# Abnormal Psychology Final Exam Review

# DSM-IV Criteria for Each Disorder

## General Anxiety Disorder

* Excessive Anxiety and worry occurring more days than not for at least six months about a number of everyday, routine events, or activities such as finance, heath, being late, car repairs, work, school, children, etc.
* The person finds it difficult to control the worry
* The person feels at least three of the following
  + Restlessness, easy fatigue, irritability, muscle tension, and sleep disturbances
* The worry causes significant impairment or distress

## Panic Disorder

* Recurrent **unexpected** panic attacks – multiple panic attacks.
* At least a month of (Duration Criteria)
  + Persistent concern about having additional attacks
  + Worry about the implications of the attack, e.g., losing control (passing out and losing control for example) having a heart attack, or “going crazy” due to attacks
  + A significant change in behavior due to attacks
* Often are diagnosed with agoraphobia

## Agoraphobia

* Anxiety about being in places or situations from which escape may be difficult or embarrassing or in which help may not be available in the event of having a panic attack. Such as:
  + Being outside the home alone
  + Being in a crowd or standing in a line
  + Being on a bridge
  + Traveling in a bus, train, or automobile
* The situations are avoided
  + Or else are endured with marked distress
  + Very afraid to go out
  + Or with anxiety about having panic
  + Or require the presence of a companion

## Specific Phobia

* Marked and **persistent** fear that is **excessive** or **unreasonable**, cued by the presence or anticipation of a specific object or situation
* Exposure provokes an immediate anxiety response, sometimes to the point of panic
* Recognizes that the fear is unreasonable or excessive
* Phobic stimulus is avoided or endured with intense anxiety or distress
* Impairs functioning

## Social Phobia

* Marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or scrutiny by others
  + Fears he/she will be embarrassed or humiliated
    - Exposure provokes an immediate anxiety response, sometimes to the point of panic
* Recognizes that the fear is unreasonable or excessive
* Phobic stimulus is avoided or endured with intense anxiety or distress
* Impairs functioning
  + If your job has you communicate, host meetings, etc. it’ll be incredibly difficult
* Specify: Generalized
  + Applied if the person has an anxiety response to multiple social situations (public speaking, using the restroom, being around a group of people you don’t know, etc.)
  + Axis 1 – Social Phobia – Generalized **or** just Social Phobia if there is only one place where they can’t function

## PTSD

* Exposure to a traumatic event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others. During event, the person felt intense fear, helplessness, or horror.
* Traumatic event is persistently re-experienced, through recurrent and intrusive distressing recollections of the event, nightmares, flashbacks, or intense psychological distress when confronted with a “trigger”.
* Persistent symptoms of increased arousal, such as difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, hyper vigilance, or an exaggerated startle response.
* Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness. For example:
  + Avoiding thinking or talking about the trauma
  + Inability to recall an important aspect of the trauma
  + Diminished interest or participation in significant activities
  + Feeling detached from others
  + Restricted range of affect (outward show of emotional state)
  + Sense of a foreshortened future (Can’t view themselves as an elderly person)
* These symptoms have endured longer than a month.
* Length of Symptoms
  + 1-3 Months – Acute PTSD
  + 3+ Months – Chronic PTSD
  + **If they have not had it for a month they would be diagnosed with acute stress disorder**.

## Obsessive-Compulsive Disorder

* What are obsessions?
  + Persistent, intrusive, and distressing thoughts, impulses, or images.
    - Cleanliness or contamination. 55% of those with OCD have fears of contamination. 37% of those with OCD have symmetry. Sexual urges (32%). Somatic Concerns (Concerns about the body, health, etc.) is about 35%
    - Dangerous obsessions, they feel they’re going to stab someone if they see a knife. If they see a knife they feel they have to knock on the table four times. It’ll help them from hurting others
    - These are not simply excessive worries about real-life problems (else that’d be generalized anxiety disorder)
  + The person attempts to ignore, suppress, or neutralize the obsession with some other thought or action.
  + The person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind.
* What are compulsions?
  + Repetitive, ritualistic behaviors or mental acts that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly.
  + The compulsions are performed to prevent or “undo” some dreaded outcome.
  + Can be mental as well; knock on the wood four times. The key is that it undoes the original thought
  + At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable.
  + The obsessions or compulsions cause marked distress, are time consuming (take more than one hour a day), or significantly interfere with the person’s functioning.

## Major Depressive Disorder

* At least 5 of the below, almost everyday all day **for at least 2 weeks**. Must have one of first two symptoms listed. Green are related to behavioral and physiological, blue is cognitive, red is emotion/motivational component
  + Depressed mood most of the day
  + Diminished interest or pleasure in activities most of the day
  + Significant appetite/weight changes
  + Sleep problems
  + Psychomotor agitation or retardation (just slow)
  + Fatigue, loss of energy
  + Feelings of worthlessness, intense inappropriate guilt
  + Unable to concentrate or make decisions
  + Recurrent thoughts of death, suicidal ideation, or suicide attempt
* Significant distress or impairment; Not due to substance or medical condition; Not better accounted for by bereavement (response to significant death).

