Schizophrenia & Related Disorders and Treatments

Be able to identify myths vs facts about schizophrenia

- Not dissociative identity disorder
- Not associated with dangerous behavior
- Myth that it can't be treated (e.g. people institutionalized/homeless permanently)
- Myth that the only symptoms are hallucinations/delusions

Need to rule out substance abuse before diagnosis

- Substance-induced psychotic disorder
- Intoxication
- Synergistic effects (mixing drugs and their impact)
- Withdrawal
  - Drugs can't give you schizophrenia, but if you are predisposed certain drugs might trigger the underlying predisposition

Other rule outs: brain injury, neurocognitive disorder, recent head trauma, other medical conditions (tumors, delirium…)

Schizophrenia Spectrum Disorders (look in the book)

- Each has certain durations and set of symptoms
- Similarity to schizophrenia
  - Brief Psychotic Disorder
    - Symptoms 1 day to 1 month
  - Schizophreniform Disorder
    - 1 month and less than 6 months
  - Delusional Disorder
    - Non-bizarre but false beliefs
    - Without any other symptoms of Schizophrenia
  - Schizoaffective Disorder
    - Accompanied by major depressive and or manic episode or symptoms

        - Psychotic symptoms are more consistent, aren't centralized to just when depressed
    - Mood disorder with psychotic features
        - Psychotic or catatonic symptoms that occur exclusively during manic or major depressive episodes
        - Only when episodes of mania or depression
    - Schizotypal, Schizoid and Paranoid Personality Disorder
        - Characterized by personality features that are subthreshold (minor) versions of many of the symptoms of Schizophrenia
            - Odd beliefs, perceptual distortions, odd thinking/speech, social anxiety…
    - PTSD
        - Flashbacks with a similar feel to hallucinations
        - Hypervigilance may be paranoid like
        - Exposure to a traumatic event
        - No other positive/negative schizophrenic symptoms
- **Psychosis**: Loss of contact with reality
    - Hallucinations: false sensory experience
    - Delusions: false beliefs (maybe a conspiracy theory)
    - A most common symptom associated with Schizophrenia

Be able to identify the symptoms (specific terms) and criteria of schizophrenia: 3 types of symptoms

- Positive: extra (excess+additions of thought, emotion, or behavior)
    - Hallucinations
        - Seeing/hearing/smelling something not there
        - Experiencing those sensations: brain imagining
            - The brain is activating things that they are seeing and hearing
    - Delusions
        - Persecution: out to get me
        - Reference: about yourself (news is about you or messages to you)

        - Grandeur: some importance that is not accurate
        - Control: someone has control of you or you have control
            - Can have one or several types of delusions
    - Disorganized thinking or speech
        - Loose associations (derailment)
        - Neologisms: made-up words
        - Perseveration: say the same thing over and over again
        - Clang or rhymes
    - Inappropriate affect
        - Situationally unsuitable (laughing at a clown in a funeral)
        - May sometimes be an emotional response to other disorder features
- Negative: deficits
    - Poverty of speech (alogia)
        - Reduction of the quantity of speech or content
        - May also have little meaning
    - Restricted affect
        - Less emotion
        - Avoidance of eye contact
        - immobile/expressionless
            - Blunted affect
            - Flat affect
    - Loss of volition
        - Feeling drained of energy/interest in normal goals
        - Unable to follow through
        - Ambivalence: conflicted feelings about most things
        - Social withdrawal
- Psychomotor
    - Slow and awkward movement
    - Repeat grimaces
    - Unusual gestures: movements seem to have a magic quality

        - Extreme symptoms collectively called *catatonia*: rigidity, posturing, experienced about 10%
    - Criteria: 1 month of 2 or more symptoms (delusions, hallucinations, disorganized speech, and or negative symptoms), the problem in their life because of it, impairment in functioning for 5 months… (6 months total)

Course of Schizophrenia

- Usually first appears: late teens-early twenties (men) or late twenties and mid-thirties (women)
- 3 Phases
    - *Prodromal*: the beginning of deterioration, mild symptoms
    - *Active*: symptoms become apparent
    - *Residual*: return to prodromal-like levels
        - Fairly functional stage
        - 75% continue to have residual problems or go back to active phases
        - Some phases can last days or years

Best prognosis

- With good premorbid functioning
- Whose disorder triggered by stress
- With abrupt onset
- With later-onset (during middle age)
- Who receive early treatment

- **Type 1**: More positive symptoms (BETTER RESPONSE TO TREATMENT)
    - Linking to biochemical brain abnorms
    - Later onset, better adjusted prior to symptoms
    - Better likelihood of improvement
- **Type 2:** More negative symptoms
    - May be linking to structural brain abnormalities

- Not going to be as impacted by medications (more of a lifelong thing probably)

Explanations: For Schizophrenia

- Biological (has most research support)
  - **Structural brain abnormalities**
    - Enlarged VENTRICLES; abnorms in hosts of brain structures- smaller amounts of brain matter
    - Smaller temporal and frontal lobes
    - Smaller amounts of gray matter
    - Abnormal blood flow to certain areas: critical to thinking
  - **Genetic Theory**
    - Inheritance and brain activity play key roles
    - **Diathesis-stress theory**
      - Predisposition *vulnerability*
      - Develops only if experiences intense and or several life stressors
    - Research support
      - Relatives of people with schizophrenia
      - Biological relatives of adoptees
      - Twins with
        - Identical: 48% chance for both
        - Fraternal: 17% chance for both
  - **Dysfunctional brain circuit (not working properly)**
    - Prefrontal cortex: thinking
    - Amygdala: process emotion/fear
    - Hippocampus: memory
  - **Dopamine hypothesis**
    - Some neurons using dopamine fire too often (producing symptoms)

