# Psychology

## Exam 3 Review

**Substance Related Disorders**

* Which drugs are problematic?
  + Cultural factors and costs associated with use

**Substance Intoxication**

* Temporary, clinically significant maladaptive behavioral or psychological changes due to the effects of the substance on the central nervous system.
  + Develop during or shortly after the substance
  + This diagnosis is rarely given

**Substance Abuse**

* A maladaptive pattern of substance use leading to clinically significant impairment or distress such as (just one):
  + Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home
  + Recurrent substance use in situations in which it is physically hazardous (Drunk driving, drunk lawn mowing, etc)
  + Recurrent substance use related legal problems (DUI, DWI, Possession, etc)
  + Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of a substance
    - You’re missing work consistently and you know you shouldn’t drink but you still do.
* To write on Axis
  + Axis 1 – Alcohol Abuse
  + Axis 1 – Heroine Abuse
  + Axis 1 – Polysubstance Abuse, Marijuana and Alcohol

**Substance Dependence**

* A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three or more of the following: Red = Physiological
  + Tolerance – Needing to take more substance to get the same effect or no longer getting the same effect with the same quantity
  + Withdrawal – Negative physical experiences when you do not have that substance. Headaches, jitteriness, irritability, etc
  + Substance is taken in larger amounts or for longer periods than intended
  + Persistent desire to cut down or control use, but unsuccessful in efforts
  + Spend a lot of time getting, using, or recovering from the substance
  + Important social, occupational, or recreational activities given up or reduced due to substance use
  + Continued use of the substance despite knowledge of it causing or exacerbating other serious physical or psychological problems
  + Pattern of substance abuse for at least one year

**DSM-V Changes to Substance Abuse and Dependence**

* Now called Substance Use Disorder
* Must have:
  + A problematic pattern of use that leads to impairment or distress
  + Two or more of the following within a 12-month period
    - Combined criteria for abuse and dependence
    - A criterion for cravings added
      * Cravings or a strong desire or urge to use (such as alcohol)

**Alcohol Use**

* Central Nervous System Depressant
  + Slows down activity of CNS
  + Relaxant and slows down everything
  + Loss of inhibition
* Effects of Alcohol
  + Binds to receptors that often attach to GABA – in effect it’s like having more GABA in your system
  + GABA is an inhibitor (calming effect)
* Extent of effects vary
  + Weight, eating, medications, heredity, tolerance, and drinking rate
* Long term effects
  + Alcohol Abuse – 10%
  + Alcohol Dependence
  + Personal and social impact
* Withdrawal Symptoms
  + Delerium Tremors
  + Cirocis of the Liver
  + Blackouts

**Marijuana (Hallucinogens)**

* 2nd Most Popular Drug after Alcohol
* Effects of Marijuana
  + Mood swings, paranoia, euphoria, eating more, memory impairment, amotivational syndrome (hangs around all day), long-term social withdrawal, lung damage, decrease in sperm count, delayed ovulation,
  + No obvious physiological withdrawal
  + Psychological Withdrawal
  + Irritability, recklessness, sleep problems, nausea, or loss of appetite
* Associated Problems with Marijuana
  + Linked to schizophrenia
  + 10% of cases of psychosis are linked to cannabis use

**Amphetamines**

* Examples: Speed, crystal meth, diet control meds, etc
* Initial Effects: Paranoia, apathy, irritability, depression, prolonged periods of sleeping when coming off the drug
* Associated Problems: FIND OUT
* Axis 1 – Amphetamine Substance Disorder

**Cocaine**

* Demographics change over time
  + Used to be a drug of the elite then crack came out (much cheaper in general and more addictive)
* Route of administration
  + They start to feel the high within ten minutes of administration. Smoked or snorted.
* Drug Effects
  + Feel euphoric, increased confidence, more powerful
* Associated Problems
  + Tolerance does develop very quickly
  + Half to 2/3 of the people who use cocaine have psychotic symptoms (paranoia)
  + Effects dopamine
  + Lung and sinus damage
  + Psychological dependence with cocaine. Very apathetic or bored when not taking the drug
  + No physical withdrawal, only psychological withdrawal