## Manic Episode

* A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least one week.
* During this period, 3 or more of the following present to significant degree:
  + Inflated self-esteem or grandiosity (superpowers, smartest person on earth, etc.)
  + Decreased need for sleep (one or two hours a night for example, **don’t feel tired**!)
  + Talkative, pressured speech (rapid speech, mile a minute like kaul)
  + Flight of ideas, racing thoughts
  + Distractible
  + Increase in goal directed activity or psychomotor agitation
  + Excess of fun but risky activity (promiscuous behavior, making risky business ventures, shopping sprees, etc.)
* Distress or impairment; Not due to substance or medical condition.

## Mixed Episode

* Meets criteria for both Manic Episode and Major Depressive Episode nearly **every day for at least one week**
* Mood disturbance causes significant impairment
* Not due to substance or medical condition

## Hypomanic Episode

* Distinct period of elevated, expansive, or irritable mood, lasting **at least 4 days**
* Same type of symptoms as in manic episode
* *NOT severe enough to cause marked impairment or to necessitate hospitalization*
* Can be seen with depression at the same time. Hypomanic by themselves aren’t awful, they just ten to turn into manic episodes

## Major Depressive Disorder

* Presence of a Major Depressive Episode
* Never been a Manic, Mixed, or Hypomanic Episode
* Either single episode or recurrent

## Dysthymic Disorder

* A Depressed mood for at least 2 years for most days
  + Poor appetite or overeating
  + Insomnia or hypersomnia
  + Low energy
  + Low self-esteem
  + Poor concentration or difficulty making decisions
  + Feelings of hopelessness
* C Symptoms absent for no more than 2 months total added up
* D No Major Depressive Disorder for first two years
* E Never Manic, Mixed, or Hypomanic Episode

## Bipolar I Disorder (Manic History)

* Presence of a Manic, Hypomanic, or Major Depressive Episode
  + If currently in a Hypomanic or Major Depressive Episode, history of Manic Episode
* Significant distress or impairment

## Bipolar II Disorder (Hypomanic + Depression)

* At least one or more Hypomanic Episodes, either past or present
* One or more Major Depressive Episodes, either past or present
* Never been a Manic or Mixed Episode
* Mood symptoms cause significant impairment

## Cyclothymic Disorder

* For at least 2 years, numerous periods of hypomanic symptoms and periods of depressive symptoms (not concurrent)
* Symptoms absent for no more than 2 months cumulatively
* No Major Depressive, Manic, or Mixed Episode
* Mood disturbance causes significant impairment; Not due to substance or medical condition

## Anorexia Nervosa

* Refusal to maintain body weight at or above a minimally normal weight for age and height
* Intense fear or gaining weight or becoming fat, even though underweight
* Disturbance in the way in which one’s body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of seriousness of the current low body weight
* In postmenarcheal females, amenorrhea – the absence of at least three consecutive menstrual cycles
* Types
  + Restricting
    - Restricting the amount of food intake and potential compensatory behavior (Exercise)
  + Binge-eating / Purging
    - Engage in purging through vomiting and laxatives
    - They’re still under 85% of their normal weight
    - Hair loss, skin discoloration, fine hair growth over body, dehydration

## Bulimia Nervosa

* Recurrent episodes of binge eating (2-40 per week)
  + Large food amount; Sense of lack of control over eating
  + Usually soft in texture and sweet because it goes down soft
* Recurrent inappropriate compensatory behavior in order to prevent weight gain
  + Vomiting, laxative use, use of enema, etc.
* The cycle occurs at least twice a week for 3 months
* Self-evaluation is unduly influenced by body shape and weight
* The disturbance does not occur exclusively during episodes of Anorexia Nervosa
* Types: Purging and Non-purging

## Substance Intoxication

* Temporary, clinically significant maladaptive behavioral or psychological changes
  + Due to the effect of the substance on the central nervous system
  + Develop during or shortly after use of the substance

## 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 lawnmoving, etc)
  + Recurrent substance use related legal problems (DUI, DWI, Posession, etc)
  + Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of a substance
* Axis 1 - Alcohol abuse or 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 3 or more of the following:
  + 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, shaking, 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
  + **Patterns of substance abuse for over at least one year.**
  + Because of the physiological dependency that’s how you tell the difference between dependence and abuse.

## 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 and pervasive
  + 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 the issues with the relationships.
  + Implications for treatment – Since they’re grained and pervasive you cannot really change them. There are no well-structured effective treatments.