- Messages traveling from dopamine-sending neurons to dopamine receptors on other neurons transmitted too easily or too often
- Based on the effectiveness of antipsychotic medications
- Challenged by atypical antipsychotics that bind to D1, D2, and D4 and Serotonin receptors
- *Related to Dopamine and Serotonin receptors*

■ **Prenatal Viral Exposure**

- Interrupts fetal brain development
- May triggered by changes in hormones or other viruses
- Evidence
  - Animal model investigations
  - Correlations of late winter births and mother influenza exposures
  - Antibodies to certain viruses of people with schizophrenia
- Immune system: microglia (brain immune cells to reduce inflammation) is especially active in brains of those with schizophrenia

○ Psychodynamic:

■ Develops from regression to pre-ego stage of primary narcissism and efforts to reestablish ego control

- Self-focused symptoms (delusions, grandeur…)

■ Schizophrenogenic Mother

- Blame on families
- Show that mothers were blamed for being cold or dismissive and without nurture
  - Not true: but negative emotions exaggerate the issue

■ Self-Theory: fragmented self

○ Cognitive Behavioral:

■ Operant conditioning: circumstances support; more recently viewed as a partial explanation

■ Misinterpretation of unusual sensations: no direct research support

- Socio-Cultural
  - Social labeling
    - Features of schizophrenia are influenced by diagnosis (self-fulfilling prophecy)
  - Rosenhan pseudo-patient study
    - Told to act out symptoms
    - Once they were diagnosed, nurses treated them like so
    - Causes experiences
  - Family dysfunction
    - Schizophrenia linked to family stress
    - High expressed emotion in the family tied to relapse
    - May be difficult to live with
  - Multicultural factors
    - Racial and ethnic group differences in rates of
    - African Americans are more likely to receive this diagnosis
      - More prone?
      - Misread cultural differences?
      - Economic hardship/life stress/low SES
      - Biased diagnosis?
  - Developmental Psychopathology
    - Applies to an integrative and developmental framework
    - Primarily talking about biology
    - Individual's genetic predisposition is implemented by a dysfunctional brain circuit
    - May eventually lead to schizophrenia if, over the course of development, he or she experiences significant stress, difficult family interactions, and or other negative environmental factors.
- Downward Drift

Treatments for Schizophrenia

- Past institutional care: over-diagnosing and not managed well

        - The primary goal to restrain and meet basic needs
        - Overcrowding understaffing… poor patient outcomes (lobotomies)
    - Milieu Therapy (1950's)
        - Creating an environment of activities, engagement, interaction, self-respect
        - Positive care
    - Token Economy: CBT
        - Perform a behavior get a reward or withhold the reward
    - Antipsychotic medications (main thing that became helpful)
        - **Antihistamines**: calming (previously used for allergies)
            - First - generation antipsychotics/ conventional
                - Reduced + symptoms in 70% of patients
                - Improvements within the first 6 months
                - Extrapyramidal side effects of first generation : Physical Symptoms
                    - Parkinsonian and related symptoms: muscle tremor, rigidity, bizarre movements…
                        - Reduction of dopamine in movement structures is what causes it (reversed with anti-parkinsonian drugs)
                    - Neuroleptic malignant syndrome (worst side effect)
                        - Potentially fatal
                        - Muscle rigidity, fever, altered consciousness…
                        - Usually in elderly
                    - Tardive Dyskinesia
                        - Writhing, tic-like involuntary movements
                        - Similar to symptoms
                        - Overlooked
                        - Difficult to eliminate
            - Second - generation antipsychotics

        - A typical, drug of choice
        - At least as effective or more effective than first-gen
        - Reduce many positive and negative symptoms
        - Side effects
            - Fewer extrapyramidal symptoms and less tardive dyskinesia
            - Agranulocytosis (like threatening drop in white blood cells)
            - Weight loss, dizziness…
    - Psychotherapy adjunct to antipsychotic medication
        - Cognitive-behavioral therapies
        - Sociocultural interventions: FAMILY THERAPY
- Cognitive-Behavioral Therapy
    - Goal: Help manage hallucinations
        - Help with attention planning
        - Educate on underlying biological causes
        - Identify events and triggers
        - Challenge inaccurate ideas
        - Reattribution better interpretations
        - Education on coping
    - New Wave of CBT
        - Hallucinations should be accepted rather than misinterpreted or overreacted to
        - Accept streams of problematic thoughts
        - Help gain a greater sense of control, become more functional, and move forward in life
- Family Therapy
    - Address conflict, more realistic expectations, family psychoeducation, referral to support groups…
    - High levels of expressed emotion is a factor for relapse
- Social Therapy

        - Address social and personal difficulties in clients' lives
            - Practical advice, problem-solving, decision making, employment counseling…
        - Research shows that this approach reduces rehospitalization
- Be familiar with the Community Mental Health Act
    - Assertive community treatment
        - Medication and psychotherapy
        - Handling daily pressures and responsibilities
        - Guidance in making decisions
        - Social skills training
    - Community treatment failure
        - Fewer than half of all people who need them receive appropriate community health services
            - Poor coordination of services
            - Shortage of services
            - Consequences
                - No treatment or short-term help/premature discharge
                - Inadequate follow-up
                - homelessness

Chapter 16: Personality Disorders

Normal personality traits vs. Personality Disorder traits

- Personality: unique and long-standing pattern of inner experience that influence outward behaviors and interactions
- Personality traits: particular, predictable, flexible characteristics
- Personality disorders: an enduring, *rigid* pattern of personality traits and *leads to significant problems and psychological pain* for self and others

- Know the "Big Five" Theory of Personality
    - *Openness to experience*
        - **High**: intellectually rounded, broad, insightful, imaginative + creative, artistics, independent, daring, non-traditional

