
    - long term and intensive therapy: an individual meets three to five a week using free association to explore unconscious motivation and earlier, unproductive patterns of resolving issues.
- Psychodynamic psychotherapy
    - based on psychoanalysis: less intense, tends to occur once or twice a week, and spans a shorter time
    - this approach recognizes the significant influence that emotions and unconscious motivation can have on human behaviour
    - more directive than psychoanalsis
- Client-centered therapy (Rogers)
    - individual is an expert on his/her own life, and that human nature is inherently constructive and social
    - without diagnoses and treatment plans, the counsellor enables the individual to sort through thoughts, feelings, ideas, and choices creatively with the help of attentive, non-judgmental and honest listening
    - unconditional positive regard, empathy, trust.
- Couples counselling
    - discussions and problem solving sessions facilitate by a therapist sometimes with the couple or entire family, sometimes with the individual
    - therapy can help couples and family members improve their understanding of
    - family therapy may be very useful with children and adolescent who are experiencing problems
    - help educate the individuals about nature of the disorder and teach them skills to cope better the effects of having a family member with a mental illness (anger or guilt)
  - Family therapy
    - discussions and problem solving sessions facilitate by a therapist sometimes with the couple or entire family, sometimes with the individual
    - can help couples and family members improve their understanding
    - may be very useful with children and adolescent who are experiencing problems
    - help educate the individuals about nature of the disorder and teach them skills to cope better the effects of having a family member with a mental illness (anger or guilt)
- Dialectic behaviour therapy (DBT), Linehan
    - DBT is a combination of behavioural and cognitive therapy originally designed for the treatment of borderline personality disorder.
    - it is used with adolescents and adults who exhibit impulsive an inappropriate acting

out behaviours (self-injury, eating disorders, suicidal tendencies, drug dependence)
    - integrates individual and groups therapies
- Electroconvulsive therapy (ECT)
    - highly controversial technique uses low voltage electrical stimulation of the brain to treat some forms of major depression, acute mania, and some forms of schizophrenia
    - life-saving technique (only when other therapies have failed), when a person is seriously medically ill and/or unable to take medication
- Biomedical treatment
    - medication alone or combination with psychotherapy for treatment of emotional, behavioural and mental disorders
- Expressive therapies
    - Art Therapy: drawing, painting, and sculpting help many people to reconcile inner conflicts, release deeply repressed emotions and foster self-awareness as well as personal growth.
    - Dance/Movement Therapy: Those who are recovering from physical, sexual, or emotional these techniques helpful for gaining a sense of ease with their own bodies. (person integrate emotional, physical and cognitive facets of self)
    - Music/Sound Therapy has been used to treat disorders such as stress, grief, depression, schizophrenia, autism in children.
- Group therapy (Yalom's influence)
    - focus on learning from the experiences of others
    - involves groups of usually 4 to 12 people
    - people with similar problems who meet regularly with a therapist
    - the therapist uses the emotional interactions of the group members to help them get relief from distress and possibly modify their behaviour
- Holistic medicine
    - the art and science of healing that addressed the whole person-body mind and spirit
    - integrates conventional and alternatives therapies (such as acupressure, yoga, energy medicine) to prevent and treat disease
    - unlimited and unimpeded free flow of life force energy through body, mind and spirit
- Interpersonal therapy (Sullivan)
    - interpersonal processes rather than intrapsychic processes
    - focuses on patient's current life and relationships within the family and work environment
    - the goal is to identify and resolve the problems with insight, as well as build on strengths
- Light therapy
    - seasonal affective disorder (SAD) is a form of depression that appears related to fluctuations in the exposure to natural light.
    - people who have SAD can be helped with the symptoms of their illness if they spend blocks of time bathed in light from a special full-spectrum light source, called a light box.
- other interventions
    - Pastoral counselling: some people prefer to seek help for mental health problems from their pastor, rabbi, or priest rather than a therapist (prayers and spirituality).
    - Play therapy: uses variety of activities such as painting, puppets to establish a communication with the therapist. Plays allows the child to express emotions and problems that would be too difficult to discuss with another person
- Relaxation and stress reduction techniques
    - Biofeedback: Learning to control muscle tension and involuntary body function

(heart rate, skin temperature) It is used in combination with, or as an alternative to medication to treat disorders (anxiety, panic, phobias)
    - Guided Imagery or visualization: Going into a state of deep relaxation and creating a mental image of recovery and wellness.
    - Massage Therapy: Rubbing, kneading, brushing and tapping a person's muscles can help release tension and pent emotion (treat trauma related depression)
- Self-help groups:
    - involve people who have similar needs
    - are facilitated by a consumer, survivor, or other layperson
    - assist people to deal with life-disrupting events such as death, abuse, serious accident, addiction, diagnosis of a physical, emotional, or mental disability for oneself or a relative
    - are operated on an informal, free of charge, and nonprofit basis
    - provide support and education
    - are voluntary, anonymous, and confidential

TOPIC 14: BURNOUT PREVENTION AND TREATMENT with BALINT GROUP

- inventors: Michael and Enid Balint, GPs and psychoanalists
- functions of a Balint group:
    - to provide a safe place for emotional reflection on troubling cases
    - to help presenter consider other understandings about the case
    - to look at blind spots, assumptions
    - to help members feel less isolated, less shame, more open to learn
    - to help members grow and develop
- benefits for clinicians
    - explore difficult or troubling situations
    - refine crucially important patient-doctor relationship skills
    - hear and learn from others' cases
    - connect with others
    - experience the power of a group
    - remember what matters about our work
    - avoid burnout, increase engagement and resilience
- participants:
    - 8-12 professional – group members, function:
        - explore doctor-patient relationship
        - look inward, be imaginative, creative, look for less conscious aspects
        - attend to and share thoughts, images, fantasies, associations, hypotheses
        - differentiate one's own experience from presenter's
        - further empathic understandings
    - 1 group leader, 1 co-leader – function:
        - create and maintain a safe space
        - structure and hold the group over time
        - protect presenter and group members
        - encourage reflection, empathy and compassion
        - attend to group development

        - debrief together after each group
- format:
    - „does anyone have a case?”
    - clarifying questions
    - group 'holds' the case
    - presenter invited back
    - (60-90 minutes long sessions)
- What is a good case to present?
    - presentations are spontaneous
    - patients we have ongoing relationships with
    - patients who we feel conflicted or strongly about
    - patients that leave us feeling unfinished
    - patients who we “take home” with us
    - patients that bubble up in the moment
- ground rules
    - avoid advice
    - respect
    - confidentiality
    - ownership of feelings