## Generalized Diagnostic Criteria for PD

* 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, and 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

## Paranoid Personality Disorder (Cluster A)

* 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 or 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, i.e., 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

## Schizotypal Personality Disorder (Cluster A)

* 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

## Schizoid Personality Disorder (Cluster A)

* A pervasive pattern of detachment from social relationships and a restricted range of expression 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 affectivity

## Narcissistic Personality Disorder (Cluster B)

* Grandiosity, need for admiration, and lack of empathy, as indicated by five (or more) of the following
  + Grandiose sense of self-importance
  + Preoccupied with fantasies of unlimited success, power, brilliance, or ideal love
  + Believes he or she is “special” and unique and can only be understood by, or should associate with, other special or high-status people
  + Requires excessive admiration
  + Has a sense of entitlement, i.e., unreasonable expectations of especially favorable treatment or automatic compliance with expectations
  + Is interpersonally exploitative, ie takes advantage of others to achieve own ends
  + Lacks empathy; is unwilling to recognize or identify with the feelings of others
  + Envies others or believes others are envious of him or her
  + Shows arrogant, haughty behaviors or attitudes

## Histrionic Personality Disorder (Cluster B)

* A pervasive pattern of excessive emotionality and attention seeking, as indicated by five (or more) of the following
  + Is uncomfortable in situations in which not the center of attention
  + Often inappropriate sexually seductive or provocative behavior
  + Displays rapidly shifting and shallow expression of emotions
  + Consistently uses physical appearance to draw attention to self
  + Excessively impressionistic speech style, lacking in detail
  + Self-dramatization, theatricality, and exaggerated-expression of emotions
  + Suggestible, ie, easily influenced by other or circumstances
  + Considers relationships to be more intimate than they actually are

## Borderline Personality Disorder (Cluster B)

* Pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following
  + Frantic efforts to avoid real or imagined abandonment
  + A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of ideations and devaluation
    - Ideation: She’s the best. Devaluation: She’s actually the worst for you.
  + Intense disturbance: markedly and persistently unstable self-image or sense of self
  + Impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating, etc)
  + Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
  + Affective instability due to a marked reactivity of mood (e.g. intense episodic dysphoria, irritability, or anxiety lasting a few hours and rarely more than a few days)
  + Chronic feeling of emptiness
  + Inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights)
  + Transient, stress-related paranoid ideation or severe dissociative symptoms
* Splitting, dichotomous thinking
  + Splitting: Good and base person

## Antisocial Personality Disorder (Cluster B)

* There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following
  + Failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
  + Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
  + Impulsivity or failure to plan ahead
  + Irritability and aggressiveness, as indicated by repeated physical fights or assaults
  + Reckless disregard for safety of self or others
  + Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
  + Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another
* The individual is at least 18 years of age
* There is evidence of Conduct Disorder with onset before age 15 years
* The occurrence of antisocial behavior is not exclusively during the course of a schizophrenic or manic episodes

## Avoidant Personality Disorder (Cluster C)

* Social inhibition, feelings of inadequacy or hypersensitivity to negative evaluation, as indicated by four (or more) of the following
  + Avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection
  + Is unwilling to get involved with people unless certain of being liked
  + Shows restraint within intimate relationships because of the fear of being shamed or ridiculed
  + Is preoccupied with being criticized or rejected in social situations
  + Is inhibited in new interpersonal situations because of feelings of inadequacy
  + Views self as socially inept, personally unappealing, or inferior to others
  + Is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing

## Dependent Personality Disorder (Cluster C) – Buster from Arrested Development

* Excessive need to be taken care of, leading to submissive and clinging behavior and fears of separation, as indicated by five (or more) of the following
  + Has trouble making everyday decisions without excessive advice and reassurance from others
  + Needs others to assume responsibility for most major areas of life
  + Has difficulty expressing disagreement with others due to unrealistic fears of loss of support or approval
  + Has difficulty initiating projects or doing things on own due to lack of self confidence
  + Goes to excessive lengths to obtain nurturance and support from others, to the point of doing aversive things
  + Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for self
  + Urgently seeks another relationship as a source of care and support when a close relationship ends
  + Is unrealistically preoccupied with fears of being left to take care of self

## Obsessive Compulsive Personality Disorder (Cluster C)

* A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, as indicated by four (or more) of the following
  + Is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost
  + Shows perfectionism that interferes with task completion
  + Is excessively devoted to work to the exclusion of leisure activities and friendships
  + Is over conscientious, scrupulous, and inflexible about matters of morality, ethics, or values
  + Is unable to discard worn-out or worthless objects even when they have no sentimental value
  + Is reluctant to delegate tasks or to work with others unless they submit to exactly his/her way of doing things
  + Adopts to miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes
  + Shows rigidity and stubbornness

## Dissociative Identity Disorder (Used to be called Multiple Personality Disorder)

* Presence of 2 or more *distinct* identity or personality states. Usually have their own way of relating to the environment, stable, and thinking/perceiving about the environment
* At least 2 of these identities recurrently take control of the persons behavior
* Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness
* Disturbance not due to substance use or general medical condition

## Dissociative Amnesia

* One or more episodes of inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be explained by ordinary forgetfulness.
* Not part of another disorder, result of substance use or medical condition. No physical injury to account for memory loss
* They’ll remember facts such as the sun rises on the east, sets on the west, but will not remember their name.

