PSY 215 Project One Template

Use the following article to support you in writing your blog post: Tips for Writing Popular Blog Posts. Complete this template by replacing the bracketed text with the relevant information.

Part One

Use this Project One Template to complete your blog post. You will first review the various psychological disorders that you've learned about in the course and select 3 disorders from your textbook's "DSM-5 Quick Guide." Using a minimum of 3 to 5 sentences per bullet for each psychological disorder, respond to each of the rubric criteria below to structure your blog post. Support your answers with credible sources when appropriate.

Blog post headline: Details of Mental Disorders

Three selected disorders:
Post-Traumatic Stress Disorder (PTSD)
Major Depressive Disorder
Social Anxiety Disorder

- In your own words, identify and describe the main **diagnostic features** of each of the disorders selected.

  The main diagnostic features of post-traumatic stress disorder (PTSD) are being exposed to a traumatic event, having reoccurring memories of the event, having dissociative reactions, having feelings of distress when seeing something that is a reminder of the traumatic event, avoiding memories of the event, having negative feelings towards oneself and/or the world, having a negative emotional state, having a disinterest in activities, and having negative effects on daily functions. A traumatic event could be experiencing or witnessing violence, a serious injury, or death. Reoccurring memories can be in forms of dreams or flashbacks. One may avoid places, people, and/or objects that remind them of the event. Someone with PTSD may have the feelings of fear, guilt, and/or shame. PTSD can interfere with a person's daily functioning by not having interest in their usual hobbies or being with their friends/family, having a difficult time concentrating at work, and/or being less optimistic.

  The main diagnostic features of major depressive disorder (MDD) are feeling depressed almost every day, having negative feelings towards oneself, having a disinterest in activities, losing or gaining weight, not being able to sleep, having loss of energy, not being able to concentrate, having suicidal thoughts, and having negative effects on daily functions. Feelings of depression can be sadness and/or hopelessness. Suicidal thoughts can consist of the thought of death with or without a plan to commit suicide. Someone with MDD cannot have experienced manic episodes (otherwise the disorder could be bipolar I or II). Major depressive disorder can interfere with daily functioning by negatively impacting personal and work relationships (ex. Preferring to stay in bed than go on a date with someone) and withdrawing from daily activities like school, work, and shopping.

  The main diagnostic features of social anxiety disorder are feeling fear or anxiety about social situations, having a fear that the person will be judged, rejected, or humiliated by others, avoiding social situations, the anxiety or fear response is unrealistic, and having negative effects on daily functions. Social situations include, but not limited to, meeting new people, public

speaking, talking to co-workers/friends, parties, and dating. The fear or anxiety response is unrealistic because there is no real threat present. Social anxiety can interfere with daily functioning by not being able to do job interviews or give presentations and negatively impacting personal and work relationships (ex. Going to a party with friends).

- Consider **biomedical** factors: Describe what it means to characterize the disorders as "diseases of the nervous system and the body."

The biomedical factors of post-traumatic stress disorder are cortisol levels, gene-environment interactions, and the size of the hippocampus. A person's levels of cortisol may vary depending on if they have been exposed to a traumatic event. "… levels of cortisol tend to be lower in people with PTSD who have experienced physical or sexual abuse" (Hooley, Nock, & Butcher, 2020, pp. 151-152). Cortisol is released during the fight-vs-flight response. People with PTSD have lower cortisol levels because they are withdrawn and avoid situations. However, people with PTSD will have higher cortisol levels when having flashbacks or reoccurring memories of their traumatic event. Also, people with a certain serotonin-transporter gene may play a role in developing PTSD. A study interviewed people 6-9 months after hurricane season. The study found that "… people who had the high-risk (s/s) genotype of the serotonin-transporter gene were at especially high risk for the development of PTSD if they also had high hurricane exposure and low social support" (Hooley, Nock, & Butcher, 2020, p. 152). Therefore, people who have high levels of support may be less likely to develop PTSD even if they have the serotonin-transporter gene. The size of someone's hippocampus can also show if they have PTSD or are at risk of developing PTSD. One study "… measured the volume of the hippocampus in combat veterans with and without PTSD. The results showed that the veterans with PTSD had smaller hippocampal volumes than did the veterans without PTSD" (Holley, Nock, & Butcher, 2020, p. 152). Considering people with PTSD have depression like symptoms, it is unclear if the smaller hippocampus' is due to the traumatic event the person experienced or their depression symptoms. Cortisol levels, gene-environment interactions, and the size of one's hippocampus are all biomedical factors of post-traumatic stress disorder.

