# New Material for Abnormal Psychology

What does was her son born? 8th

Paraphilias: Theory and Therapy

* **The Behavioral Perspective**
  + **Classical Conditioning**
    - You bring a prepubescent boy into a shoe store. He gets horny but not originally because of the shoes. Shoes are not by themselves arousing but if you pair them they can be.
  + **Operant Conditioning**
    - Being around certain things is then reinforced through the process of having an orgasm. Say someone accidentally saw a person in a window naked, then went home and later had an orgasm. This orgasm reinforced the idea of naked people in windows.
  + **Treatment – Counter Conditioning**
    - Covert Sensitization – Masturbate while fantasizing about fetish, right before climax and then right before climax think of something aversive. I.e. someone walks in and catches them. After enough repetitions the stimulus will be uncoupled with the response.
    - Masturbatory Satiation – Works on basic idea of physiology. Ask the person to masturbate to orgasm with an appropriate stimulus (wife). Immediately afterwards ask them to fantasize their fetish or situation and to try to have another orgasm while fantasizing about this other thing. This then becomes unpleasant.
    - Orgasmic Reorientation – Become aroused while fantasizing about the object. Become aroused and start masturbating, before climax think about an appropriate stimulus (wife, gf, etc).

Schizophrenia

* **Overview**
  + **Loss of contact with reality**
  + **Disorganized patterns of thinking**
    - Hard time keeping coherent and logical train of thought. Really weird connection between thoughts.
  + **Gross interferences with functioning**
  + **Includes all dimensions of functioning**
    - Thinking, emotions, behaviors, motor movements, etc
* **Common Misperceptions**
  + Schizophrenia is **not** Dissociative Identity Disorder (Multiple Personality Disorder)
  + Individuals with schizophrenics **do not** tend to be violent towards themselves or others
    - 10% have violence; more often than not it’s towards them.
  + Not all cases are chronic
    - 1/3 are chronic, 1/3 are variable course of illness, 1/3 will have one and recover
* **Schizophrenia Symptoms**
  + **Positive Symptoms**
    - The presence of something that is normally absent (e.g., hallucination, delusions)
      * Delusions
      * Disorganization of thought and speech
      * Hallucinations
      * Inappropriate affect
  + **Negative Symptoms**
    - The absence of something that is normally present (lack of affect, social withdrawal)
  + **Psychomotor Symptoms**
    - Disturbances in movements
* **Positive Schizophrenic Symptoms**
  + **Delusions**
    - Ideas that an individual believes whole-heartedly bit have no basis in fact.
      * Delusions of persecution – Someone is trying to harm you in some way.
      * Delusions of reference – Somebody thinks something relevant has personal meaning for them. Thinking that if someone coughs during class they’re trying to send you a message.
      * Delusions of grandeur – Being a messenger of god, angel, being god themselves
      * Delusions of control – Idea that someone else in controlling their behavior. Aliens, government, etc
  + **Disorganization of thought and speech**
    - Loose Associations
      * Ideas jump from one to another, with the result that the person wanders further and further away from the topic.
    - Neologisms
      * Made up words
    - Perseveration
      * Repetition of thoughts or statements
    - Clanging
      * Pattern of sounds seem to govern word choice rather than logical patterns.
  + **Hallucinations**
    - Heightened perceptions and hallucinations
      * Feeling that sensations are being flooded
      * Perceptions that occur in the absence of external stimuli
    - Vague perceptual disturbances (shadows), oal factory( smelling things), tactile (touch) feeling something is crawling on them, head or body is shaping in size
  + **Inappropriate affect**
    - Emotions that are unsuited to the situation
* **Negative Symptoms**
  + **Poverty of Speech (Alogia)**
    - Does not speak very much or the content lacks. Those with positive symptoms will be very talkative, those with negative symptoms will get nothing when you’re trying to engage with them (one or two word short answers)
  + **Blunted Affect (Flat Affect)**
    - Lack of an emotional response
    - No changes in facial expression, no indication they’re responding to you in any way or experiencing emotion.
  + **Loss of Volition (Apathy)**
    - Person loses their will to do things. It’s hard for them to get up and feel motivated to do things.
  + **Social Withdrawal**
    - They do not want to be around other people, not because they’re afraid but they just don’t want to be around them.
* **Psychomotor Symptoms**
  + **Catatonic Stupor**
    - Do not move. Unaware of the environment. You could throw balls at their head and they wouldn’t do anything.
  + **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. They stay in the position in which you put them.
  + **Catatonic Excitement**
    - When someone gets into an agitated space of physical motion. Jittery, unable to sit still, have feelings that they have to get up and move around.
* **Course of Disorder**
  + **Usually emerges between late teens and mid-30s**
    - Not normally seen in a child
    - For males, late teens to mid 20s.
    - For females, early 20s to early 30s.
      * More likely to have degree since they get degree before they are diagnosed
  + **Course varies, but generally 3 phrases**
    - Prodromal Phase
      * Before the person becomes fully psychotic. This is for example the day before you know you have a cold when you nose is itchy. Very long, between 2-3 years. Most people do not know they’re in it until it’s already passed into the active phase. Decline in function (school or occupational). Some may have little psychotic symptoms.
        + BIPS (Brief Intermittent Psychotic Symptoms)

