# Shit I don’t know for the Abnormal Psychology Final

## 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

## 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

## 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

## 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

## 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.

## 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**

## 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

## 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

## 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”

## 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

## 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.

## 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

## 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)

## 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