The biomedical factors of major depressive disorder (MDD) are genetic influences, neurochemical factors, abnormalities of hormonal regulatory and immune systems, neurophysiological and neuroanatomical influence, and sleep and other biological rhythms. Twin studies have shown that there is a moderate genetic connection to major depressive disorder (Hooley, Nock, & Butcher, 2020, p. 218). Although, genetics play a role in MDD, environmental factors still have more influence. An observation was made about the link between the amount of norepinephrine and serotonin neurotransmitters and depression. "This observation led to the once influential monoamine theory of depression—that depression was at least sometimes due to an absolute or relative depletion of one or both of these neurotransmitters at important receptor sites in the brain" (Hooley, Nock, & Butcher, 2020, p. 219). A person with normal levels of norepinephrine and serotonin has lower risk for developing MDD. However, no single neurotransmitter or interactive neurotransmitters have been linked to depression. Cortisol levels and the hypothalamic-pituitary-adrenal axis (HPA) can impact the risk of depression for some people. Research found "… that in about 45 percent of patients with serious depression, dexamethasone, a potent suppressor of plasma cortisol in normal individuals, either fails entirely to suppress cortisol or fails to sustain its suppression" (Hooley, Nock, & Butcher, 2020, p. 220). This research shows that people with depression, who experience stress, have high rates of cortisol and are unable to suppress the levels of cortisol.

People with low thyroid levels are also more likely to have depression. "People with low thyroid levels (hypothyroidism) often become depressed, and approximately 20 to 30 percent of patients with depression who have normal thyroid levels nevertheless show dysregulation of this axis" (Hooley, Nock, & Butcher, 2020, p. 220). Both cortisol levels and thyroid levels play a role in depression. Brain damage can also be a biological risk factor for depression. Research found that "… damage… to the left, but not the right, anterior prefrontal cortex often leads to depression" (Hooley, Nock, & Butcher, 2020, p. 221). Other abnormalities of the brain that can be linked to depression are a decrease in volume and/or activity in the orbital prefrontal cortex, dorsolateral prefrontal cortex, hippocampus, anterior cingulate cortex, and the amygdala (Hooley, Nock, & Butcher, 2020, pp. 221-222). These abnormalities are in areas of the brain that are responsible for memory, cognition, attention, perception of threats. People with depression are also more likely to have sleep issues (difficulty falling asleep, staying asleep, and/or frequently waking up during the night). There may be vulnerability markers for major depressive disorder considering "… the reduced latency to enter REM sleep and the decreased amount of deep sleep often precede the onset of depression and persist following recover…" (Hooley, Nock, & Butcher, 2020, p. 222). This offers the idea that people who spend less time in deep sleep are more at risk for developing MDD because lower quality sleep leads to more negative emotions. Studies have also discovered that circadian rhythms (our internal biological clock) can be connected to depression (Hooley, Nock, & Turner, 2020, p. 222). If a person has an abnormal circadian rhythm, they have an increased risk of developing depression because the circadian rhythm impacts a person's hormones, digestion, and everyday habits. Overall, there are many known biomedical factors of major depressive disorder.