Attenuated Positive Symptoms (delusions, hallucinations, etc) but they are at a minimum level.

They’ll hear voices for 2 minutes a day, but they can easily dismiss them.

* + - Active Phase
      * Continue to see decline in function
      * The duration depends on how long they’ve waited before they get help from a psychologist.
    - Residual Phase
      * A return to premorbid (before the illness) level. Often times it does not get back to that 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
* **Diagnostic Criteria for 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
* **DSM-V Changes**
  + **No more subtypes under DSM-V except for “With Catatonic Features”**
* **Schizophrenia: Associated Features**
  + Dysphoric Mood – increased level of anxiety and depression
  + Anhedonia – Loss of pleasure
  + Disturbance in sleeping and eating patterns
  + Inability to concentrate
  + Lack of insight – Can fluctuate over the course of the illness
* Subtypes of Schizophrenia
  + 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
* **Type I vs. Type II Schizophrenia**
  + **Type I**
    - 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**
    - 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
* **Schizophrenia: Etiology**
  + **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
* **Etiology: Biological**
  + **Neurotransmitters**
    - Dopamine Hypothesis
      * Schizophrenia is connected to excess dopamine activity
      * **For:** Stems from research on phenothiazenes, a class of antipsychotic drugs that block the brain’s receptor sites for dopamine. Degree of improvement they show is based on the potency of the drug. They will show jerky movement if they’re treated with too much dopamine. Too much dopamine schizophrenia, too little it’s Parkinson’s. Amphetamine, which release dopamine, can release psychotic symptoms.
      * **Against:** Has no specificity. Is it because it’s too much dopamine or their dopamine receptors are more sensitive or do they have too many dopamine receptors. If it is fully related to dopamine then there shouldn’t be a delay between the treatment and actually getting better. Saying it’s just dopamine is too simplistic. In people who have schizophrenia you don’t see an excess of dopamine metabolites in their cerebral spinal fluid.
      * High degree of relevance with serotonin. Drugs that effect serotonin like LSD can cause psychotic symptoms.
  + **Brain Structure**
    - Ventricular Size – Increased
      * Open spaces in your brain that has cerebral spinal fluid.
    - Frontal Cortex – Reduced Volume
      * Higher level thinking; inhibition, etc. are reduced in size.
    - Temporal Lobes – Reduced Volume
      * Sensory area, auditory area
    - Amygdala – Reduced size in amygdala
  + **Prenatal Brain Injury**
    - Those with schizophrenia are more likely to have a prenatal brain insult (virus, birth complications,
    - Lack of vitamin D or sunlight exposure
    - More likely to have schizophrenia if born in winter months
* **Etiology: Sociocultural**
  + **Social Labeling**
    - The idea that once somebody becomes labeled with an illness, they then start acting in a way that fulfills that label and it becomes a self fulfilling prophecy
  + **Family Dysfunctioning**
    - Schizophrenogenic Families
      * Those with schizophrenia in their family have been high stress, not functional, etc
    - Expressed Emotion
      * Families with family members with schizophrenia have higher expressed emotion
      * Three components
        + Hostility – Blames the patient
        + Criticism – Highly critical of the individual
        + Over involvement
        + A relapse is 4x as higher for those in an overinvolved family
    - Bi-directional Interactions
      * Patient -> Family and Family -> Patient. They wil say they do not have family support.
* **Etiology: Neurodevelopmental**
  + **Weinberger’s Model – GOOGLE THIS SHIT!**
  + **Early Problems with Motor Skills**
    - Halting, jerking movements. They seem uncoordinated, whereas those that are healthy they look normal. Researcher looked at baby videos of the schizophrenic at age one and two.
  + **IQ**
    - Low(er) IQ
  + Obstetric Complications
    - For individuals with obstetric complications, lack of oxygen, high BP during third trimester, premature birth, etc they will have higher rates of illness.
* **Casual and Maintaining Factors**
  + **Social Factors**
    - Premorbid Functioning – Those with a low premorbid functionality have a higher relapse rate
    - Social Problem Solving – Tend to generate fewer solutions for a problem and are overconfident in the solutions they do provide.
    - Social Skills
    - Social Cognition – How you think about other people. Schizophrenics will say that they wanted to do XYZ to them.