        - **Low**: narrow-minded, unimaginative + conventional, simple, down-to-earth, traditional, conservative, narrow interests
    - *Conscientious*
        - **High**: hard-working, self-disciplined, responsible, reliable, dutiful, organized, preserving
        - **Low**: relaxed, "chill," disorganized, unreliable, lazy, flaky, impractical, inefficient, careless, negligent
    - *Extraversion*
        - **High** (extraverted): higher levels of good feelings, sociable (energized by others), talks sooner, more eye contact, firmer handshake, excitement (seeking, more impulsive, risky)
            - **"Geared to respond**:" better divided attention, resistance to distraction, resistance to interference, better short-term recall + learning style: speed over accuracy
        - **Low** (introverted): lower levels of good feelings, withdrawn (energized by alone time), contemplative and deliberate
            - **"Geared to inspect:"** better at tasks requiring vigilance and careful attention to detail, long-term memory for words, and perform better when sleep deprived + learning style: accuracy over speed
    - *Agreeableness*
        - **High**: nice, empathetic, affectionate, cooperative, accommodating, trusting, altruistic, compliant, loyal, committed, tender, dependent, conflict-avoidant
        - **Low**: straight-forward, hesitant, questioning, suspicious, debating, critical
    - *Neuroticism*
        - **High**: higher levels of negative emotions, anxious/worried, distressed, tense, moody, hostile, vulnerability, hypochondriasis, lonely, insecure, less satisfied in relationships, college students (more likely to feel homesick)
        - **Low**: lower levels of negative emotions, calm/relaxed, hardy, secure

Be familiar with each Personality Disorder:

- Paranoid Personality Disorder

  A personality disorder marked by a pattern of extreme distrust and suspiciousness of others.

  - High N, Low E, Low O
  - **Characteristics**: cold and distant affect, difficulty establishing intimacy (limited close relationships), excessive trust in own ideas and abilities (critical of weakness/fault in others), suspicion is usually not "usual" (may be rational or can involve elaborate themes/conspiracies)
  - **Supporting theories**:
    - Psychodynamic: early interactions with demanding parents → lack of trust → suspicion
    - Cognitive: maladaptive assumptions (i.e. "people are evil and will attack you if given the chance")
    - Biological: genetic causes (supported by twin studies)
  - Treatment:
    - Challenges: few come to treatment willingly, others distrust and rebel against their therapists, treatment is slow, and gains are limited
    - Psychodynamic: object relations, self-therapy
    - Behavioral: anxiety reduction, interpersonal problem-solving improvement
    - Cognitive: develop more realistic interpretations of others
    - Biological: antipsychotic medications
- Schizoid Personality Disorder - A personality disorder in which a person persistently avoids social relationships and shows little emotional expression. (Batman)
  - Low E, Low O
  - Characteristics: avoidance of social relationships (prefers to be alone/reclusive, poor social skills, lack of enjoyment of others, lack of intimacy/interest, generally unaffected by praise or criticism), little emotional demonstration (emotionally flat, humorless)

        - Supporting theories:
            - Psychodynamic: (particularly object relations) link between disorder and an unsatisfied need for human contact (possibly d/t absent/abusive parents)
            - Cognitive: believe that people with this disorder suffer from deficiencies in their thinking
        - Treatment:
            - Challenges: meds of very low benefit, many do not come in for treatment, and limited progress in treatment
            - Cognitive-behavioral: education and focus on emotions, thoughts, and pleasurable experiences
            - Behavioral: teach social skills
            - Group therapy: safe environment for social contact
    - Schizotypal Personality Disorder -display a range of interpersonal problems marked by extreme discomfort in close relationships, very odd patterns of thinking and perceiving, and behavioral eccentricities
        - High N, Low E, High O
        - Other characteristics: loneliness, ideas of reference, bodily illusions, unusual speech habits, focus on selves, often described as "strange," persistent refusal to make eye contact, bizarre clothing
        - Supporting theories:
            - Psychodynamic: family conflicts and psychological disorders in parents
            - Biological: high dopamine activity, brain structure abnormalities, attention/memory problems, mood disorder (Depression)
        - Treatment:
            - Cognitive-behavioral: reconnect to world, recognize the limits, social skills training, recognize unusual thoughts and perceptions, speech lessons
            - Antipsychotic: somewhat helpful in reducing certain thought problems

- Antisocial Personality Disorder - A personality disorder marked by a general pattern of disregard for and violation of other people's rights.
  - High N, High E, Low A, Low C
  - Other characteristics: repeated lying (and little remorse), recklessness, impulsiveness, cruel, sadistic, aggressive, impulsive, care little about feelings of others, injuring people/animals, destroying property, breaking rules
  - Excluding substance abuse disorder, APD is most linked to adult criminal behavior
  - High rate of unemployment, divorce, drug, abuse, murder, suicide
  - ***Must be 18+ to receive this diagnosis
  - Supporting theories:
    - Psychodynamic: absence of parental love, leading to a lack of basic trust
    - Biological: lower serotonin activity, dysfunctional brain circuits
    - Cognitive: attitudes of others trivialize the importance of other people's needs
    - Behavioral: may be learned through modeling or unintentional reinforcement (operant conditioning)
  - Treatment:
    - Treatments are typically ineffective (lack of conscience, empathy, or desire to change
    - Cognitive: guide clients to think about moral issues and others' needs, psychoeducation
    - Sociocultural: therapeutic community approach tried in hospitals and prisons
    - Biological: atypical antipsychotic drugs also have been tried but symmetric studies are still needed
- Borderline Personality Disorder - A personality disorder characterized by repeated instability in interpersonal relationships, self-image, and mood and by impulsive behavior

