# Abnormal Psychology

## November 29, 2012

* **DSM-5 : Restricted and Repetitive Behaviors (RRBs) Criteria**
  + **Restricted, repetitive patterns of behavior, interests, and activities, as manifested by at least:**
    - Two of the following
      * Stereotyped Motor or verbal behaviors
        + Motor stereotypies; Echolalia, repetitive use of objects
      * Excessive adherence to routines
        + Ritualized behavior; distress to small changes
      * Restricted fixated interests
        + Abnormal in intensity and focus
      * Unusual sensory behaviors
        + Adverse reaction to specific sounds or textures; indifferent to pain/heat/cold; fascination with lights or spinning objects
* **DSM-5: Social-Communication Criteria**
  + **Clinically significant, persistent deficits in social communication and interactions, as manifest by all of the following:**
    - Marked deficit in nonverbal or verbal communication used for social interaction
      * Reduced eye-to-eye gaze, gesturing, facial expressivity
    - Lack of social reciprocity
      * Abnormal social approach and initiation; reduced sharing
    - Failure to develop and maintain peer relationships appropriate to developmental level
      * Difficulty making friends; reduced interest in people; inability to adjust behavior to different social contexts
* **Cognition/IQ**
  + **Impaired intelligence, memory (the process of getting new memories in there is difficult but once there it’s set), weak central coherence (looking as a whole, they will not see the H made out of S’s – they have a hard time seeing things holistically or as a whole), savant skills (remarkable abilities within one specific area but impaired in other areas – incredibly rare)**
* **What is social cognition?**
  + **The perception, processing and interpretation of social information**
  + **A broad construct: From detecting biological motion to understanding complex social dynamics and everything in between**
  + **Basic Social Cognition: Face Processing**
    - Faces instantly confer a lot of information
      * Do you know me? Am I male or female? About how old am I? Am I in a good mood?
      * How do you know this information though?
    - Sophisticated Face Recognition
      * Remarkable ability to identify people from faces
        + Recognize high school classmates with 90% accuracy up to 35 years after graduation and with a class size of up to 900 students
      * Our visual memory for other visual stimuli (ie objects) is not nearly as good
    - What makes faces so special?
      * Specialized neural region and expert perceptual abilities
      * *Not structurally defined area, not born with but rather you develop*
      * Fusiform Face Area
      * Autistic people will look at the mouth, curve of chin, etc
      * A health individual will have a consistent pattern between the eyes and mouth
    - **Face perception follows a protracted developmental course**
      * Neonate preference
        + Restricted visual input during infancy results in long-term impairments of face perception
        + Inner/Outer Advantage
        + Inversion effect increases with age
  + **Development of Theory of Mind (TOM)**
    - Join attention is at age 1
      * Is the child pointing to get you to make you pay attention to them?
    - Intentional gesturing and vocalization (2)
    - Use mental state terms (3)
    - 1st order TOM (4)
      * Sally and Anne, where’s the ball?
    - 2nd order TOM (6/7)
      * Train station example
    - Deception, sarcasm, irony, faux pas, metaphor (8-11)
* Autism Diagnosis
  + Reliably diagnosed by 2 years of age
  + Regression
    - A child may start developing normally until 2 years of age, for whatever reason they start to regress. They may start to lose words or language all together. Difficulties with motor activities. Childhood disintegrative disorder is much like this.
  + The ways of diagnosing autism doesn’t happen until 1 or 2 (pointing + speech). Identifying it needs to come more from biological factors (difference in brain, etc)
* **Etiology**
  + **Psychological: Bad Parenting**
    - They over interacted with their children, etc
  + **Biological**
    - Genetic
    - Brain overgrowth
      * Children with autism grew bigger heads by 12 months
      * This is when we first see behavioral signs of autism
      * Parts of the brain that aren’t being used are pruned and die off. This is why kids lose their ability to differentiate monkey faces. In Autism there is a failure of pruning, causing brain overgrowth. Normally they have larger temporal lobes compared to most people.
* **Treatment**
  + **Success varies**
    - No one is ever “cured” They learned to adaptively manage their autism
  + **Basic Principles**
    - The earlier the better
    - Maximize engagement with environment
      * Spend less time doing those isolating type things like repetitive behaviors. Branch out as much as you can.
    - Involve parents
  + **Methods**
    - Behavioral
      * Lovaas
        + Applied behavior analysis. Operant conditioning. Strictly behavioral, reward the behaviors you want to see continues and ignore the behaviors you do not want to see continue. Try to get the child to engage in appropriate behaviors. About 40 hours per week. Success varies.
      * TEACCH
        + Draws on the same principles as the Lovaas methods. Geared towards adolescences and adults. Structured environment for behavioral tasks. Go about their day in a predictable day that meets the criterion for repetitive routines. Independent functioning and independent living.
    - Biological: SSRIs
      * Controls hyperactivity and agitation
      * Antipsychotic medications are used with autistic individuals, it decreases self injury behaviors
      * The FDA has approved antipsychotic drugs in children as young as 5.