**Section 1:**

***- What is a psychological disorder?***

A Psychological disorder can also be described as a mental illness or mental health condition. Psychological disorders can consist of changes in mood, thoughts and feelings. These conditions can deeply affect an individuals behaviour, causing disruption in relationships, social life and overall wellbeing. (Ferguson, S. (2023)).

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| --- | --- |
| **Harmless symptoms** | **Harming symptoms** |
| Doesn’t shower often | Reduce of sleep – 4-5hr a night |
| Wears hoodie despite hot weather | Delusions (believes that people are communicating with him in morse code. Hearing people speak to him. Believes there are signs hidden in LED flicker rates) |
| Minimal eye contact | Won’t shower |
| Patchy appetite | Speaks to himself |
| Stable weight | Drastic mood swings/energy spikes |
| Low hygiene | Speaking rapidly and off topic |
| Missing events | Isolation |
| Claimed alight fire hissing was “comforting” | Hallucinations (claimed numbers rearranging on page) |

***Biological –* (genes, brain chemistry - feel)**

- sleep reduction

- wears hoodies despite hot weather

- refuses to shower occasionally

- low hygiene

- patchy appetite

- unusual sleep pattern (sleeps after school, stays up until early morning)

***Psychological –* (thoughts – think)**

- delusions (believes streetlights flash in morse code)

- hallucinations (numbers rearranging on page as he reads)

- speaks to himself

- speaking rapidly and off topic

- hears people speaking to him (auditory hallucinations)

- claims that people communicate online in secret codes

- mood swings (hyper to withdrawal, energy spikes)

- attempts to jam “illicit frequencies”

***Social –* (social interactions)**

**-** missing events (skips football training)

- isolation (doesn’t hangout with friends outside of school - stays to himself)

- holds minimal eye contact

- dropping grades (slipping from A’ to C’s)

- quiet speech

Biological, psychological, and social factors all influence and affect one another in everyday life. Sam D experiences late night thoughts of morse code inscriptions and auditory hallucinations, thus causing sleep deprivation. This is an example of how psychological factors can tie into biological. Though not noted, this then hinders social factors and social interactions. This reduction in sleep has affected Sam’s sleeping pattern, him sleeping throughout the afternoons/daytime rather then at night (biological). Unusual sleep patterns and/or a low amount of hours of sleep can impair cognitive functions. For Sam, he struggles with staying on topic when speaking, and has drastic mood swings (psychological). Therefore, his lack of energy has caused him to have a severe drop in grades and isolation (social).

**Section 2:**

From collected data, Sam D is evident of these core symptoms:

- hallucinations (numbers rearrange when he reads )

- auditory hallucinations (hears people speak to him )

- delusions (believes people online communicate in codes, believes streetlights flash and represent morse code, believes there are “signals” hidden in LED flicker rates )

- lack of sleep (4-5hr per night)

- drastic mood swings/energy spikes

- isolation

- speaking rapidly and off topic

- reduces to shower

Data has been dated from the 28th of August to the 1st of October, exactly 1 month. Over this month, Sam has been experiencing a various selection of symptoms. They have been consistent over the month, although they have potentially been ongoing for a longer period of time. Sam notes down his late night events insouciantly and mentions himself being wide awake “again”, indicating that this could be a consisting disturbance. To further back this up, with his hallucination at school, he had little to no reaction to it in relation to someone that were to newly experience it. Therefore it is uncertain on when these symptoms began.

Sam D’s symptoms suggest a case of Schizophrenia, due to his consistent hallucinations, delusions, disorganized speech, and catatonic behaviour. These are required features that meet the diagnostic criterion. The characteristically symptoms of Schizophrenia involve a range of cognitive, behavioural, and emotional dysfunctions. (DSM). Sam has not had these symptoms arise as a result of drug use, alcohol consumption or medication effects. Derived from the collected information, Sam has been undergoing continuous hallucinations and delusions, which **must** be persistent for at least 1 month. No family history of autism spectrum disorder or other communicated disorders have been reported, thereby further backing up the appropriateness of this diagnosis. He experiences emotional dysregulation, a slight case of anhedonia (lack of interest in food), and functional consequences (limited social contacts and social withdrawal). He laughs in the absence of an appropriate stimulus (incongruent affect), disturbed sleep patterns, and impaired insight towards his symptoms and possible condition. Schizophrenia has also proven to be more prevalent to males, and typically, psychotic features emerge between late teens and mid-30’s. In males, the disorder can often cause lower educational achievement, greater cognitive impairment, and more prominent symptom severity, all of which are evident in Sam’s case. Given the constellation of symptoms and matching clinical features, it is beyond evident that Sam has and is in need of diagnosis of Schizophrenia, and further assessment and monitoring will be essential to tailor appropriate therapeutic strategies to discover a correct treatment.