- High N, Low A, Low C
- Characteristics: major shifts in mood (prone to bouts of anger, which sometimes result in physical aggression and violence), unstable self-image, impulsivity (may direct impulsive anger inward and harm themselves), unstable personal relationships
- Supporting theories:
  - Psychodynamic: childhood stress or conflict, absence of parental love → lack of trusting relationships
  - Psychodynamic (object-relations): lack of early acceptance or abuse/neglect by parents
  - Biological: overly reactive amygdala, underactive prefrontal cortex, lower brain serotonin activity, and genetic predisposition
  - Bisocial: combination of unstable internal and external forces that produce anxiety → erratic behavior
  - Sociocultural: particularly likely to emerge in cultures that change rapidly
- Treatment:
  - Psychotherapy: dialectical behavior therapy (gold standard), integrative treatment approach
  - Biological: mood stabilizers, antipsychotics (recommend use in combination with DBT)

- Histrionic Personality Disorder - A personality disorder characterized by a pattern of excessive emotionality and attention seeking.
  - High N, High E, High A, High O
  - Characteristics: dramatic, flamboyant, sexually seductive behavior, highly emotional interactions that are self-centered and superficial
  - May seem especially warm and engaging at first, but their theatrics soon prove to be desperate, shallow, and short-lived
  - Supporting theories:
    - Psychodynamic: believe children experienced unhealthy relationships (fears of being unloved and/or abandoned)

        - Cognitive: lack of substance and extreme suggestibility)
        - Sociocultural/multicultural: in part related to society's norms and expectations
    - Treatment:
        - Cognitive: address helpless beliefs, develop better and more deliberative ways of thinking and solving problems, identify friends/partners that can meet their needs
        - Psychodynamic/group therapy: assist patients with dependency issues
        - Meds: less successful, except as a means of relieving depression (if present)
- Narcissistic Personality Disorder - marked by a broad pattern of grandiosity, need for admiration, and lack of empathy.
    - High N, High C, High O, Low A
    - Characteristics: exaggerates achievements and talents (often arrogant), selective about friends (often favorable first impressions), common among normal teens and does not usually lead to adult narcissism
    - Supporting theories:
        - Psychodynamic: cold, rejecting parents → grandiose self-presentation and self-sufficient replaces warm relationships
        - Cognitive-behavioral: may develop an overvalued sense of self with if treated too positively rather than too negatively in early life
        - Sociocultural: possible link between narcissistic personality disorders and era of narcissism in society
    - Treatment:
        - No treatment has had much success
        - Very difficult to treat
            - Seek treatment for other issues (such as couples therapy)
            - May try to manipulate therapists to support their sense of superiority

            - Psychodynamic: recognize underlying insecurities, needs, and defenses
            - Cognitive-behavioral: redirect self-centered thinking
    - Avoidant Personality Disorder - A personality disorder characterized by consistent discomfort and restraint in social situations, overwhelming feelings of inadequacy, and extreme sensitivity to negative evaluation
        - High N, Low E
        - Characteristics: social withdrawal out of fear of criticism or inadequacy, take few risks for fear of failure, rarely express own opinions for fear that others disagree, expect the worst from people (criticism, contempt, rejection), prefer to stay at home
        - Supporting theories:
            - Psychodynamic: focus mainly on the general sense of security/shame in childhood
            - Cognitive: harsh criticism and rejections in early childhood leads to assumption that others will always judge them negatively (fears become conditioned)
            - Behavioral: failure to develop normal social skills → relationships suffer
        - Treatment:
            - Modest success
            - Seek acceptance and affection in psychotherapy (treated similarly to social anxiety and other anxiety disorders)
            - Group therapy: provides practice in social interactions
            - Biological: antianxiety and antidepressant drugs are also sometimes useful
    - Dependent Personality Disorder - A personality disorder characterized by a pattern of clinging and obedience, fear of separation, and an ongoing need to be taken care of.
        - High N, High A

        - Characteristics: submissive and passive style (excessive clinging, obedience, submissive, inability to express personal autonomy and independence), unable to make own decisions, look to others for nurturance and support
        - Supporting theories:
            - Psychodynamic: similar to theories of depression
                - Freudian: unresolved conflicts during the oral stage
                - Object-relations: early parental loss/rejection
                - Other: overinvolved and overprotective parents
            - Behavioral: received unintentional rewards and punishments for clinging/loyal behaviors
            - Cognitive: used of two maladaptive attitudes: helplessness, inadequacy
        - Treatment:
            - At least moderately helpful
            - Psychodynamic: similar to depression treatments (look at underlying issues)
            - Cognitive-behavioral: challenge/change helpless assumptions
            - Biological: antidepressants are helpful when depression is comorbid
            - Groupt: provides clients opportunity for peer support and modeling
    - Obsessive-Compulsive Disorder - A personality disorder marked by such an intense focus on orderliness, perfectionism, and control that the person loses flexibility, openness, and efficiency.
        - High E, High C, Low A, Low O
        - Characteristics: intense focus on orderliness, perfectionism, control (often work very hard, very well organized, unreasonably high standards, less flexible and open, fears mistakes, may be afraid to make decisions), inflexible concern for rules, regulations, details (tendency to be rigid and stubborn, elevates rules over social life, difficulty expressing affection, often stiff and superficial)