## Dissociative Fugue

* Sudden, unexpected travel away from home or one’s customary place of work, with inability to recall one’s past
* Confusion about personal identity or assumption of new identity
* Usual exclusions (meds, substance, med condition, other disorder)

## Depersonalization Disorder

* Persistent and recurrent experiences of feeling detached from, and as if an outside observer of one’s mental processes or body
* Reality testing remains intact

## Hypoactive Sexual Desire Disorder (Sexual Desire Disorder)

* Uninterested in sexual activity and sexual fantasy and a resulting low level of sexual activity

## Sexual Aversion Disorder (Sexual Desire Disorder)

* Persistent or recurrent extreme aversion to, and avoidance of, genital sexual contact with a sexual partner

## Female Sexual Arousal Disorder (Sexual Arousal Disorder)

* Persistent or recurrent inability to attain or maintain adequate vaginal lubrication and the swelling response of sexual excitement

## Male Erectile Disorder (Sexual Arousal Disorder)

* Persistent or recurrent inability to attain or maintain an adequate erection.
* Usually over 50 years old

## Female/Male Orgasmic Disorder (Orgasmic Disorder)

* Persistent or recurrent delay in, or the absence of, orgasm following a normal sexual excitement phase

## Premature Ejaculation (Orgasmic Disorder)

* Persistent or recurrent ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes it

## Paraphilia’s

* Recurrent, intense sexual urges, fantasies, or behaviors that involve unusual objects, activities, or situations, and cause significant distress or impairment in important areas of functioning
* Behavior lasts for at least six months

## Schizophrenia

* **Two (or more) of the following for at least 6 months:**
  + Delusions
  + Hallucinations
  + Disorganized speech
  + Grossly disorganized or catatonic behavior
  + Negative symptoms
  + Dysfunctions – work, interpersonal relationships, self-care are markedly diminished

## Type I Schizophrenia

* Positive Symptoms
  + Delusions, hallucinations, etc.
* Relatively good premorbid adjustment
* A good responsiveness to traditional antipsychotic drugs
* Fair outcome of disorder
* Abnormal neurotransmitter activity

## Type II Schizophrenia

* Negative Symptoms
  + Blunted and flat affect, social withdrawal, etc.
* Relatively poor premorbid adjustment
* Poor responsiveness to traditional antipsychotic drugs
* Poor outcome of disorder
* Abnormal brain structures

## Schizophreniform Disorder

* Lasts 1-6 months
* Same symptoms as schizophrenia, except decline in functioning is not necessary
* Not likely to be the final diagnosis. Provisional Diagnosis.
* You use specifiers:
  + With good prognostic indicators
    - Absence of wanted or flat affect, rapid onset of psychotic symptoms, confused at height of psychotic episode
  + Without good prognostic indicators

## Schizoaffective Disorder

* Symptoms that meet criteria for schizophrenia, concurrent with either:
  + Major Depressive Episode
  + Manic Episode
  + Mixed Episode
* During the same time, there have been delusions or hallucinations without mood symptoms for 2 weeks (not a mood disorder with psychotic symptoms)
* Must have psychotic symptoms for one month

## Brief Psychotic Disorder

* A psychotic disturbance lasting more than one day but less than a month
* Normally have a full recovery
* There are specifiers with why they’re having the psychotic symptom
  + Without a marked stressor
  + With a marked stressor
  + With postpartum onset

## Delusional Disorder

* Nonbizarre Delusions (do occur in real life for some people) for at least 1 month
  + CIA is watching you, Mafia is after you, Barack Obama is in love with you, etc.
* Has never met criteria for schizophrenia
* Apart from delusions, functioning is not impaired and behavior not odd or bizarre
* Very late onset, between 40-55

## Shared Delusional Disorder

* A delusion develops in an individual in a context of a close relationship with another person who has an already established delusion
* The delusion is similar in context to the other persons
* If the pair is separated, the one with shared delusional disorder, typically gets better

## Psychotic Disorder Due to a General Medication Condition

* MS can induce psychotic symptoms. If they’re secondary to a medical condition they’re given this.

## Substance-Induced Psychotic Disorder

* If the psychotic symptoms are second to substance abuse, intoxication, or dependence. During intoxication or withdrawal. Hard to make a difference between this and Schizophrenia

## Psychosis NOS (not otherwise specified)

* If we don’t have enough information to make a specific diagnosis, symptoms do not meet full criteria for any particular disorder

# Models

## Psychoanalytical Model

* Behavior is determined largely by the underlying psychological forces, which the person is not consciously aware of. All internal forces are dynamic and abnormal symptoms result because of conflicts between forces.
* This model brings up two points
  + Deterministic Assumption – All behavior is determined by past events
  + The Unconscious Exists – Dreams and Freudian slips are examples
* Id, ego, and superego

## Behavioral Model

* Wattson and Skinner
* You learn through observable response.
  + Not stopping at a red light -> learn from accident

## Cognitive Model

* The cognitive model describes how people’s perceptions of, or spontaneous thoughts about, situations influence their emotional, behavioral (and often physiological) reactions.