    - Social Networks – Reduced social networks. Primarily family and limited.
  + Environmental Factors
    - EE – Rates of relapse for EE is 4x as high.
    - Life Events - ???
    - Social Class - When things start to get odd for someone, people tend to move into the cities. Once somebody gets there it’s easy for him or her to fall through the cracks. Then they get stuck there. Increased stress.
    - Season of Birth – Causal
* Treatment
  + Medication
    - Typical
      * Blocks the dopamine (D2) receptor
      * Side effects – extrapyramidal symptoms (Parkinson’s symptoms)
        + Tardive Dyskinesia – Involuntary movement of mouth and face. Once off medication it continues for life
    - Atypical
      * Blocks D2 receptors and the serotonin (5-HT2) receptor
      * Fewer side effects
  + CBT
    - Why adjunctive treatments?
      * Medications have little effect on negative symptoms
      * 25-50% still experience residual symptoms
      * 45-60% are noncompliant with medication
    - Techniques
      * Strong focus on monitoring and coping
      * Use behavioral experiments
      * Use role-plays
      * fCBT – Focus on how symptoms interfere with achieving goals, not symptom reduction
* **Treatment: CBT**
  + **Why adjunctive treatments?**
    - Medications have little effect on negative symptoms
    - 25-50% still experience residual symptoms
    - 45-60% are non-compliant with medication
  + **Techniques**
    - Psychoeducation
    - Strong behavior focus on monitoring and cooing
    - Using behavioral experiments
      * Example: The patient who thought she was the therapist and Dr. Pinkham was the client.
    - Use role-plays
    - fCBT – Focus on how symptoms interfere with achieving goals, not symptom reduction
  + **Efficacy**
* **Treatment: Pscyhosocial**
  + **Insight Therapy:** Therapist challenges patients statements, expresses opinions, and provides guidance
  + **Family Therapy:** Therapist offers guidance, training, practical advice, psychoeducation 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
* **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**
  + **Nothing changes in DSM-V Criteria!**
* **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**
  + **DSM-V Changes**
    - In order to be diagnosed with this you must have mood disturbances for one third of the psychotic illness
  + **Specifiers**
    - Bipolar (Manic or Mixed)
    - Depressive (major Depressive Episode)
* **Schizoaffective vs Schizophrenia + Mood Disorder**
  + **Mood Disturbance for a substantial part of the psychotic illness for Schizoaffective**
* **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**
    - **You cannot hear as well, see as well, and they might try to explain these unusual perceptions they’re having. You may see this in early dimensia**
  + **More common in female**
  + **Types of Delusions**
    - Erotomanic
      * Person believes who is typically of a higher status is in love with them. Not normally a sexual interest.
    - Grandiose
      * Having a special (not romantic) with someone of higher interest. Hillary Clinton is your best bud.
    - Jealous
      * Believe your partner is unfaithful to you, unfounded beliefs
    - Persecutory
      * Related to paranoia
    - Somatic
      * Some bodily function is not working correctly. Body is misshapen or ugly. I think there’s a foul odor coming from my skin.
  + DSM-V Changes
    - This is now going to include bizarre delusions as well
    - Specifiers
      * Bizarre Delusions
      * Shared Delusions
* **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**
  + **DSM-V Changes**
    - **Nix Shared Delusional Disorder**
* **Others…**
  + **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.
    - Examples
      * Someone who has only auditory hallucinations. They’d get Psychosis NOS.
      * Psychosis for less than a month but not remitted, Psychosis NOS. A fill in until Schizophreniform
      * If we know they have psychosis but we can’t come up with a cause
* **Disorders of Childhood**
  + **Disruptive Disorders**
    - ADHD
      * 3 Primary Characteristics of ADHD
        + Inattention, Hyperactivity, and Impulsivity
    - ODD
      * Oppositional Defiant Disorder
    - CD
      * Conduct Disorder
  + **Emotional Disorders**
    - Depression, separation anxiety, other anxiety disorders
    - Depression
      * Disturbed sleep, irritability,
  + **Developmental Disorders**
    - Autism (axis 1), mental retardation (axis 2), disorders of learning
  + **DSM-IV Pervasive Developmental Disorders**
    - Autistic Disorder
      * Social impairment
      * Communication impairment
      * Restricted repetitive/stereotyped behaviors, interests, or activities
    - Asperger’s Disorder
      * Higher functioning form of autism