        - Supporting theories:
            - Psychodynamic: dominates theories but research is limited
            - Freudian: anal regressive
            - Cognitive: believe that illogical thinking processes help maintain it
        - Treatment:
            - People do not usually believe there is anything wrong with them
            - Unlikely to seek treatment
            - Biological: SSRIs
- Know the 3 categories of personality disorders and Cluster Names, which is in each Cluster, as well as:
    - Odd
        - Display behaviors similar to, but not as extensive as, schizophrenia
        - Few people with these disorders seek treatment and treatment success is limited
        - Cluster: Paranoid Personality Disorder, Schizoid Personality Disorder, Schizotypal Personality Disorder
    - Dramatic
        - Highly emotional
        - Cluster: Antisocial Personality Disorder, Borderline Personality Disorder, Histrionic Personality Disorder, Narcissistic Personality Disorder
    - Anxious
        - People typically display anxious and fearful behavior
        - AS with most of the personality disorders, research is very limited
        - Cluster: Avoidant Personality Disorder, Dependent Personality Disorder, Obsessive-Compulsive Disorder
- Know how each PD is different from similar diagnoses (e.g., OCD vs. OCPD)
- Be able to connect which PD had warning signs or likely behaviors or diagnoses from childhood

Chapter 17: Disorders Common Among Children and Adolescents

Understand the various disorders diagnosed before age 18, and differential diagnosis

- **For each disorder, be aware of any similarity with a disorder diagnosed in adulthood and any differences. **
- **Separation Anxiety Disorder**
    - A disorder marked by excessive anxiety, even panic, whenever the person is separated from home, a parent, or another attachment figure.
        - Child has difficulty being away from parent/parental figure
        - Often reluctant or refuses to go anywhere where they may be separated from said figure
        - Worry that when separated, something may happen to their parents (getting hurt or may die) or that something bad may happen to them (getting kidnapped or lost), preventing them to see their parents again
    - Best Treatments
        - Cognitive-behavioral (most favorable)
            - Is tailored to the child's cognitive abilities, unique life situation, and the limited control they have over their life
        - Psychoeducation: provide parent training and arrange school interventions to treat anxious children
        - Psychotherapy with drug therapy
            - Prescribing antianxiety, antidepressant and antipsychotic drugs
            - Antidepressant therapy is most favorable
- **Major Depressive Disorder & Bipolar Disorder** (Review past chapter on mood disorders)
    - Causes
        - Triggered by negative life events such as major changes, rejection or ongoing abuse
    - Risks
    - Treatment

        - Cognitive-behavioral therapy
        - Interpersonal psychotherapy
        - Antidepressant drugs
        - A combination of Cognitive-behavioral therapy AND Antidepressant drugs seems to be most helpful
        - *Mostly, family-focused approaches to improve parent-child relationships and for the child to build coping skills*
- **Disruptive Mood Regulation** (the new category in the DSM-5 after the childhood bipolar label had been overapplied)
    - A childhood disorder marked by severe recurrent temper outbursts along with a persistent irritable or angry mood
    - Symptoms/Criteria
        - For at least a year, individual repeatedly displays severe outbursts of temper that are extremely out of proportion to triggering situations and different from ones displayed by most other individuals of his or her age.
        - The outbursts occur at least three times per week and are present in at least two settings (home, school, with peers).
        - Individual repeatedly displays irritable or angry mood between the outbursts.
        - Individual receives initial diagnosis between 6 and 18 years of age.
    - How it is distinguished from bipolar
- **Oppositional Defiant (OD) and Conduct Disorders (CD)**
    - **OD:** A disorder in which children are repeatedly argumentative, defiant, angry, irritable, and perhaps vindictive.
        - May argue repeatedly with adults
        - Ignore adult rules and requests
        - Deliberately annoy other people
        - Feel much anger and resentment
    - **CD:** A disorder in which children repeatedly violate the basic rights of others and display significant aggression. (6-17-year old and mostly boys) may lead to antisocial personality disorder

- Aggressive and may be physically abusive to people and animals
- Deliberately destroying property
- Skipping school or running away from home
- Shoplifting, mugging, armed robbery, etc.
- Physical violence may progress as they get older and may include rape or some rare cases, homicide
- Criteria:
    - Individual repeatedly behaves in ways that violate the rights of other people or ignores the norms or rules of society, beyond the violations displayed by most other people of his or her age.
    - At least three of the following features are present over the past year (and at least one in the past 6 months): • Frequent bullying or threatening of others • Frequent provoking of physical fights • Using dangerous weapons • Physical cruelty to people • Physical cruelty to animals • Stealing during confrontations with a victim • Forcing someone into sexual activity • Fire-setting • Deliberately destroying others' property • Breaking into a house, building, or car • Frequent lying • Stealing items of value under non-confrontational circumstances • Frequent staying out beyond curfews, starting before the age of 13 • Running away from home overnight at least twice • Frequent truancy from school, starting before the age of 13.
    - Significant impairment.
- Different kinds of conduct disorder
    - Overt-destructive pattern: in which individuals display *openly* aggressive and confrontational behaviors
    - Overt-nondestructive pattern, dominated by openly offensive but non-confrontational behaviors such as lying to their face
    - Covert-destructive pattern, characterized by *secretive* destructive behaviors such as violating other people's property, breaking and entering, and setting fires on purpose
    - Covert- nondestructive pattern, in which individuals *secretly* commit *nonaggressive behaviors*, such as being truant from school

- Best/Worst treatment options and challenges for OD and CD
  - CD: **Parent Management Training** where therapists combine family and cognitive-behavioral interventions to help improve family functioning and help parents deal with their children more effectively
    - Parent-child interaction therapy
    - Multisystemic therapy: make needed changes across multiple contexts of children's lives by treating family dynamics and making adjustments in children's school, social lives and in the community
  - Prevention programs where they change the unfavorable social conditions before a CD is able to develop
    - Seeks to ease the stresses of poverty, promote more positive school environments, and improve parent child rearing skills; works best when family is involved

