Abnormal Psychology

AP Psychology

Learning Targets: Abnormal Psychology

- **AP students in psychology should be able to do the following:**
- **• Describe contemporary and historical conceptions of what constitutes psychological disorders.**
- **• Recognize the use of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association as the primary reference for making diagnostic judgments.**
- **• Discuss the major diagnostic categories, including anxiety and somatoform disorders, mood disorders, schizophrenia, organic disturbance, personality disorders, and dissociative disorders, and their corresponding symptoms.**
- **• Evaluate the strengths and limitations of various approaches to explaining psychological disorders: medical model, psychoanalytic, humanistic, cognitive, biological, and sociocultural.**
- **• Identify the positive and negative consequences of diagnostic labels (e.g., the Rosenhan study).**
- **• Discuss the intersection between psychology and the legal system (e.g.,confidentiality, insanity defense).**

Learning Targets: Treatment

- **AP students in psychology should be able to do the following:**
- **• Describe the central characteristics of psychotherapeutic intervention.**
- **• Describe major treatment orientations used in therapy (e.g., behavioral,**
- **cognitive, humanistic) and how those orientations influence therapeutic planning.**
- **• Compare and contrast different treatment formats (e.g., individual, group).**
- **• Summarize effectiveness of specific treatments used to address specific**
- **problems.**
- **• Discuss how cultural and ethnic context influence choice and success of**
- **treatment (e.g., factors that lead to premature termination of treatment).**
- **• Describe prevention strategies that build resilience and promote competence.**
- **• Identify major figures in psychological treatment (e.g., Aaron Beck, Albert Ellis,**
- **Sigmund Freud, Mary Cover Jones, Carl Rogers, B. F. Skinner, Joseph Wolpe).**

Lesson One: Introduction

- **By the end of this lesson, I will be able to:**
- 1. Describe contemporary and historical conceptions of what constitutes psychological disorders.
- Video Introduction

How Do We Define Abnormal?

- Psychological Disorder
  - a “harmful dysfunction” in which behavior is judged to be:
    - **atypical**--not enough in itself
    - **disturbing**--varies with time and culture
    - **maladaptive**--harmful
    - **unjustifiable**--sometimes there’s a good reason

Historical Perspective

- **Perceived Causes**
  - movements of sun or moon
    - lunacy--full moon
  - evil spirits, exorcism, caged like
  - **Ancient Treatments:** animals, beaten, burned, castrated, mutilated, blood replaced with animal's blood, trepanation.

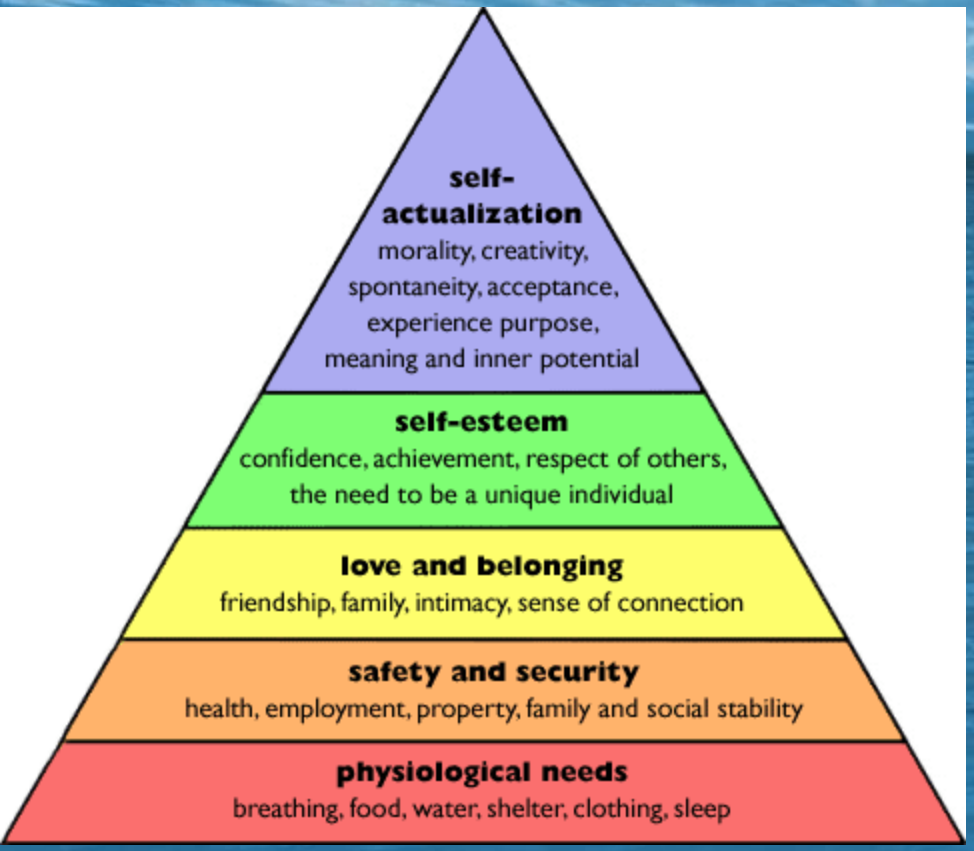
So What Causes Abnormal Behavior?