      * Normal language with single word by age 2 – phrases by age 3
    - Rett’s Disorder
      * Exclusive female neurodevelopmental disorder with genetic link
      * Progressive delays from 6 months through adulthood-apraxia (impaired motor function)
    - Childhood Disintegrative
      * “Heller’s Syndrome” Normal development up to age 2 but then loss of skills to age 10
      * Causes by lipid storage diseases, subacute sclerosing panencephalitis, tuberous sclerosis
    - PDD Not Otherwise Specified
      * Diagnosis for those that do not meet full criteria for other disorders
* **A Brief History of Autism**
  + **Leo Kanner, 1943: “Autistic Disturbances of Affective Contact”**
    - “Fundamental disorder in the children’s ***inability to relate themselves*** in the ordinary way of people and situations from the beginning of life.”
  + **Hans Asperger, 1944: “Autistic Psychopathy in Childhood”**
    - “Little professors”
    - “Severe and characteristic difficulties of social integration”
  + **Both shared ideas of social difficulties. Both use the word Autism as well.**
* **Autism as a Diagnosis**
  + **“Autism” coined to characterize the “relative and absolute predominance of the inner life” observed in patients with schizophrenia (Bleuler, 1911)**
  + **DSM I (1952) and DSM II (1968) only list “childhood schizophrenia”, with autism as a characteristic**
  + **Autism, as a distinct disorder, appeared in DSM III (1980)** 
    - Research during the 1970s key for differentiating autism and schizophrenia
      * Developmental timelines very differently
      * SCZ and autism do not co-occur in families
        + A child with autism has no higher chance in getting diagnosed with schizophrenia later on in life
  + **If they don’t have language and communication deficits/delays then they’re given a diagnosis of Asperger’s**
  + **Other associated characteristics:**
    - Abnormal sensory issues
    - Hyperactivity
    - Self injury
    - Abnormal sleeping habits
    - Gastro intestinal issues (more likely in lower functioning individuals)
  + **The lead author falsified data to say that autism was caused by vaccines**
* **Autism Today: Basic Characteristics**
  + **Affects all ethnic and socioeconomic groups**
  + **3-4 times more prevalent in males**
  + **Familial transmission (Genetic component)**
  + **Soaring Prevalence Rate:**
    - Autism has always been there
    - Increase in parental age
    - The expanding definition of autism
    - Better diagnosis at both ends
      * Differentiating at the lower end
      * Identification at the higher end
    - Increased awareness by practitioners and families
    - Social factors: Parental age / Assortative Mating
      * Like minded individuals are finding each other and procreating
      * Broader Autism Phenotype: Most family members of those with autism show subclinical rates of autism (social awkwardness, etc)
        + They may find each other and have a kid. If two positive people have a kid they’re going to have a higher possibility of having the kid
        + Highest rates of autism are in silicon valley and North Carolina
    - Other yet unexplained contributions?
      * No empirical support for infant vaccines as a cause
      * Cannot yet rule out other environmental factors (mercury, etc)
    - Is it an epidemic?
      * Probably not, it’s rather just higher public awareness.
* **DSM-V Changes**
  + **One unified label: *Autism Spectrum Disorder***
    - Subsumes Asperger’s syndrome, 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
* Why these changes?
  + Why combine all of these diagnoses?
    - Research does not support distinction between disorders
    - Mirrors the broader movement within psychiatry to view disorders dimensionally rather than categorically
  + Why only two primary syndrome categories?
    - Social and communication deficits are inseparable
    - Removal of language delay from criteria
      * Not “Unique or universal” to ASD
    - Fixated interest and certain repetitive behaviors are distinctive
      * There is an overlap with autism and OCD, but people with autism do not have the obsessions only the compulsions. They just don’t have the fear that something bad is going to happen, they just like their schedule.
  + Controversy
    - Elimination of Asperger’s Syndrome
      * Less stigmatizing diagnosis is now gone.
    - More restrictive criterion
* DSM-V: Restricted and Repetitive Behavior (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
  + 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-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)
      * Look at the powerpoint on BB
    - Deception, sarcasm, irony, faux pas, metaphor (8-11)
    - *Superior Temporal Sulcus – look this up*
* 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.