- **Enuresis and Encopresis:**
  - **Enuresis:** A childhood disorder marked by repeated bed-wetting or wetting of one's clothes.
    - Could be a symptom of broader anxiety and underlying conflicts (psychodynamic)
    - Result of improper, unrealistic, or coercive toilet training (cognitive-behavioral)
    - Small bladder capacity, weak bladder muscles, and/or disturbed sleep patterns
    - Cognitive-behavioral treatment
      - Classical conditioning:
        - Bell-and-battery technique
      - Dry-bed training: training in cleanliness and retention control
        - Awakened periodically during the night, practice going to the bathroom and then rewarded
  - **Encopresis:** A childhood disorder characterized by repeated defecating in inappropriate places, such as one's clothing

        - Involuntary, starts at the age of 4; *more common in boys*
            - Causes: intense social problems, shame and embarrassment
                - Try to hide their condition and avoid social situations (school or camp) in which they might embarrass themselves
            - Biological factors: constipation (most common), stress, improper toilet training
            - Treatment: cognitive-behavioral and medical approaches
                - Interventions to eliminate constipation (laxatives, change in diet)
                - Biofeedback training
- **Child Abuse:** Prevalence, Forms, Treatments
    - 5-16% of children in the US are physically abused each year
        - 1 of every 10 children is a victim to severe violence
    - 13% of all child deaths are due to abuse
    - Girls and boys are physically abused at the same rate
        - More common among the poor, but perpetrated in all socioeconomic groups
    - Abusive parents have poor impulse control, low self-esteem, higher levels of depression, and weak parenting skills
        - Many were abused themselves as children and have had poor role models
    - Psychological abuse: severe rejection, excessive discipline, scapegoating and ridule, isolation and refusal to provide help of a child with psychological problems
    - Child sexual abuse: the use of a child for gratification of adult sexual desires, may occur outside or inside of home
    - Treatments:
        - Parents Anonymous: helping the parents to develop insight into their behavior, provide training on alternatives to abuse, and teach coping and parenting skills
        - Prevention programs: home visitations and parent training

        - Early detection programs: educating all children about child abuse, teaching them skills for avoiding or escaping from abusive situation, encouraging children to tell and adult, and assuring them that the abuse is never their own fault
- Neurodevelopmental Disorders
    - Impacts on brain functioning that emerge at birth or during very early childhood and affect the individual's behavior, memory, concentration, and/or ability to learn
    - Disorders included: ADHD, Autism Spectrum Disorder, Intellectual Disability
- **ADHD**- A disorder marked by the inability to focus attention, or overactive and impulsive behavior, or both.
    - Potential causes: possible brain circuit interconnectivity disruption, higher threshold for stimulation
    - Diagnosing (assessment is difficult):
        - Over/underdiagnosed
            - Hyperactivity typically diagnosed and treated
            - Girls less likely to be diagnosed, non-Caucasian children underdiagnosed
    - Criteria:
        - Individual presents one or both of the following patterns:
            - (a) For 6 months or more, individual frequently displays at least six of the following symptoms of inattention, to a degree that is maladaptive and beyond that shown by most similarly aged persons: • Unable to properly attend to details, or frequently makes careless errors • Finds it hard to maintain attention • Fails to listen when spoken to by others • Fails to carry out instructions and finish work • Disorganized • Dislikes or avoids mentally effortful work • Loses items that are needed for successful work • Easily distracted by irrelevant stimuli • Forgets to do many everyday activities.
            - (b) For 6 months or more, individual frequently displays at least six of the following symptoms of hyperactivity and impulsivity, to a degree that is maladaptive and beyond that shown by most similarly aged

persons: • Fidgets, taps hands or feet, or squirms • Inappropriately wanders from seat • Inappropriately runs or climbs • Unable to play quietly • In constant motion • Talks excessively • Interrupts questioners during discussions • Unable to wait for turn • Barges in on others' activities or conversations.

- Individuals displayed some of the symptoms before 12 years of age.
- Individuals show symptoms in more than one setting.
- Individual experiences impaired functioning.

- Best Treatment options for ADHD
  - Drug therapy: taking methylphenidate (stimulant; Adderall, Ritalin, Concerta)
  - Cognitive-Behavioral therapy and combination therapies:
    - Operant conditioning
    - Parent management training and school interventions
- Multicultural Factors and ADHD diagnosis
  - African-American and Hispanic children are less likely to be assessed, receive diagnosis, or undergo treatment than non-Hispanic white American children
    - Less likely to be treated with stimulant drugs or a combination of CBT and drug therapy
    - Less likely to receive adequate follow-up care
  - Socioeconomic factors:
    - Poorer children are less likely than wealthier ones to be identified as having ADHD and less likely to receive effective treatment

- **Autism Spectrum Disorder**
  - Symptoms appear early (age 3)
  - Children with this disorder are often over and under stimulated easily
  - Restricted interests and activities, repetitive, rigid
  - Lack of responsiveness and social reciprocity
  - Language and communication problems that take various forms (i.e. echolalia and pronominal reversal)
  - Causes:

        - Biological: prenatal or birth complications, genetics, brain abnormalities (i.e. cerebellum abnormality)
        - Cognitive: failure to develop a theory of mind (r/t awareness of self and others) and attention dificenciences (difficulty in having a shared experienced--r/t corpus callosum, amygdala, and prefrontal cortex abnormalities)
        - Sociocultural: high levels of family dysfunction, social stress, and environmental stress, not supported by research
    - Treatment:
        - *Cognitive-behavioral: reinforcement, should be consistent, starts at young age, family involvement important, teaching appropriate behaviors and social skills
        - Communication training
        - Parent training: support for parents
        - Community integration: for higher functioning
- **Intellectual Development Disorder** – criteria
    - Categories of severity (e.g., mild, etc) and associated IQ
        - General intellectual functioning that is well below average, along with poor adaptive behavior
            - IQ must be 70 or lower
            - Difficulty with communication, home living, self-direction, work, and/or safety
            - Symptoms must appear before age 18
        - Mild: IQ 50-70
            - Sociocultural and psychological factors
                - Poor and understimulating environment
                - Inadequate parent-child interactions
                - Insufficient early learning experiences
        - Moderate: IQ 35-49 (~10%)
            - Can care for self, benefit from vocational training
            - Can work in unskilled/semiskilled jobs