## Which of those above views are in the current view of psychopathology?

* The integrative model. Biological, Psychological, Interpersonal, Developmental, and Emotion.

## Reciprocal Gene-Environment Model

* Genes shape how we create our environments
* Our traits may influence our likelihood of engaging in activities or seeking out situations that could trigger our vulnerabilities
* Examples: Drug addiction and antisocial behavior

## Diathesis-Stress Model

* Diathesis (Genetic) – A tendency to express traits or behaviors
* Stress (Environmental) – Life events or contextual variables

# Neurotransmitters

## Dopamine

* Controls the brain's reward and pleasure centers. Regulates emotional responses.
* Low Dopamine – Parkinson’s Disease & Higher Chance of Addictive Tendencies
* High Dopamine – Schizophrenia
* **Related to the following disorders:**
  + **Schizophrenia, Parkinson’s, etc.**

## Serotonin

* Regulates learning, mood, and sleep.
* **Related to the following disorders:**
  + **Panic Disorder, MDD, Bipolar, Anorexia/Bulimia,**

## GABA

* Inhibitory, helps calm those prone to anxiety.
* Lack of GABA causes anxiety
* **Related to the following disorders:**
  + **Generalized Anxiety Disorder,**

## Norepinephrine

* Stress hormone
* Regulates fight or flight response
* **Related to the following disorders:**
  + **Bipolar**

# Substance Abuse / Dependence

## DSM-IV and DSM-V Criteria for Substance Abuse & Dependence

Substance Abuse – DSM-IV

* 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 moving, 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
  + Axis I – Alcohol Abuse
  + Axis I – Polysubstance Abuse, Marijuana and Alcohol

Substance Dependence – DSM-IV

* A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by 3 or more of the following:
  + 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, shaking, 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 over at least one year.

## Etiology of Substance Abuse/Dependence

* Causes
  + **Integrative Model (Look at 10/18/2012)**
    - 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 however over time the positive effects go away there’s then negative reinforcement to not have to go through the withdrawal and/or stressed family life, etc.

* + - * Classical Conditioning Paradigm
        + Cues that cause cravings for the drugs. Being in a room where you used to use drugs
    - Cognitive Explanations
      * Expectancy Effects
        + What caused them to originally start the drug?
      * Cravings
        + Intensified cravings for drugs by cues or seeing someone else

## Treatment Strategies for Substance Abuse/Dependence

* Behavioral Treatments
  + Aversion Therapy
    - Pair with something aversive.
    - Antabuse for alcoholics
    - They 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 trouble relaxing, teach them other ways of relaxing.
    - Teach assertiveness and social skills to deal with peer pressure
* Cognitive-Behavioral Treatments
  + Relapse-prevention training
    - The goal is to maintain a period of recovery
    - Clarify the desire to quit and help identify triggers
* Biological Treatments
  + Detoxification
    - Controlled, medically assisted, withdrawal
    - Helps replace the substance they were using
    - Methadone for heroine
  + Antagonist Drugs
    - As long as they keep taking the drug it will block the positive effects of the substance they’re taking
    - Naltrexone for Heroine
  + Aversive Drugs
    - Antabuse for Alcohol
  + Drug Maintenance Therapy / Agonist Substitution
    - Delivering the drug in a more acceptable (less harmful) way
* Sociocultural Treatments
  + Self-help programs (Alcoholics Anonymous)
  + Community Prevention Programs – “Just Say No”

## Clusters for Personality Disorders

* **A – Odd or Eccentric**
  + Paranoid Personality Disorder
  + Schizotypal Personality Disorder
  + Schizoid Personality Disorder
* **B – Dramatic, Emotional, or Erratic**
  + Narcissistic Personality Disorder
  + Histrionic Personality Disorder
  + Borderline Personality Disorder
  + Antisocial Personality Disorder
* **C – Anxious or Fearful**
  + Avoidant Personality Disorder
  + Dependent Personality Disorder
  + Obsessive Compulsive Personality Disorder

## Stages of Normal Human Sexual Response Cycle

1. **Desire** – Sexual urges occur in response to sexual cues
2. **Arousal or Excitement** – Subjective sense of sexual pleasure; physiological signs of sexual arousal
3. **Plateau** – Continued state of increased arousal before orgasm
4. **Orgasm** – Sexual pleasures peak and sexual tension is released as muscles in pelvic region contract.
5. **Resolution** – Decrease in arousal and return to normal state. Females will go back to plateau stage.