**Opiates**

* Derivatives of opium: Heroine, morphine, codeine
* Drug Effects
  + Make you feel very good and prevent the feeling of pain
  + Euphoria and relaxation
* Associated Problems
  + Highly addictive psychologically and physically
  + Very strong withdrawal symptoms – chills, fever, nausea, vomiting, insomnia, and muscle aches lasting for three days
  + When used frequently there’s malnutrition because people don’t think about eating
  + Consequences due to needle sharing

**Hallucinogens**

* Examples: LSD, PCP
* Effects of Hallucinogens
  + Perception - Hallucinates
  + Mood – Laugh a lot even though not particularly happy
  + Behavior – Can become enraged
  + Cognition – People act in many different ways, racing thoughts
  + Associated problems
    - Can cause psychosis
    - Tolerance develops very quickly and tolerance can also wear off very quickly
    - Bad trips (1/8) and flashbacks (even when not using)
    - No withdrawal symptoms, it just wears off

**Potential Causes**

* Integrative Model
  + Psychological
    - Behavioral
    - Cognitive
  + Biological
  + Social
* Cognitive Behavioral Perspective
  + Behavioral Explanations
    - Operant Conditioning Paradigm – There isn’t always reinforcement
  + Opponent Process Theory
    - People initially begin using drugs because of the positive effects. Over time once the positive effects go away there’s negative reinforcement to not have to go through the withdrawal and/or stressed family life.
  + Classical Conditioning Paradigm
    - Cues that cause cravings for the drugs. Being in the room where you used to do drugs
  + Cognitive Explanations
    - Expectancy Effects
      * What caused them to originally start the drug?
    - Cravings
      * Intensified cravings for drugs by cues or seeing someone else
* Cognitive Behavioral Treatment
  + Behavioral Treatments
    - Aversion Therapy
      * Pair with something aversive such as antabuse
      * You must be very committed in order to benefit from aversion therapy since you can stop at any time
    - Teach Alternative Behaviors
      * If someone is using substances because they have a difficult time relaxing they’ll be taught to relax through alternative means.
      * Teach assertiveness and social skills to deal with peer pressure.
    - Relapse-prevention training
      * Goals here are to maintain period in recovery
      * Clarify their desire to quit
      * Help identify triggers (Stress, holidays, etc)
      * Found to be effective but not footproof
    - Biological Perspective
      * Genetic Predisposition
        + Concordance rate of alcoholism for monozygotic twins – 50%
        + Concordance rate of alcoholism for non-monozygotic twins – 28%
      * Biological Factors
        + Reward pathway

Ventral Striatum

Nucleus Accumbenus

Both areas show high levels of dopamine activity

Reward Deficiency Syndrome – More biological

* + - * + Biological Treatments

Detoxification

Controlled, medically assisted, withdrawal

Helps replace the substance they were using

Methodone for heroine

Antagonist Drugs

As long as they keep taking this drug they will block the positive effects they were getting

Naltrexone for heroine

Aversive Drugs

Antabuse, they introduce negative effects for substance use

Drug Maintenance Therapy / Agonist Substitution

Delivering the drug in a more acceptable (less harmful) way

* + - * Sociocultural Treatments
        + Self-help programs (Alcoholics Anonymous)

Some problems with AA is they don’t know how effective they are

* + - * + Community Prevention Programs

“Just say no”

Aimed at youth, large scale.

**Personality Disorders**

* Axis II Disorders (Stable and Enduring Problems)
* Personality traits lie on a continuum
* Characteristics of personality disorders
  + Traits are rigid, undesirable, and maladaptive
  + Ingrained an dpervasive
  + Chronic
  + Ego-syntonic vs. Ego-dystonic
    - Ego-Syntonic – Personality disorders are in line with persons self-view. They will not see it as something unusual or distressing, rather that’s just the way they are.
    - Ego-Dystonic – Most Axis I disorders are not in line with persons view of self. This is why people seek treatment for Axis I disorders
  + Impact on relationships – The partner or the other person in the relationship is having issues with the relationships
  + Implications for treatment – Since they’re ingrained and pervasive you cannot really change them. There are no well-structured effective treatments.