        - Severe: IQ 20-34 (~3-4% display)
            - Usually require careful supervision
            - Perform only basic work tasks
            - Rarely able to live independently
        - Profound: IQ below 20 (~1-2% display)
            - With training, may learn or improve basic skills but need a very structured environment
    - Risks/Potential causes of developmental disabilities
        - Biological factors: some genetic factors
        - Unfavorable condition before, during, or after birth:
            - Chromosomal causes:
                - Down syndrome: chromosome 21
                - Fragile X Syndrome: child has defective X chromosome
                    - Too little or none of FMR1 protein
                    - More common in boys because they only 1 X chromosome (XY) than girls (XX)
    - Interventions: quality of life depends largely on sociocultural factors
        - Intervervention programs try to provide comfortable and stimulating residences, social and economic opportunities, and a proper education
    - Therapy:
        - Sometimes these patients experience emotional and behavioral problems
            - 30% or more have a comorbid diagnosable psychological disorder
            - Some have low self-esteem, interpersonal problems, and adjustment difficulties
        - Individual or group therapy can be helpful to some degree
            - Psychotropic medication is sometimes prescribed

TABLE: Comparison of Childhood Disorders

Disorder	Usual Age of Identification	Prevalence among All Children	Gender with Greater Prevalence	Elevated Family History	Recovery by Adulthood
Separation anxiety disorder	Before 12 years	4%-10%	Females	Yes	Usually
Selective mutism	2-4 years	1%	Females	Yes	Often
Conduct disorder	7-15 years	5%-10%	Males	Yes	Often
Enuresis	5-8 years	7%	Males	Yes	Usually
Encopresis	After 4 years	1.5%-4%	Males	Unclear	Usually
ADHD	Before 12 years	7%	Males	Yes	Often
Autism spectrum disorder	0-3 years	2%	Males	Yes	Sometimes
Specific learning disorders	6-9 years	5%-10%	Males	Yes	Often
Intellectual disability	Before 10 years	1%-3%	Males	Unclear	Sometimes

Chapter 18: Disorders of Aging and Cognition

- Geropsychology definition, challenges of aging
  - 65+
  - 2 types of psych problems:
    - 1. Complications of common disorders (i.e. depression, anxiety, sleep, etc.)
    - 2. Cognitive disorders (i.e. delirium, deli mild/major neurocognitive disorders)
- Disorders of Cognition: Know how to distinguish them from one another
  - Delirium- criteria, possible causes
    - Clouding of consciousness
    - Difficulty concentrating, with attention, sequential thinking
    - Leads to misinterpretations, illusions, and sometimes hallucinations

        - Possible causes: fever, poor nutrition, certain diseases, stroke, head injury, stress, poisoning
- Neurocognitive Disorders – criteria, severity ratings, evidence for early onset
    - Significant decline in at least one area of cog functioning:
        - Memory
        - Attention
        - Visual perception
        - Decision making/planning
        - Language ability
        - Social awareness
        - Changes in personality/behavior (sometimes)
    - Mild neurocognitive dx: cognitive decline is mild to moderate; able to be independent
    - Major neurocognitive dx: cognitive decline is substantial and interferes with a person's ability to be independent
    - Disorders that can lead to neurocognitive disorders: viral and bacterial infections (HIV/AIDS, meningitis, advanced syphilis), traumatic brain injury, brain seizure disorder, drug abuse
    - **Alzheimer's: (most common) 2/3rds of all cases of neurocognitive disorders**
        - Starts with mild memory problems, lapses of attention, and language/communication
        - As symptoms worsen, difficulty completing complicated tasks and remembering important appointments → then struggle with simple tasks, distant memories are forgotten, may have noticeable personality changes
        - As dementia intensifies, people are less aware of their limitations
        - Usually remain in good physical health until the later stages of diseases
        - Become fully dependent upon others. Lose almost all knowledge of the past, and fail to recognize the faces of even close relatives
        - *Depletion of acetylcholine plays a critical factor in Alzheimer's*
        - *Causes:* beta-amyloid protein (plaques) and neurofibrillary tangles

- Plaques: sphere-shaped deposits of beta-amyloid protein that form in spaces b/tw cells in hippocampus, cerebral cortex, & other regions/vessels
- Neurofibrillary tangles: twisted protein fibers found within cells of the hippocampus

- *Genetic theories:*
  - Early-onset disease: mutation in particular genes increase the tangle formations
  - Late-onset: combination of genetic, environmental, and lifestyle factors (not heritable)
  - *Alternative genetic theory:* may be multiple genetic causes triggering the numerous tangle formations and the onset of Alzheimer's
    - Gene forms that start the process by first promoting beta-amyloid protein formations and plaques
    - Gene forms that more directly promote tau protein abnormalities and tangle formations
- *Brain structure and biochemical activity:*
  - Two systems for learning and recall:
    - Short-term memory (working memory)--gathers new information; info must be consolidated into long-term memory
    - Long-term memory: info accumulated over the years; remembering stored info is called retrieval
  - Memory:
    - Prefrontal lobes: hold info temporarily and to continue working with the information as long as it is needed
    - Temporal lobes and diencephalon; helps transform short-term memory into long-term memory
    - *Damage to or improper functioning of one or more of these areas may cause dementia*

- Biochemical changes (occur in cells as memories form):
    - Several chemicals are responsible for the production of proteins in key cells when new information is acquired and started
    - If their activity is distrubed, the proper production of protein may be prevented, and the formation of memories interrupted