# Schizophrenia

## Overview of Schizophrenia

* Loss of contact with reality
* Disorganized patterns of thinking
* Gross interferences with functioning
* Includes all dimensions of functioning
  + Thinking, emotions, behaviors, motor movements, etc.
* Emerges between late teens and mid-30s

## Positive Symptoms of Schizophrenia

* **Positive Symptoms -** The presence of something that is normally absent
* **Delusions** – Ideas that an individual believes whole-heartedly but has no basis in fact
  + **Delusions of Persecution**
  + **Delusions of Reference** – Something thinks something relevant has personal meaning for them. I.e. if you cough in class you’re trying to send a message.
  + **Delusions of Grandeur** – Being a messenger of god
  + **Delusions of Control** – Idea that someone else is controlling their behavior such as aliens, the government, etc.
* **Disorganization of thought and speech**
  + **Loose Associations** – Ideas jump from one to another, wandering father and farther away from the topic.
  + **Neologisms** – Made up words
  + **Perseveration** – Repetition of thoughts or statements
  + **Clanging** – Patterns of sounds seem to govern word choice rather than a logical pattern.
* **Hallucinations**
  + **Heightened perceptions and hallucinations** – Perceptions that occur in the absence of external stimuli
  + **Vague Perceptual Disturbances** (shadows), **oal factory** (smelling things), **tactile** (touch)
* **Inappropriate affect -** Emotions that are unsuited to the situation

## Negative Symptoms of Schizophrenia

* **Negative Symptoms -** The absence of something that is normally present (lack of affect, social withdrawal, etc.)
  + **Poverty of Speech (Alogia)** – Does not speak very much
  + **Blunted Affect (Flat Affect)** – Lack of an emotional response
  + **Loss of Volition (Apathy)** – Person loses their will to do things
  + **Social Withdrawal –** They do not want to be around other people

## Psychomotor Symptoms

* **Psychomotor Symptoms** - Disturbances in movement
  + **Catatonic Stupor** – Do not move, unaware of the environment.
  + **Catatonic Rigidity** – Will hold an upright posture for an incredibly long time. You cannot move them.
  + **Catatonic Posturing** – When somebody has a waxy type of flexibility.
  + **Catatonic Excitement** – When someone gets in an agitated space of physical motion. They’re jittery and unable to sit still

## Phases of Schizophrenia

* **Prodromal Phase**
  + The phase before someone becomes fully psychotic. Between 2-3 years in length. Decline in function
    - BIPS (Brief Intermittent Psychotic Symptoms)
      * Attenuated positive symptoms but at a minimum level
* **Active Phase**
  + Continue to see decline in functioning
  + The duration depends on how long they’ve waited before they get help from a psychiatrist
* **Residual Phase**
  + A return to premorbid (before the illness) level. Often times it does not get back to the same level.
* **Recovery**
  + A late and/or rapid onset and/or psychotic episode with a trigger (Stress) are all good things for getting into recovery

## Subtypes of Schizophrenia under DSM-IV

* **Paranoid** – Preoccupation with one or more delusions or frequent auditory hallucinations
* **Disorganized** – Disorganized speech and behavior, flat or inappropriate affect
* **Catatonic** – Primarily psychomotor disturbance, immobility or excessive motor activity
* **Undifferentiated** – do not fully meet one category
* **Residual** – Absence of prominent symptoms, continuation or attenuated/residual symptoms

## Etiology of Schizophrenia

* **Diathesis-Stress Model**
  + Schizophrenia is due to…
    - *Genetically inherited diathesis* (biological predisposition) and *environmental stress* (Certain kinds of psychological events, personal stress, or societal expectations)
* **Genetics**
  + Family Studies
    - The more closely one is related to individual with Schizophrenia, the more likely one is to develop the disorder
  + Twin Studies
    - Concordance rate for monozygotic twins: 46%
    - Concordance rate for dizygotic twins: 17%
  + Adoption Studies
    - Children of Schizophrenic parent who were adopted developed disorder at same rate as children of Schizophrenic parent who remained with biological parent
* **Dopamine Hypothesis**
* **Sociocultural**
  + **Social Labeling** – The idea that once somebody is labeled with an illness they start acting in a way that fulfills that label and becomes a self-fulfilling prophesy
  + **Family Dysfunction**
    - Schizophrenogenic Families
      * Those with schizophrenia in their family have high stress and are already not functional.
    - Expressed Emotion
      * Families with family members with schizophrenia have higher expressed emotion
      * Three components
        + Hostility
        + Criticism
        + Over involvement
* Neurodevelopmental
  + Early Problems with motor skills
    - Halting, jerky movements. They seem uncoordinated, whereas those that are healthy look normal.
  + IQ
  + Obstetric Complications
    - For individuals with obstetric complications, lack of oxygen, high blood pressure during third trimester, premature birth, etc. will have a higher rate of illness

## What truth is there / against the dopamine hypothesis?

* The Dopamine Hypothesis states that schizophrenia is connected to excess dopamine activity
* **For:** Research from phenothiazine’s, antipsychotic drugs that block the brain receptor’s sites for dopamine. They found that the degree of improvement was based on the potency of the drug, they also found that too much caused them to become jerky.
* **Against:** It has no specificity. Is it because there is *too much* dopamine or is it because their dopamine receptors are *more sensitive* or do they have *too many dopamine receptors*? If Schizophrenia were completely related to dopamine then there wouldn’t be a delay between the treatment and actually getting better. It’s far too simplistic. There is also ***not*** an excess of dopamine metabolites in their cerebral spinal fluid. There is also a high degree of relevance with serotonin since drugs that effect serotonin like LSD cause psychotic symptoms.