- **Each perspective of psychology assigns different reasons.**
- **Psychoanalytic – abnormal behavior results from internal conflict in the unconscious stemming from early childhood experiences.**
- **Example: failure to resolve childhood issues.**

More Causes:

- **Behavioral** – Abnormal behavior consists of maladaptive responses learned through reinforcement of the wrong kinds of behavior.
- Example: Child getting what they want all the time.

Causes

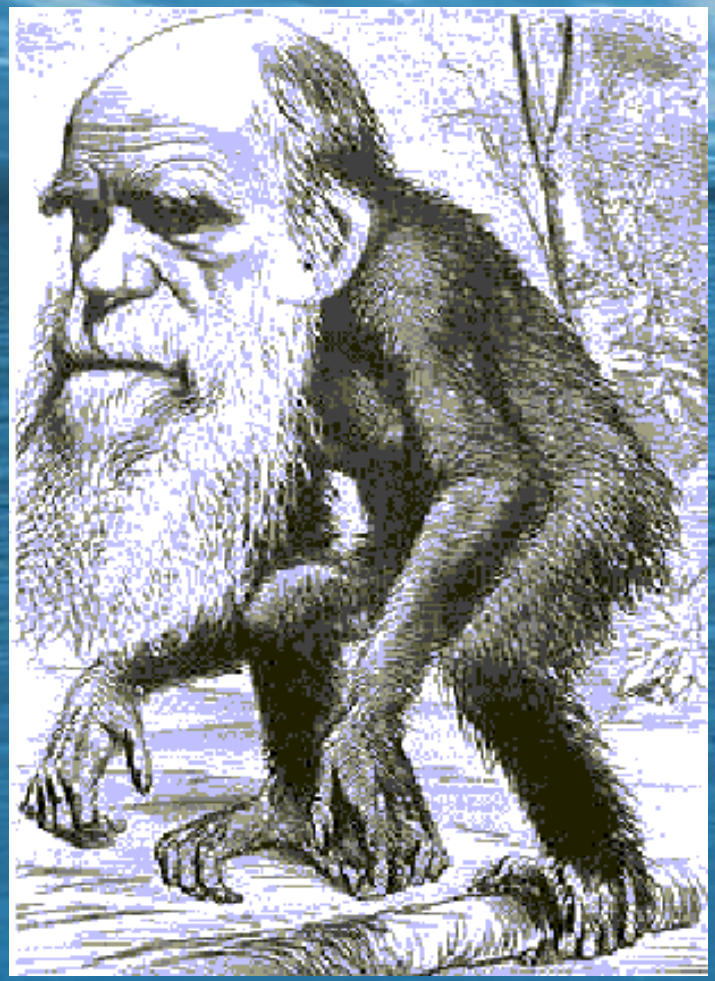


- Humanistic – Abnormal behavior results from conditions of worth society places on the individual, which cause poor self-concept.
- Example: If a person keeps failing (getting fired) at their job(s), they will show maladaptive behavior.