The biomedical factors of social anxiety disorder are behavioral inhibition and genetics. Behavioral inhibition "… shares characteristics with both neuroticism and introversion" (Hooley, Nock, & Butcher, 2020, p. 173). Children with behavioral inhibition are often shy and avoid unfamiliar people, places, and situations. People with behavioral inhibition as children have an increased risk of developing social anxiety later in life. Social anxiety can also be caused by genetics. A twin study, as well as other studies, concluded that "… there is a modest genetic contribution to social anxiety; estimates are that between 12 and 30 percent of the variance in liability to social anxiety is due to genetic factors" (Hooley, Nock, & Butcher, 2020, p. 174). Along with the idea of genetics, someone's gender can impact their risk factor for social anxiety. "Social anxiety is more common among women (about 60 percent of sufferers are women)…" (Hooley, Nock, & Butcher, 2020, p. 171). Women may be more at risk for social anxiety because of their hormones. Both genetics and behavioral inhibition are biomedical factors of social anxiety.

- Consider **clinical** factors: Describe the similarities between the disorders selected. In what ways might these similarities impact diagnosis and treatment?

Some diagnostic features are similar between the three disorders (PTSD, MDD, and social anxiety) which can impact the diagnosis and treatments. Diagnostic features that are similar between PTSD and social anxiety would be avoiding something, whether it is memories/reminders of the traumatic event or social situations. Diagnostic features that are similar between PTSD and MDD are having negative feelings toward themselves and having feelings of depression. Diagnostic features that are similar between PTSD, MDD, and social anxiety are having disinterest in activities and having negative effects on their daily functions

(inability to work or maintain healthy relationships). These similarities can cause a challenge for a therapist to diagnose someone with PTSD, MDD, or social anxiety.

In order to diagnose someone, one would have to look more specifically at the cause of their behaviors and other diagnostic features. For example, someone with PTSD would have to have witnessed or experienced a traumatic event, however the definition of traumatic is different for everyone. Or for someone with social anxiety, they would need to show that they have a difficult time in social situations numerous times. MDD may be harder to diagnose because the cause can be unclear. A therapist can also look at other diagnostic features of the disorders to narrow them down. Other diagnostic features of PTSD, that at not shared with MDD or social anxiety, are having flashbacks or distress when thinking about their traumatic event. Other diagnostic features of MDD, that are not in PTSD or social anxiety, are losing/gaining weight, sleep issues, and loss of energy. Other diagnostic features, that are not in PTSD or MDD, are having a fear of being judged, humiliated, or rejected by others and the anxiety/fear response is unrealistic. There is also the possibility of someone having a disorder due to biological factors and not environmental factors. It is important to diagnose someone correctly because treatments can vary.

Although, PTSD, MDD, and social anxiety can all be treated with cognitive behavioral therapy (CBT) and the use of selective serotonin reuptake inhibitors (SSRIs), there are other treatments available specifically for the disorders. Treatments for post-traumatic stress disorder include the following: telephone hotlines, crisis intervention, psychological debriefing, medications (SSRIs), and CBT (Hooley, Nock, & Butcher, 2020, pp. 154-157). Treatments for PTSD can help someone reduce their PTSD symptoms by learning how to cope with them, make sense of their trauma, and increase their self-esteem and positive thoughts. Some people may completely eliminate their PTSD symptoms through treatment. Treatments for major depressive disorder are medications (monoamine oxidase inhibitors (MAOIs), tricyclic antidepressants (TCAs), and selective serotonin reuptake inhibitors (SSRIs)), electroconvulsive therapy (transcranial magnetic stimulation and deep brain stimulation), cognitive-behavioral therapy, behavioral activation treatment, interpersonal therapy, and family/marital therapy (Hooley, Nock, & Butcher, 2020, pp. 240-246). Treatments for MDD can help someone sleep better, have more positive thoughts, improve their mood, and improve their cognition. Treatments for social anxiety disorder are cognitive-behavioral therapy, cognitive therapy, behavioral therapy, and medications (MAOIs and SSRIs). A specific cognitive behavioral therapy used to treat social anxiety is cognitive restructuring. Cognitive restructuring is where "… the therapist attempts to help clients with social anxiety identify their underlying negative, automatic thoughts... After helping clients understand that such automatic thoughts… often involve cognitive distortions, the therapist helps the clients change these inner thoughts and beliefs through logical reanalysis" (Hooley, Nock, & Butcher, 2020, p. 174). Treatments for social anxiety help someone increase their confidence levels, feel comfortable interacting with others, and improve their relationships. Treatments for all psychological disorders can lead someone to live a successful, normal life.