**Generalized Diagnostic Criteria for Personality Disorder**

* An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture in at least 2 of the following ways:
  + Cognitions (Perceive and interpret information)
  + Affectivity (Overall emotional response to things)
  + Interpersonal Functioning
  + Impulse Control
* It is pervasive and inflexible across social and personal contexts
* It leads to distress or impairment
* It has an onset in adolescence or early adulthood and is stable over time
* It is not better accounted for as manifestation of another disorder

**DSM-IV Personality Disorder**

* Categorical vs. Dimensions
  + Current approach is categorical
  + DSM-V will likely use a categorical/dimensional hybrid
    - Levels of personality functioning
    - 6 Disorder types assessed for degree of “match”
    - 5 broad higher order personality trait domains also rated

**DSM-V Personality Disorders**

* Levels of personality functioning
  + Self
    - Identity – Experience of oneself as unique
    - Self direction – A pursuit of coherent, meaningful goals
  + Interpersonal
    - Empathy – Comprehension and appreciation of other’s experiences and motivations
    - Intimacy – Depth and duration of positive connections with others
  + Each is rated from 0-4 (4 is worst)
* Retained Diagnosis
  + Reformulated based on levels of personality functioning
    - Antisocial
    - Avoidant
    - Borderline
    - Narcissistic
    - Obsessive-Compulsive
    - Schizotypal
* New Diagnoses
  + Personality Disorder Trait Specified
    - Negative Affectivity – Experiencing negative emotions frequently and intensely
  + Detachment – Withdrawal from others
  + Antagonism – Behaviors that put the person at odds with others (really annoying, doesn’t consider other people, etc)
  + Disinhibiting – Engaging in behaviors on impulse
  + Psychoticism – Unusual and bizarre Experiences

**Cluster A – Odd or Eccentric**

* Diagnostic Criteria for Paranoid Personality Disorders
  + A pervasive distrust and suspiciousness of others such that their motives are interpreted as **malevolent**, as indicated by four (or more) of the following
    - Suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her
    - Is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends and associates
    - Is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her
    - Reads hidden demeaning or threatening meanings into benign remarks or events
    - Persistently bears grudges. Is unforgiving of insults, injuries, or slights
    - Perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack
    - Has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner
  + 2.5% prevalence
  + More in males than females
  + Higher rates of paranoid personality disorder in those who have had family members diagnosed with schizophrenia
  + Treatments – None
* Diagnostic Criteria for Schizotypal Personality Disorder (Desire close relationships and often feel lonely)
  + A pervasive pattern of interpersonal deficits, cognitive or perceptual distortions, and eccentricities of behavior, as indicated by five (or more) of the following:
    - Ideas of reference
    - Odd beliefs or magical thinking that influences behavior and is inconsistent with subcultural norms
    - Unusual perceptual illusions, including bodily illusions
    - Odd thinking and speech
    - Inappropriate or constricted affect
    - Behavior or appearance that is odd, eccentric, or peculiar
    - Lack of close friends and confidants other than first degree relatives
    - Excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about self
  + 3% Prevalence
  + Slightly more men than women
  + Related to schizophrenia, just to a lesser level and doesn’t fluctuate as much
  + Treatment – Work on basic social skills
* Diagnostic Criteria for Schizoid Personality Disorder
  + A pervasive pattern of detachment from social relationships and a restricted range of emotions in interpersonal settings, as indicated by four (or more) of the following
    - Neither desires nor enjoys close relationships, including being part of a family
    - Almost always chooses solitary activities
    - Has little, if any, interest in having sexual experiences with another person
    - Takes pleasure in few, if any, activities
    - Lacks close friends or confidants other than first-degree relatives
    - Appears indifferent to the praise or criticism of others
    - Shows emotional coldness, detachment, and flattened affectivities
  + Between 2-5% prevalence
  + Potential link to autism
  + More prevalent in males
  + Don’t come in for treatment, but if they do they’ll work on social skills, work out with the person to benefits of social interactions