Causes:

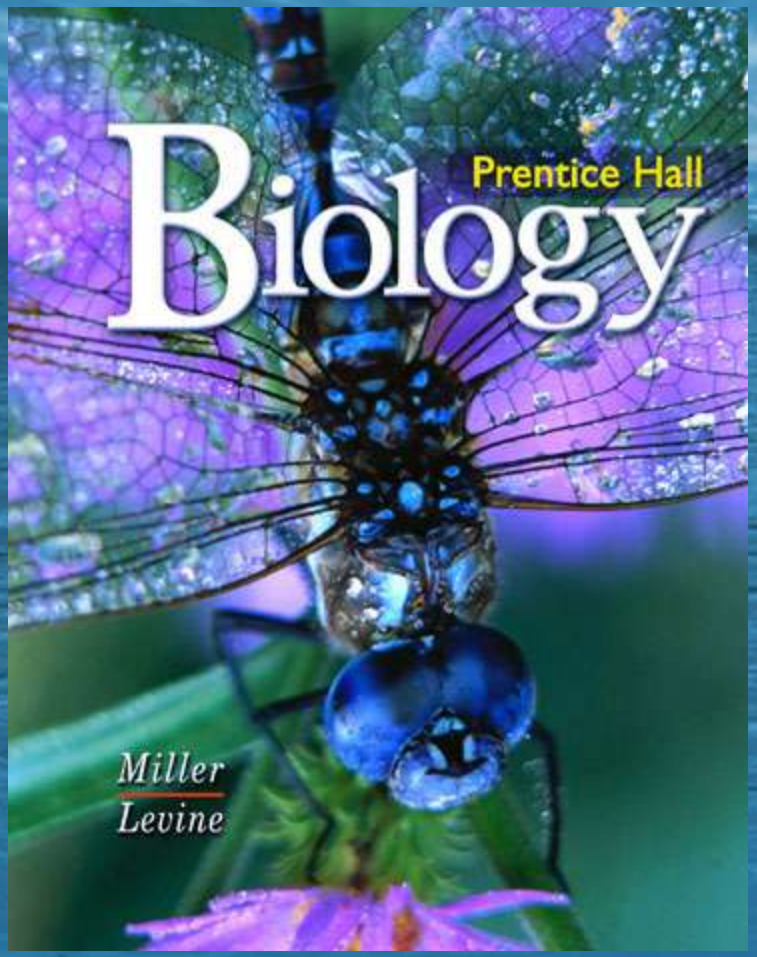
- **Cognitive** – comes from irrational and illogical perceptions and belief systems.
- **Example** – We do not handle situations in the appropriate manner because of some kind of mental distortion of “truth” or right or wrong (belief bias)

Causes:



- **Evolutionary** – natural selection – you brain does not perform psychological mechanisms effectively.
- Example – Your parents handle situations in a maladaptive so you might do the same