- Consider **historical** factors: Describe the ways deinstitutionalization has impacted patient rights, levels of care, and access to treatment of the disorders over time.

Post-traumatic stress disorder was not recognized as a disorder until 1980. Throughout history, PTSD symptoms went by different names. During the civil war, it was named nostalgia/melancholia or exhaustion. During World War 1, it was named shell shock and

delayed-onset PTSD was called old-sergeant syndrome. After the Vietnam War, PTSD was referred to as combat fatigue, until 1980 when it was officially named post-traumatic stress disorder. (Committee on the Assessment of Ongoing Effects in the Treatment of Posttraumatic Stress Disorder, 2012, paras. 1-3). When PTSD was referred to as nostalgia/melancholia or exhaustion, it was believed that it was due to "… the heavy packs that soldiers carried, insufficient time for new recruits to acclimatize to the military lifestyle, homesickness, and… poorly motivated soldiers who had unrealistic expectations of war" (Committee on the Assessment of Ongoing Effects in the Treatment of Posttraumatic Stress Disorder, 2012, para. 1). Although men were fighting wars, medical professionals did not believe that what the men were experiencing was the cause of traumatic events. Throughout history, mental health was not considered as important as physical health. PTSD was not impacted by deinstitutionalization because PTSD was recognized as a mental disorder in 1980, however, deinstitutionalization occurred starting in 1955 (Torrey, 1997, para. 2). "The deinstitutionalization of mentally ill persons has three components: the release of these individuals from hospitals into the community, their diversion from hospital admission, and the development of alternative community services (Lamb & Bachrach, 2001, para. 3). Considering, throughout most of history people did not recognize PTSD as a mental disorder, people who did have PTSD were not put in mental institutions. There also is a big misconception that only war veterans develop PTSD. Anyone can develop PTSD, such as sexual assault victims, police officers, fire fighters, photojournalists, and victims of terrorist attacks. People with PTSD also had a difficult time finding treatment due to lack of resources. However, today people recognize PTSD and there are outreach centers for those with PTSD.

Major depressive disorder was effected by deinstitutionalization. Depression was first named melancholia (Nemade, n.d., para. 2). Depression has been recognized throughout history; however, treatments were harsh. Around the 400s B.C., people believed that depression was due to being possessed by demons and therefore used exorcism techniques (beatings, restraints, and starvation) on those with depression (Nemade, n.d., para. 3). Hippocrates used bloodletting as a way to treat depression (Nemade, n.d., para. 4). He believed that removing blood from a person's body would cure them of depression. He was unaware that depression was a mental illness and not a physical one. Treatments for depression were harsher as time moved on. In the 400s AD, drowning and burnings were used as treatments, along with exorcism techniques (Nemade, n.d., para. 6). People did not realize that harmful actions towards those with depression only worsened their depression. Treatments that have compassion and empathy towards those with depression are the most beneficial. It was not until the 1600s that some treatments involved non-violent actions. Although witch-hunts were occurring, Robert Burton, an English writer, believed that diet, exercise, distraction, travel, purgatives, bloodletting, herbal remedies, marriage, and music therapy could be treatments for depression (Nemade, n.d., para. 8). Although Burton still views depression as more of a physical illness, it was a big step forward from the beatings, drownings, and burnings. However, treatment of depression went down again during the 1700s. In the 1700s, society believed that "…affected people should be shunned or locked up. As a result, most people with mental illnesses became homeless and poor, and some were committed to institutions. (Lamb & Bachrach, 2001, para. 9). Considering society does not accept those with abnormal behaviors or those who they think cannot contribute to society in a beneficial way, society purposefully outcasted people with depression and other mental health issues. Even today, society continues to outcaste people with mental disorders. A major issue in many communities is the fact that people with mental health disorders are homeless and do not receive the resources they need. This can be due to