- *Other explanations:* natural substances, such as zinc, may produce brain toxicity
    - *Autoimmune theory:* changes in aging brain cells may trigger an autoimmune response (immune system attacks brain cells)
    - *Viral theory:* resembles Creutzfeldt-Jakob disease (form of dementia caused by a virus), however, no such virus has been detected in the brains of patients with Alzheimer's
- *Assessing/predicting:*
    - Battery of assessments: neuropsychological assessments: cognitive, perceptual, and motor functioning, brain scans, blood tests
    - Biomarkers: low hippocampus activity? (may play a role)
    - **PREVENTION and EARLY INTERVENTION are key!**
- Treatment: medication, cognitive techniques, behavioral interventions, support for caregivers, sociocultural approaches
    - Meds affect acetylcholine and glutamate (neurotransmitters important for memory)
        - Limited benefits, high risk of harmful side effects, most helpful for mild stages of Alzheimer's, but the drugs have been approved by the FDA
        - Vitamin E seems to help prevent or slow down further cognitive decline, but this effect is only modestly supported by research
    - Available treatments:

        - Alternative meds being investigated
        - Can naprosyn and ibuprofen reduce Alzheimer's?
            - Research results have been mixed
        - Physical exercise may be preventative
        - Behavior-focused interventions:
            - Role-playing and modeling appropriate behaviors
            - Positive reinforcement
            - Family training
        - Caregiving can take a heavy toll on the close relatives
        - Sociocultural approaches (day-care and assisted living)
            - Some facilities may help slow the cognitive decline of residents and enhance their enjoyment of life
    - Symptoms and Causes of the Other Types of Neurocognitive Disorders
        - *Vascular neurocognitive disorder*
            - Stroke/CVA → blood flow cut off causing damage
            - Symptoms start suddenly and then progress
                - Confusion, difficulty concentrating and organizing, memory issues, unsteady gait, urges to urinate, apathy
                - Cognitive functioning may continue to be normal in the areas of the brain not affected by the stroke
- Know how to distinguish Huntington's, Pick's, Creutzfeldt-Jakob, and Parkinson's diseases
    - **Pick's Disease** (Frontotemporal neurocognitive disorder): affects the frontal (planing, executive functioning) and temporal lobes (language, emotional control, behavior)
        - Early behavior and personality changes can differentiate it from Alzheimer's
        - Distinguished at autopsy
    - **Creutzfeldt-Jakob** (Neurocognitive disorder due to prion disease)
        - Symptoms: spasms of the body, poor coordination, visual disturbances, failing memory, behavior changes

        - Caused by a slow-acting virus (prion) that may live in the body for years before the disease develops
        - Late onset
        - Once activated, quick deterioration with rapid, progressive, fatal course
    - **Huntington's Disease:** inherited progessive disease; memory problems w/ personality changes and mood difficulties, worsens over time
        - Due to degeneration of nerve cells in the brain
        - Symptoms: difficulty organizing, focusing, prioritizing, and finding words, mood difficulties and personality changes (i.e. impulsivity, sexual promiscuity), movement problems, difficulty producing speech or swallowing
    - **Parkinson's Disease:** slowly progessive neurological disorder marked by tremors, rigidity and unsteadiness
        - Can later cause dementia
        - Symptoms: slow movements, rigid muscles, loss of automatic movements, speech changes (softer, hesitant, monotone, slur)
        - Likely caused by Lewy bodies (protein clumps)
            - Lewy body disease: build up of protein deposits that cause cells to lose function and die
                - Starts with dementia and then motor issues
                - Symptoms: changes in thinking, behavior, and movement, visual hallucinations, sleep disturbances
- Treatments: drug therapy, CB interventions, support for caregivers
    - Sociocultural approaches: day-care facilities that provide treatment programs and activities for outpatients during the day and returning them to their home and families for the night
        - Assisted living facilities: brings in some degree of improvement in patients
- Mental Health in the Aging Population: Symptoms, Risk Factors, Causes, Treatment
    - Issues affecting mental health of the elderly:
        - Racial and ethnic discrimination against the elderly

- "Double jeopardy:" being both old and a member of a minority group
- "Triple jeopardy:" older women in minority groups

- Inadequacies of long-term care
  - Many require long-term care outside the family
    - Partially supervised apartment
    - Senior housing complex
    - Nursing home
    - Quality of care
- Need for health maintenance approach to medical care in an aging world

- **Depression in later life** – risk factors, treatment
  - Most common disorder for older adults
  - Risk factors: health problems
  - Highest rate in women; 20% elderly develop depression overall (most common disorder)
  - No difference in symptoms or criteria (high risk of death by suicide)
  - Depression among older people is correlated with developing significant medical problems
  - May lead to higher rates of suicide so it's hard to help
  - Treatment:
    - CBT, interpersonal therapy, meds, or a combo
      - More than half improve
      - Altered ECT can be tried for those that don't get better
    - Metabolism changes with age interfere with safety and effectiveness of antidepressants
      - Also, a higher risk of causing some cognitive impairment in the elderly
- **Anxiety disorders in later life**
  - Related to threats of life
  - Impending awareness of one's mortality: declining health, loss of friends, partners, and families, developmental (generativity vs stagnation)

        - Treatment: interpersonal therapy, CBT, anti-anxiety meds (must be used cautiously in older people)
    - **Substance abuse in later life**
        - Alcohol abuse declines after 65
        - Under-reporting?
        - Chronic alcoholism vs late-onset alcoholism
        - Prescription drug misuse
    - **Psychotic disorders in later life** – causes of symptoms
        - Higher rates of psychotic symptoms
        - Medical conditions
        - Psychosis