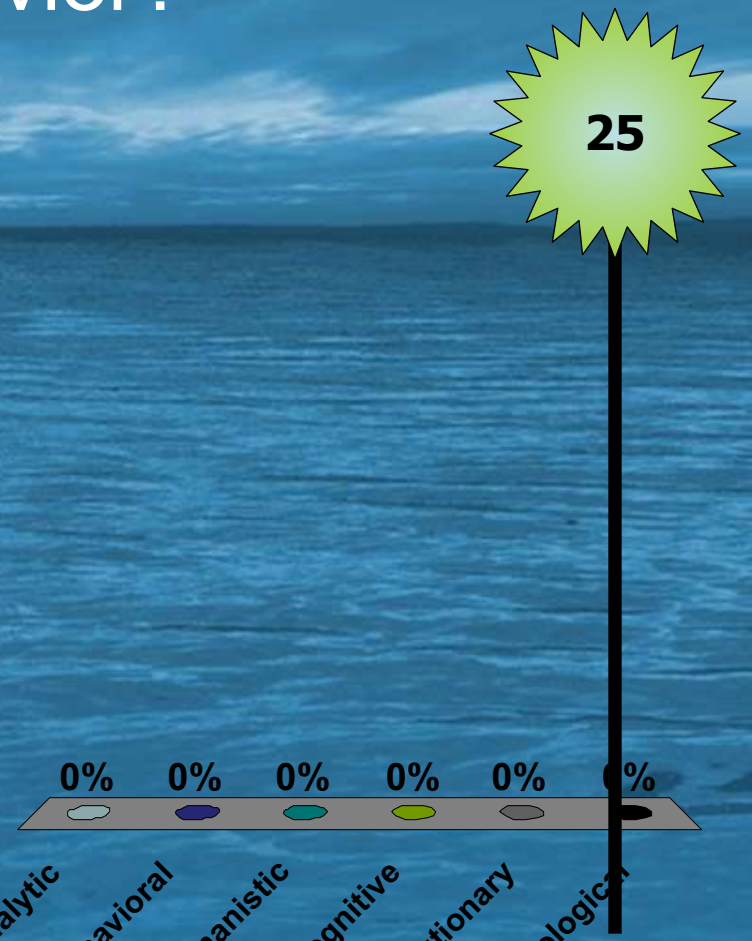
Causes: Biological



- **Biological** – Abnormal behavior is the result of neuro-chemical and/or hormonal imbalance
- Example – Dopamine levels – schizophrenia or Parkinson's

Which of the following perspectives do agree with most regarding the causes of abnormal behavior?

1. Psychoanalytic
2. Behavioral
3. Humanistic
4. Cognitive
5. Evolutionary
6. Biological



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Lesson Two: DSM-IV and Medical Model

- **By the end of this lesson I will be able to:**
- **1. Recognize the use of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association as the primary reference for making diagnostic judgments.**
- **Before we start – discussion from yesterday**

Discussion Starter:

1. What does abnormal mean to you?
2. What do you think causes abnormal behavior?

Psychological Disorders

- **Medical Model**
  - concept that diseases have physical causes
  - can be diagnosed, treated, and in most cases, cured
  - symptoms can be cured through therapy, which may include treatment in a psychiatric hospital

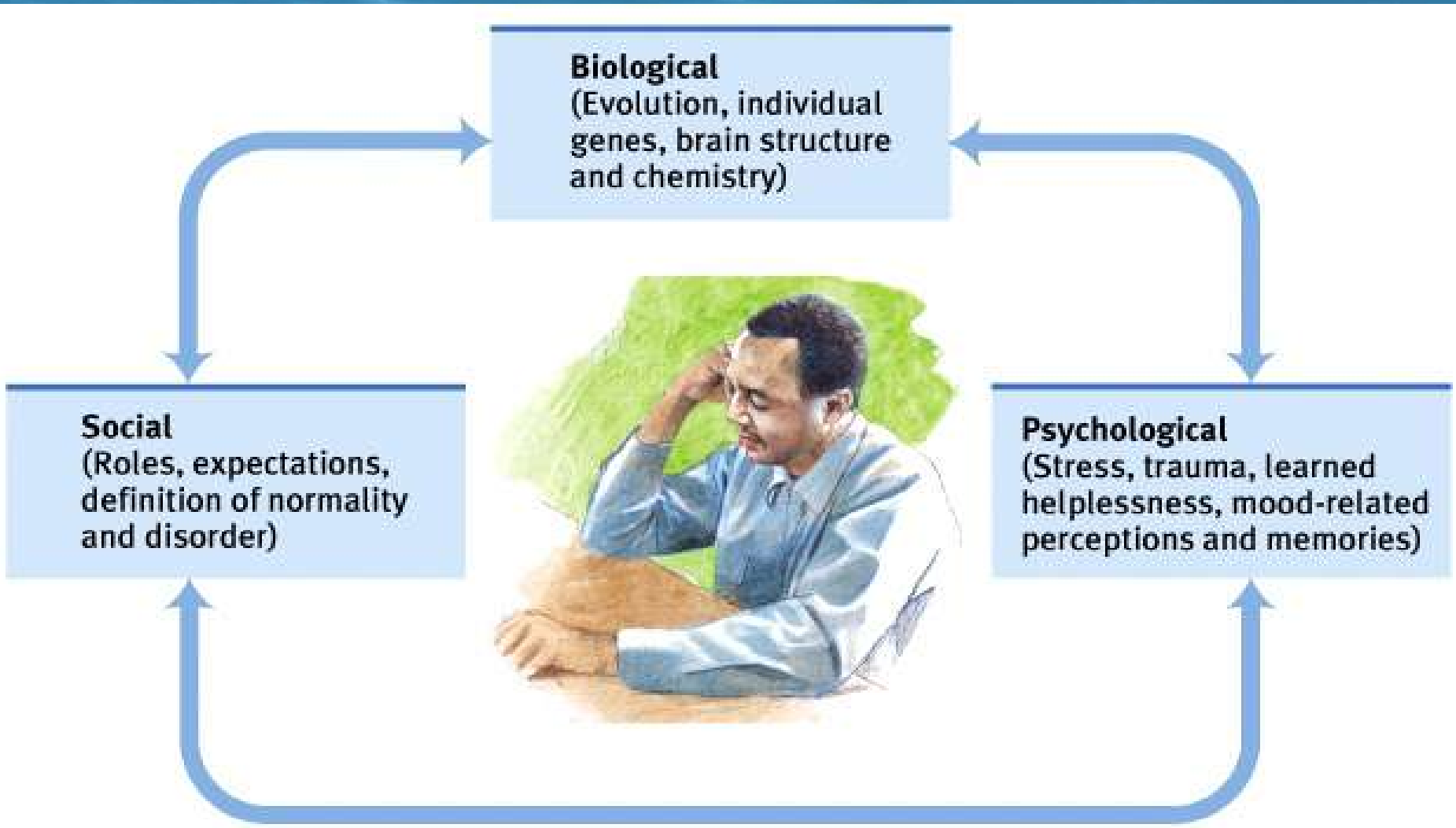
Medical Model Terms:

- **Psychopathology** – study of the origin, development, and manifestations of mental or behavioral disorders
- **Etiology** – the apparent cause and development of the illness
- **Prognosis** – forecasts the probable cause of an illness

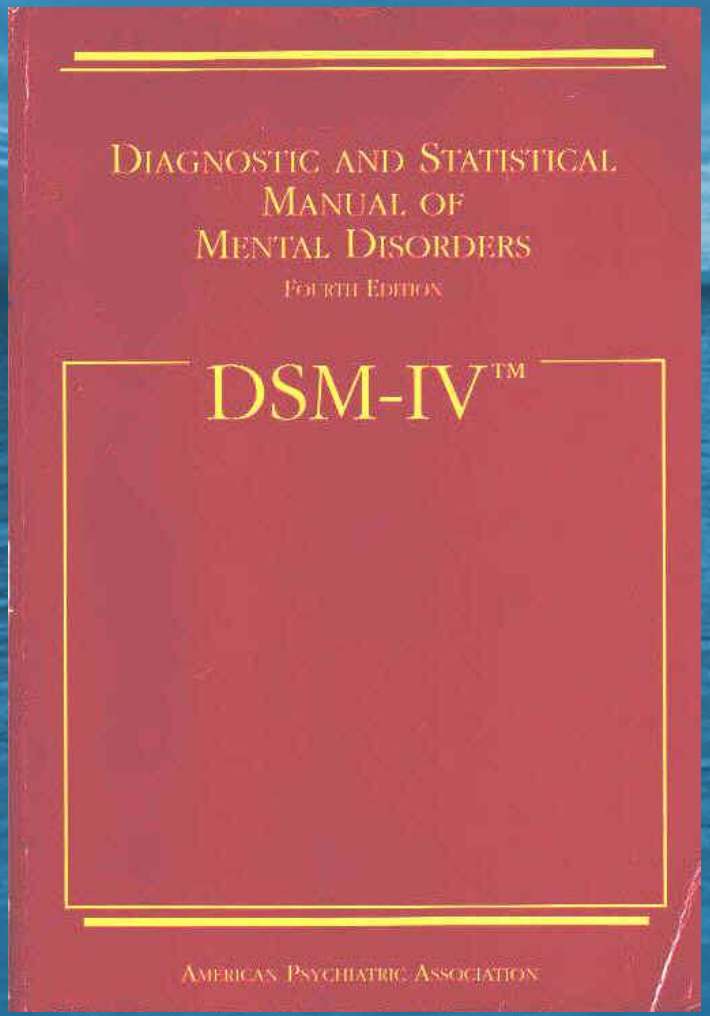
Psychological Disorders

- **Bio-Psycho-Social Perspective**
  - assumes that biological, sociocultural, and psychological factors combine and interact to produce psychological disorders
  - Do you agree?