## Treatments for Schizophrenia

* Biological
  + Typical
    - Blocks the dopamine receptors
    - Side effects – extrapyramidal symptoms (Parkinson’s symptoms)
      * Tardive Dyskinesia – Involuntary movement of mouth and face. Continues for life even after medication is stopped.
  + Atypical
    - Blocks dopamine receptors and serotonin receptors
    - They have few side effects
* Psychological - Cognitive-Behavioral Therapy
  + Why adjunctive treatments?
    - Medications have little effect on the negative symptoms
  + Techniques
    - Strong focus on monitoring and coping
    - Use behavioral experiments
    - Use role-plays
    - fCBT – Focus on how the symptoms interfere with achieving goals, not symptom reduction
* Psychosocial
  + Insight Therapy – Therapists challenge patients statements, expresses opinions, and provides guidance
  + Family Therapy – Therapist offers guidance, training, practical advice, psych coeducation about disorder, and emotional support and empathy
  + Social Therapy – Therapist offers practical advice and tries to improve individual’s problem solving, decision making, and social skills

## DSM-V Changes to Schizophrenia

* There are no more subtypes under DSM-V except for “With Catatonic Features”

# Childhood/Developmental Disorder

## Childhood/Developmental Disorders

* **DSM-IV Pervasive Developmental Disorders**
  + **Autistic Disorder**
    - Social and communication impairment, restricted repetitive/stereotyped behaviors, interests, or activities
    - 3-4 times more prevalent in males
    - Familial transmission (Genetic Component)
  + **Asperger’s Disorder**
    - Higher functioning form of autism
    - They do not have language or communication deficits/delay
  + **Rett’s Disorder**
    - Exclusive female neurodevelopmental disorder with genetic link
    - Progressive delays from 6 months through adulthood (impaired motor functioning)
  + **Childhood Disintegrative**
    - “Heller’s Syndrome”
    - Normal development up to age 2 but then loss of skills to age 10
    - Caused by lipid storage diseases, subacute sclerosing panencephalitis, tuberous sclerosis
  + **PDD Not Otherwise Specified**
    - Diagnosis for those that do not meet the full criteria of other disorders

## DSM-V Changes to Autism

* **One unified label – *Autism Spectrum Disorder***
  + Subsumes Asperger’s, PDD-NOS, and Childhood Disintegrative Disorder
  + Rett’s Disorder will not be included since it has a chromosomal link (Chromosomal Disorder)
* **Reduced to Four Criteria**
  + Persistent deficits in social communication and social interaction
  + Restricted, repetitive patterns of behavior, interests, or activities
  + Symptoms must be present in early childhood
  + Symptoms together limit and impair everyday functioning
* **3 Specifiers by amount of support required for functioning**
  + Requiring Very Substantial Support
    - Institutionalized, cannot function on their own
  + Requiring Substantial Support
  + Requiring Support

## Etiology of Autism

* Psychological: Bad Parenting
  + They over interact with their children, etc.
* Biological
  + Genetic
  + Brain Overgrowth
    - Children with autism have bigger heads by 12 months of age.
    - At this point there will be behavior signs of autism
    - In Autism there is a failure of pruning, causing brain overgrowth. They normally have larger temporal lobes compared to most people. This is why children lose the ability to differentiate monkey faces as they grow up.

## Treatment of Autism

* Success varies, no one is ever cured. They learn to adaptively manage their autism.
* Basic Principles
  + Maximize engagement with the environment, the earlier the better
  + Involve the parents
* Methods
  + Behavioral
    - Lovaas
      * Applied behavior analysis. Operant conditioning. Strictly behavioral, reward the behaviors you want to see continue and ignore the ones you do not want to see continue. Roughly 40 hours per week.
    - TEACCH
      * Draws on the same principles as the Lovaas methods. Geared towards adolescences and adults. Structured environment for behavioral tasks. They go about their day in a predictable way that meets the criterion for repetitive routines. This is geared for independent functioning and independent living.
* Biological
  + SSRI’s
    - Controls hyperactivity and agitation
    - Antipsychotic meds are used with autistic individuals with self-injury behaviors as young as 5.

## DSM-V: 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 stereotypes, 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
* The theory is that the moving of the hands is a calming effect since they know how their hands are going to move, etc.

## DSM-V: Social-Communication

* Clinically significant, persistent deficits in social communication and interactions, as manifest by all the 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?

* Development of Theory of Mind (TOM)
  + Joint attention is at age 1
  + 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)

## Elements of ADHD

* Inattention, Hyperactivity, and Impulsivity

## Primary Treatment Strategies of ADHD

* Biological
  + Stimulants – Adderall, Strattera, and Antidepressants
* Psychological
  + Cognitive-Behavioral Intervention – Mainly used in adults
    - Try to combine short term and long term. If cognitive behavioral intervention works they’ll try not to use drugs.