"… community resistance, severe fragmentation of services, and insufficient and inadequate housing opportunities have often conspired to create barriers to appropriate residential placement for these severely mentally ill persons (Lamb & Bachrach, 2001, para. 11). The poor continue to be the ones labeled as mentally ill because they do not have access to services or treatment centers. Not being able to afford housing can be the cause of depression and/or worsen depression. Socioeconomic status greatly impacts a person's risk of developing depression. Although deinstitutionalization has negative effects, people are starting to realize what resources should be available for people with depression and other mental disorder. People have learned "… that service planning must be tailored to the needs of each individual; that hospital care must be available for those who need it; that services must be culturally relevant; that severely mentally ill persons must be involved in their service planning; that service systems must not be restricted by preconceived ideology; and that continuity of care must be achieved" (Lamb & Bachrach, 2001, abstract). Creating long term and effective solutions to help those with depression can help bring those people back into society. While we are a long way away from removing the stigma around depression, we are progressing in the right direction.

Social anxiety disorder was mostly unknown as a disorder throughout most of history. Social anxiety was first described as shyness by Hippocrates (Thomas, 2018, para. 3). There was no reason than to believe being shy was a mental disorder. During the 1800s and 1900s different studies by people were done to understand social anxiety, but it was still referred to as shyness. In 1846, a man named Casper studied the phobia ereutophobia (the fear of blushing). Then in 1903, social phobia was first included as a reference in a book classifying phobias (Thomas, 2018, paras. 9-10). Considering there was little research done about social anxiety, people who did have social anxiety had no resources available and were looked at by society as just shy people. People with social anxiety blended in with society, so they were not mistreated by people (unlike people with other disorders, such as depression). In 1950, a psychiatrist named Joseph Wolpe, developed new techniques for behavioral therapy which led to an increase in research for phobias. However, it was not until 1980 that social phobia was added to the DSM-III (Thomas, 2018, paras. 11-14). Although social phobia was officially apart of the DSM, many studies still needed to be done to recognize the factors and develop treatments for social anxiety. In 1994, social anxiety got its name in the DSM-IV, along with improvements to the diagnostic criteria (Thomas, 2018, para. 18). Although it took centuries before having a reliable definition and diagnostic criteria for social anxiety, we now know the factors that contribute to social anxiety and how to treat someone with the disorder. Today, parts of society still view social anxiety as being shy and people can be misdiagnosed, but resources are available for those with social anxiety.

- Consider **sociocultural** factors: Describe the social and cultural changes that have caused shifts in the public's perception of the disorders over time.

Sociocultural factors of post-traumatic stress disorder (PTSD) include being a minority, being in a negative social environment, stigma's, and how people adjust after being in combat. Minorities are more at risk for developing PTSD. After the attacks on the World Trade Center Towers in 2001, people were assessed for PTSD. "Two to three years after the attacks, 15 percent of people were assessed as having PTSD. Compared with whites, African American and Hispanic survivors were more likely to have PTSD" (Hooley, Nock, & Butcher, 2020, p. 152). African Americans and Hispanics are more likely to have PTSD due to their limited resources