Psychological Disorders



Psychological Disorders



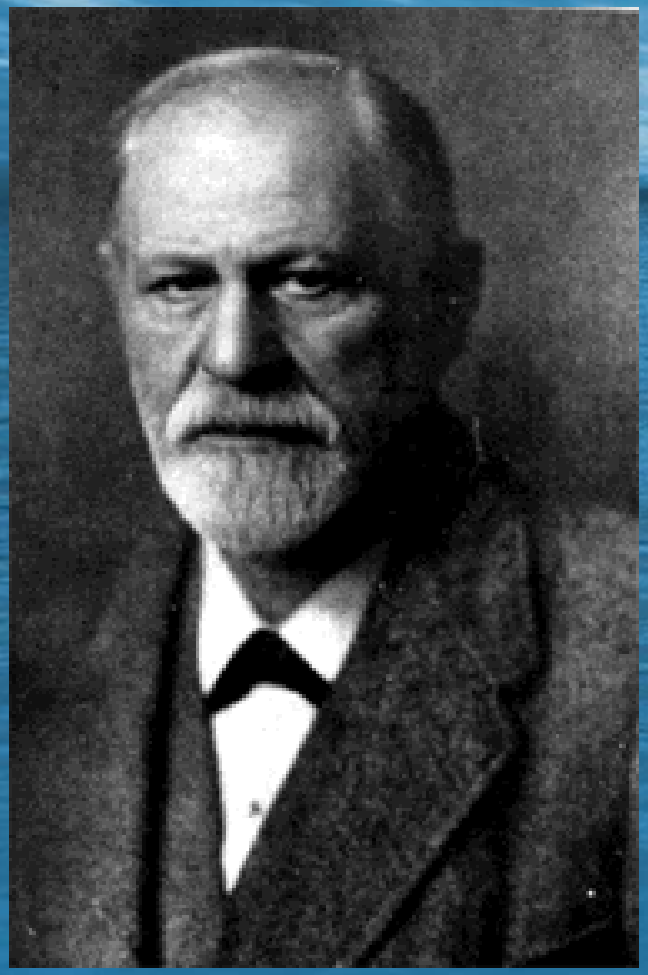
- **DSM-IV**
- American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (Fourth Edition)
  - a widely used system for classifying psychological disorders

Click on the book!!!

More About The DSM-IV:

- **Separated into Categories:**
- Axis I – Clinical Syndromes (schizophrenia)
- Axis II – Developmental disorders and personality disorders
- Axis III – Physical conditions
- Axis IV – Severity of Psychosocial Stressors
- Axis V – Highest Level of Functioning
- Most American insurance companies require a DSM-IV diagnosis for payment of health benefits
- **Critics** – “labeling is disabling”

Psychological Disorders



- **Neurotic Disorder**
- usually distressing but that allows one to think rationally and function socially
- **Psychotic Disorder**
  - person loses contact with reality
  - experiences irrational ideas and distorted perceptions
  - **Insanity** – the inability to determine right from wrong

Lesson Three: Anxiety Disorders

- **By the end of this lesson, I will be able to:**
- 1. **Discuss the major diagnostic categories, including anxiety and somatoform disorders, mood disorders, schizophrenia, organic disturbance, personality disorders, and dissociative disorders, and their corresponding symptoms.**

Anxiety Disorders

- **Anxiety Disorders**
  - Feelings of impending doom or disaster from an unknown.
  - Symptoms – sweating, muscular tension, and increased HR and BP

Anxiety Disorders

- **Panic Disorder**
  - marked by a minutes-long episode of intense dread in which a person experiences terror and accompanying chest pain, choking, or other frightening sensation.
  - Can last anywhere from a few minutes to a few hours.
  - These attacks have no apparent trigger and can happen at any time.

Anxiety Disorders:

- **Generalized Anxiety Disorder**
  - This is basically an extended version of a panic disorder.
  - The person may experience multiple episodes which may occur quite frequently or for a long duration.
  - May have trouble sleeping, be tense, and irritable

Anxiety Disorders

- **Phobia**
  - persistent, irrational fear of a specific object or situation.
  - Nearly 5% of the population suffers from some mild form of phobic disorder.
  - A fear turns into a phobia when a person avoids the fear at all costs, disrupting their daily life.