The presentation raises concern for schizophrenia, though there is sufficient evidence to suggest a diagnosis of bipolar I disorder. Although there is no documented history of prior mood disorders meeting full diagnostic criteria, recent behavioural data communicates the high probability of a manic episode as of the past month. He suffers from a decreased need for sleep, flight of ideas with subjective experience of racing thoughts (reports of ideas flowing so fast his “hands cant keep up”) and distractibility (DSM-5, criterion B5) – speaks rapidly and off topic (criterion B3). He exhibits an increase in goal-directed activity (obsessive need to discover hidden codes/frequencies etc.), possible excessive involvement in high risk activities (neglecting to turn off a bunsen burner), indicating a clear presence of psychotic features. This feasible episode is also not attributable to the physiological effects of a substance or medication. His mother has reported a noticeable change in behaviour, however he has not been necessitated to hospitalization. Despite this, his pronounced symptoms have caused significant impairment in social and occupational areas in his life, prompting referral to an early psychosis service by his GP. Though he meets almost every required symptom in the criterion to finalise a confident diagnosis, there is no conclusive evidence that he has experienced a manic episode once before in his lifetime, which therefore precludes a definite diagnosis of Bipolar I disorder at this current stage. Nonetheless, gathered records strongly suggest that he is presently experiencing his first manic episode. Although a diagnosis of Bipolar I disorder with psychotic features is highly probable, the overall presentation more closely aligns with a primary psychotic disorder. Given available evidence, a diagnosis of schizophrenia is more strongly supported.

**Section 3:**

**My calculated treatment approach for Sam D is a combination of cognitive behavioural therapy (CBT) and Cognitive Behavioural Therapy for Psychosis (CBTp). Though it is documented that medications are the most efficient approach to Schizophrenia, I believe that psychotherapy will be extremely helpful as to provide him with support and navigate him towards enhancing coping strategies and social functioning. This therefore will help him become knowledgeable of his psychosis, helping him understand what’s happening and how to manage. CBTp will help Sam address his persistent delusions, hallucinations and limited insight. This approach is supported by clinical evidence demonstrating its efficiency in reducing the severity of psychotic symptoms. In addition, family therapy is strongly recommended given the mothers growing concern for her son and his state, this will then foster better communication and reduce conflict and/or worry. Possible arts and creative therapies may also be explored as it could benefit Sam to help him verbally express himself and improve his ability to verbalize internal experiences. Treatment teams like his current GP must continue, with the addition of a psychiatrist who can then coordinate necessary medication management and overall treatment planning. While therapy aims to provide long-term skills and insights, medication primarily focuses on symptom management. Antipsychotic medicines will be introduced as it is considered to be most common prescribed when treating schizophrenia. They control symptoms mainly by affecting brain receptors for different neurotransmitters, or chemical messengers. Most antipsychotic medications act on dopamine and serotonin receptors (mayo clinic 2023). This is critical in alleviating positive symptoms such as his hallucinations, delusions, and disordered thinking. Sam will begin treatment with low doses, and regular monitoring will be conducted to assess for negative side effects and for his functional progress. In summary, this treatment model emphasizes a biopsychosocial approach, aiming to not only manage and reduce Sam’s symptoms, but also to offer him an effective long-term recovery.**

**Reference**

Ferguson, S. (2023). *Psychological Disorders: Types, Symptoms, Treatment*. [online] Healthline. Available at: <https://www.healthline.com/health/psychological-disorders>.

Mayo Clinic (2023). *Mayo Clinic*. [online] Mayoclinic.org. Available at: <https://www.mayoclinic.org>.

American Psychiatric Association (2022). *Diagnostic and statistical manual of mental disorders*. 5th ed. Boston: Pearson.