compared to the resources whites have. In those two to three years after the attacks, African Americans and Hispanics may not have been able to receive mental health treatment and/or have less social support from others. A negative social environment leads to a greater risk of PTSD. A study consisting of Israeli men who were psychiatric war causalities showed regression in their psychiatric symptoms after a year. The regression may have been "… due to the negative attitudes of the community. In a country so reliant on the strength of its army for its survival, considerable stigma is attached to psychological breakdown in combat" (Hooley, Nock, & Butcher, 2020, p. 153). The stigma the Israeli men experienced is experienced by many soldiers from all over the world. The stigma causes soldiers who have PTSD to be looked down upon by their communities which increases their thoughts of shame and guilt. Some communities are combating the stigma by helping soldiers with their mental health. People have developed certain strategies to help soldiers get through stressful situations. These strategies include "Strategically placed combat stress control teams deploy as soon as is practical after combat engagements to provide timely counseling to troops… the military also makes an effort to provide breaks from long engagements by providing "safe" zones that include… amenities" (Hooley, Nock, & Butcher, 2020, p. 153). By combating the stigma of PTSD in combat situations hopefully can lead to decreasing the stigma of PTSD in other situations (sexual assault and other forms of violence). Someone's ethnicity, social environment, society's stigma, and (if a soldier) how they adjust after being in combat are all sociocultural factors of PTSD.

Sociocultural factors of major depressive disorder (MDD) include cross-cultural differences in depressive symptoms and cross-cultural differences in prevalence. Considering different cultures label depressive symptoms differently, it can influence who is diagnosed with depression and who is not. "For example, in Western cultures the "psychological" symptoms of depression (e.g., guilt, worthlessness, suicidal ideation) are prominent, whereas they are not prominently reported in non-Western cultures… where rates of depression are relatively low" (Hooley, Nock, & Butcher, 2020, p. 239). People in western cultures and Asian cultures view mental health differently due to their differences in social norms and lifestyles. "Western cultures view the individual as independent and autonomous, so when failures occur, internal attributions are made", however, "in many Asian cultures individuals are viewed as inherently interdependent with others" (Hooley, Nock, & Butcher, 2020, p. 239). So, when we view ourselves as the cause of failures, we are more likely to have feelings of depression (which displays the psychological symptoms of depression). In contrast to Asian cultures, Asians are less likely to blame themselves for failures and will show less symptoms of depression. In recent years, western culture has influenced Asian cultures, which has led to an increase in depression rates in Asian countries. "… one study of adolescents from Hong Kong and the United States found levels of depressive symptoms and hopelessness to be higher in the adolescents from Hong Kong" (Hooley, Nock, & Butcher, 2020, p. 239). As cultures intertwine, the rates of mental disorders can fluctuate. Some cultures views of depression still remain unchanged. "For example, Australian aborigines who are "depressed" show none of the guilt and self-abnegation commonly seen in more developed countries" (Hooley, Nock, & Butcher, 2020, p. 239). Knowing that everyone at some point in their lifetime experiences emotions of sadness; it would be interesting to view how cultures that do not show symptoms of depression cope with feelings of sadness or hopelessness. There is a large difference in prevalence rates of depression among numerous countries. This may be due to "… differences in willingness to report the presence of a mental disorder due to stigma, as well as different levels of important psychosocial risk variables in different cultures and different levels of stress" (Hooley, Nock, & Turner, 2020, p. 239). The way society views people with depression can influence if people seek treatment. Also

the way cultures express their emotions can influence the rates of depression. More likely than not there are much higher rates of depression that are not being recorded due to people's fear of being labeled and stereotyped by society (e.g. people with depression are lazy). Overall, minorities are at higher risk of developing depression and the way cultures view depression impact the rates of depression.