## What are the general criterions for learning disorders? Descriptions? Look at table 14.1 on pg. 512

## Criterion for Intellectual Disability (Mental Retardation)

* Sub average IQ (Below 70)
* Concurrent deficits or impairments in present adaptive functioning in at least two of the following areas:
  + Communication
  + Self-care
  + Home living
  + Social/Interpersonal Skills
  + Use of community resources
  + Self-direct
  + Functional academic skills
  + Work
  + Leisure
  + Health
  + Safety
* Onset before 18

## What are characteristics of a good assessment?

* **Reliability** – The degree to which measures are consistent
  + Internal Consistency – Across items
  + Test-Retest – Across time
  + Inter-rater Reliability – Across raters
* **Validity** – The test measures what it is intended to measure
  + Face Validity – Appears to measure correctly; makes sense
  + Predictive Validity – Predicts future behavior
  + Concurrent Validity – Agrees with measures from other assessment techniques
* **Standardization** – The test is administered and scored the same way across individuals.

## Parts of the multi-axial system of DSM-IV

* Axis I – Major Disorders
* Axis II – Stable, enduring problems
* Axis III – Related medical disorders
* Axis IV – Psychosocial & Environmental Problems
* Axis V – Global Assessment of Functioning (0-100)

## Patterns of Suicide Attempts

* Highest rate is elderly, white, men
* Men are much more likely to complete suicide
* Women are more likely to attempt suicide

## What is a panic attack?

* Intense fear or discomfort, in which 4 (or more) of the following symptoms develop abruptly and peak within 10 minutes. Fairly common, 15% experience a panic attack in the world in their lifetime. The 15% would not qualify for a diagnosis, only 5% of the population goes on to develop the disorder.
  + Heart pounding, Sweating, Trembling, Shortness of breath, Sensation of choking, Chest pain, Nausea, Dizzy/faint/lightheaded, Derealization (feelings of unreality), Depersonalization (feeling detached from self), Fear of losing control/going crazy, Fear of dying, Numbness/tingling, and Chills/hot flashes/flushed

## How do you differentiate from Agoraphobia and Specific Phobia?

* When you have specific phobia you only have the fear response when IN the situation.

## What’s the difference between social phobia and avoidant personality disorder?

* Avoidant Personality Disorder focuses on monitoring self and other peoples reactions. You also see a high comorbidity with other disorder.
* Social Phobia – Focused on one situation.

## Fundamental Differences between DSM-IV and DSM-V

* DSM-IV is Categorical (and protypical)
* DSM-V will be Categorical/Dimensional Hybrid (and protypical)

## Definition of Abnormal

* Deviant – Social Norm vs. Statistical
* Distressing – Self vs. Others & Presence vs. Absence
* Dysfunctional
* Dangerous – Self vs. Others

## Definitions

**Fear** – Immediate, present-oriented. A response to something in the environment.

**Anxiety** – Apprehensive, future-oriented.

**Panic Attacks** – Abrupt experiences of intense fear. Occur at inappropriate times.

**Dissociative Disorders** – Mental processes that produce a lack of connection in a persons thoughts, memories, actions, or sense of their identity.

**Sexual Dysfunctions** - Disruption of the sexual response cycle or pain during intercourse

**Paraphilia -** Sexual desires or behaviors involving unusual sources of gratification

**Gender Identity Disorders** - Dissatisfaction with one’s own biological sex and a desire to change to the opposite sex. Doesn’t have to do with sexual desire or sexual orientation.

**Emotion** – Consists of cognition, behaviors, and physiology

**Equifinality** – The final point is the same.

**Neuropsych** **Test** – Function of the brain without being invasive.

**Shaping** – Successive approximation. For every bit closer the dog gets to doing a trick you give it a treat.

**Habituation** – Decreased response to a stimulus from the repeated presentation.

**Psychopaths vs. Antisocial** – Psychopaths have personality traits whereas antisocial is observable behavior

**OCPD** – Lack define obsessions and compulsions, rather they’re just really into cleanliness for example.

**Delayed Ejaculation** – New name for Male Orgasmic Disorder under DSM-V

**Reward Deficiency Disorder** – Unable to produce an adequate feeling of well being and are at a higher risk of becoming addicted.

**Thought-Action Fusion** – The idea that thinking something is as bad as doing it.

**Childhood Schizophrenia** – Under DSM I and DSM II only list “Childhood Schizophrenia” with autism as a characteristic

**Broader Autism Phenotype** – Most family members of those with autism show subclinical rates of autism (social awkwardness, etc.)

**Disruptive Disorders** – ADHD, ODD (Oppositional Defiant Disorder), CD (Conduct Disorder)

**Emotional Disorders** – Depression, separation anxiety, and other anxiety disorders

Note: Mental Retardation is Axis II.