The sociocultural factors for social anxiety disorder are individualism and collectivism, social norms, embarrassment, self-construal's, gender role and gender role identification, and shame. Collectivism is defined as "… the relationship between members of social organizations that emphasize the interdependence of its members" (Hoffman, Asnaani, & Hinton, 2010, para. 23). Individualism is the opposite, individual emotion and individual initiative is what is expected and the norm. Therefore, people who go outside of their society's norm (collectivist or individualist) are more at risk for developing social anxiety disorder. While it may not be 100% in all cases, looking at a society's norms versus an individual's norms would be a good starting indicator as to the individuals anxiety levels. Considering social anxiety is the fear of being judges, embarrassed, and/or rejected by society, people living in societies with strict social norms (collectivist societies) have an increased risk of developing social anxiety disorder. For example, "… it is easier to embarrass individuals from Southeast Asia because more rules for social behaviors exist there" (Hoffman, Asnaani, & Hinton, 2010, para. 29). The relationship between self-construals and collectivist/individualist societies can impact a person's social anxiety. "Self-construals are overarching schemata that define how people relate to others and the social context" (Hoffman, Asnaani, & Hinton, 2010, para. 32). People can develop an independent self-construal where one might "…view oneself as autonomous and separate from the social context" (Hoffman, Asnaani, & Hinton, 2010, para. 32). This is in contrast to an interdependent self-construal where one might view themselves "… as being intricately connected and integrated with others in the social group" (Hoffman, Asnaani, & Hinton, 2010, para. 32). It has been noticed that people with interdependent self-construal are more likely to be aware of embarrassment and social ques, but people with independent self-construal may not feel embarrassed or be able to be embarrassed may lack awareness of social ques. People of different genders also have different risk levels of developing social anxiety disorder. "… women are slightly more likely than men to have SAD…" (Hoffman, Asnaani, & Hinton, 2010, para. 40). Gender roles and gender identifications are linked to interdependent and independent self-construals. Society has created different expectations for men and women. Men are expected to show masculinity by not expressing their emotions, being strong, and show dominance. Women are expected to show femininity by being shy, submissive, and gently. Women may be more likely to have social anxiety because they have to have both interdependent and independent self-construals. For example, American women have to "… reconcile the mixed messages they receive from a culture that broadly emphasizes independence and autonomy but expects females specifically to be interdependent and connected with others" (Hoffman, Asnaani, & Hinton, 2010, para. 42). These conflicting ideals can lead to higher levels of social anxiety. Another sociocultural factor of social anxiety disorder is the feelings of shame. Shame can be viewed differently among cultures. For example, "In Japan, shame-prone and self-effacing behavior seems to be given positive functional value and is actively promoted by society, whereas the American culture might tend to prohibit shame-prone behaviors ..." (Hoffman, Asnaani, & Hinton, 2010, para. 49). A society that promotes the feelings of shame is more likely to have lower rates of social anxiety disorder compared to one that prohibits the feelings of shame. The ideas of individualism and collectivism, social norms, embarrassment, self-

construal's, gender role and gender role identification, and shame are sociocultural factors that influence social anxiety disorder.

Part Two

For Part Two, choose 1 disorder from the 3 you discussed in Part One. Respond to each of the three questions in a minimum of 3 to 5 sentences. Support your answers with credible sources when appropriate and address the rubric criteria.

One selected disorder:
Post-traumatic Stress Disorder

Consider the mind-body connection: Describe whether a discernible **bidirectional relationship** exists between the disorder and physical illness. If so, explain.

There is a bidirectional relationship between PTSD and physical illness. People with PTSD are more likely to have health problems than those without PTSD. Some studies suggest that PTSD causes neurological changes in one's brain. Considering PTSD symptoms consist of feelings of distress, shame, and guilt, flashbacks, and avoiding places and objects that remind the person of their traumatic event, neurological changes and worse physical health can be expected. "…these neurochemical changes may create a vulnerability to hypertension and atherosclerotic heart disease that could explain in part the association with cardiovascular disorders… abnormalities in thyroid and other hormone functions, and to increased susceptibility to infections and immunologic disorders…" (Jankowksi, 2018, para. 6). Although physical health has numerous factors (alcohol and drug usage, gender, age, weight, etc.), it can be assumed that PTSD is the main cause of a person's decrease in physical health. Studies have shown a link between PTSD and cardiovascular disorders using electrocardiograms (ECG). "… PTSD was found to be associated with nonspecific ECG abnormalities, atrioventricular conduction defects, and infarctions" (Jankowksi, 2018, para. 11). Since, the ECG's showed abnormalities, people with PTSD are more susceptible to heart disease and heart attacks due to their severe stress and anxiety. It is also important to note that, most studies done on PTSD has focused on male veterans, so more research needs to be completed on women with PTSD and PTSD of those who are not military. Studies have concluded the bidirectional relationship between PTSD and physical illness.

Consider the impact of language and messaging: Describe how the **words we use** (e.g., in casual conversation, in media communications) when discussing a disorder influence our willingness or ability to manage the disorder.

The words we use when discussing PTSD can influence someone's willingness or ability to manage the disorder. For example, the use of death related words had negative effects on people with PTSD. " In the recent trauma group, the increase in death-related word usage may reflect an acute reaction and processing of the recent trauma... In the group who experienced trauma far in the past, it may reflect a higher prevalence of severe, chronic depression that is linked to a higher risk of suicide" (Todorov, Mayilvahanan, Cain, & Cunha, 2020, para. 26). Considering people with PTSD also have

symptoms of depression, it is understandable that using death related words would increase the depression symptoms. In order to positively influence a person's willingness or ability to manage PTSD, we should educate ourselves about PTSD and listen to the stories of people with PTSD. Educating ourselves about PTSD can help us understand what people with PTSD are going through and to help us keep things in perspective (Smith & Robinson, 2020, para. 11). Educating ourselves can help find resources for people with PTSD and show people that they have support and are not alone. People with PTSD who have someone to listen to them will have positive effects on how they manage their PTSD symptoms. An important step that a person with PTSD needs to make in order to progress through their trauma is talking about their traumatic event. Talking is part of the healing process and if someone shows that they do not like what the person with PTSD is saying, the person will likely shut down and not open up to anyone (Smith & Robinson, 2020, paras. 14-15). We need to give an open and positive space for people with PTSD to talk about their experiences. Especially with the use of social media, we need to do our best to avoid using death related words, negative and un-supportive content, and focus on using positivity and openness to help influence those with PTSD to manage their disorder.

Consider the effect of lifestyle choices: Describe the small, but significant, **changes in attitude/behavior** we can make that could help us to manage the symptoms of the disorder.

Some small, but significant, changes in attitude/behaviors that people with PTSD can make to help manage their symptoms are challenging their sense of helplessness, get moving, living a healthy lifestyle, and seeking professional treatment. People with PTSD often having feelings of shame, guilt, and helplessness. However, taking time to do volunteer work, donate blood, help a friend in need, or donate to a charity can help someone challenge their sense of helplessness (Smith, Robinson, Sigel R., & Sigel J., 2020, para. 18). Spending time doing those activities gives someone the feeling that they are needed and wanted. Moving around and exercising can also help someone manage their symptoms of PTSD. Exercises such as spending time in nature, walking, swimming, running, dancing, rock climbing, and boxing can help someone focus more on their physical body than their thoughts and emotions (Smith, Robinson, Sigel R., & Sigel J., 2020, paras. 20-22). Moving around helps clear someone's mind, improve their sleep, and boost their mood. Exercise is one part of many in living a healthy lifestyle. Other parts include making time to relax, avoiding alcohol and drugs, eating a balanced diet, and getting enough sleep (Smith, Robinson, Sigel R., & Sigel J., 2020, paras. 27-30). Balancing out exercise with the other parts of a healthy lifestyle can decrease the chance of physical illnesses that can be cause by PTSD, as well as improving one's emotions and thoughts. The benefits of a healthy lifestyle can be enhanced by combining it with professional treatment. Although some can manage their PTSD with symptoms by themselves, seeking treatment as soon as possible increases their chance of relieving their symptoms sooner. Some may be reluctant to seek treatment, however, it is good to "… keep in mind that PTSD is not a sign of weakness, and the only way to overcome it is to confront what happened to you and learn to accept it as a part of your past" (Smith, Robinson, Sigel R., & Sigel J., 2020, para. 31). It is important for someone with PTSD to have support from friends and family and support from a professional. Help from a professional can give the person a different perspective on their situation and help the person learn coping skills. Combining all of the changes in attitudes/behaviors has the most benefits of helping someone manage their PTSD symptoms.

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