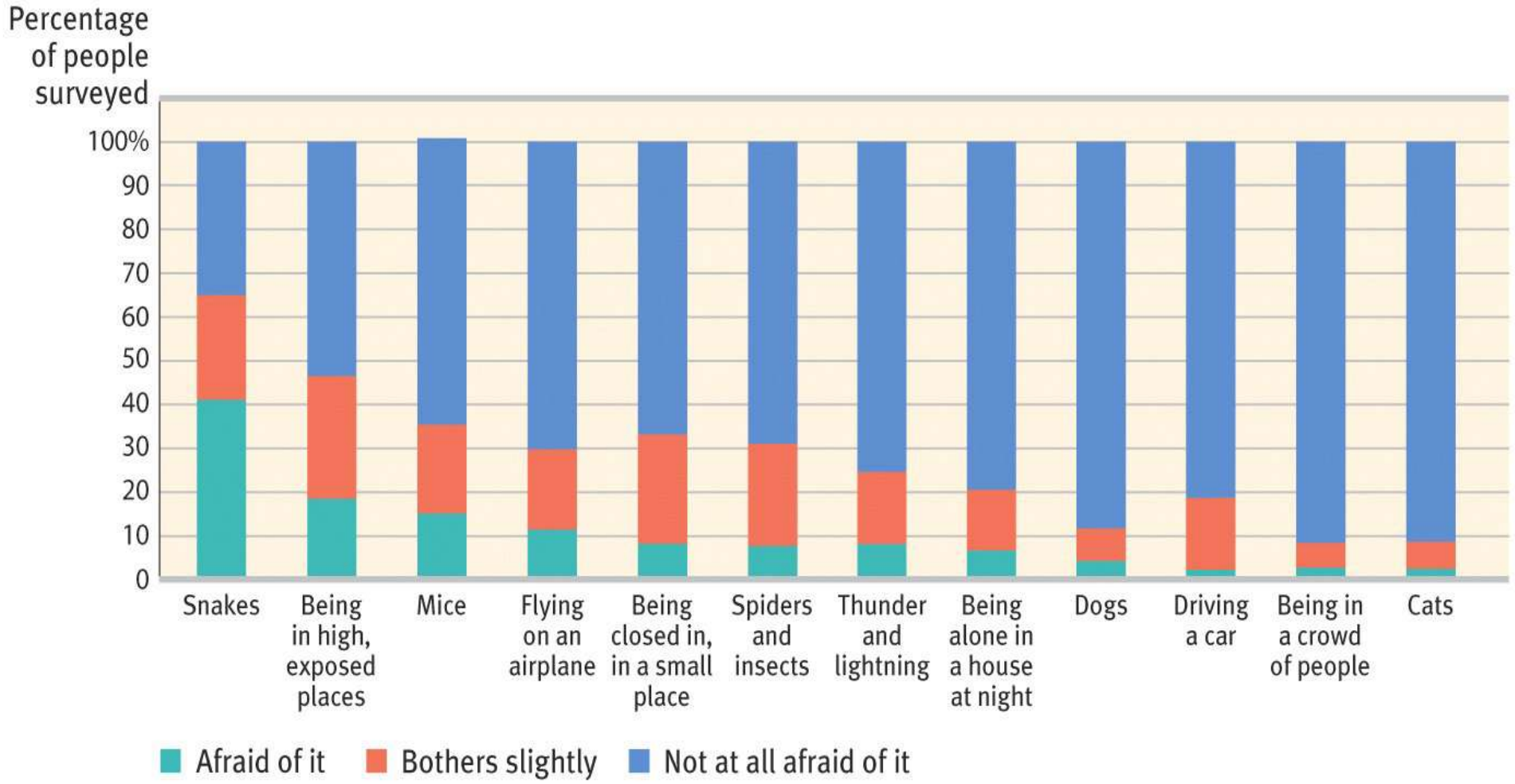
Common Phobias:

Click the Picture!!

- Agoraphobia – fear of being out in public
- Acrophobia – fear of heights
- Claustrophobia – fear of enclosed spaces
- Zoophobia – fear of animals (snakes, mice, rats, spiders, dogs, and cats)
- Didaskaleinophobia- Fear of going to school

Anxiety Disorders

- Common and uncommon fears



So, How Do You "cure" A Person With A Phobia?

- **Systematic Desensitization** – Provide the person with a very minor version of the phobia and work them up to handling the phobia comfortably.
- **Example**: Fear of snakes:
- 1. Have them watch a short movie about snakes
- 2. Have them hold a stuffed animal snake
- 3. Have them hold a plastic snake
- 4. Have them hold a glass container with a snake inside
- 5. Have them touch a small harmless snake
- 6. Gradually work to holding a regular size snake

Another Way:

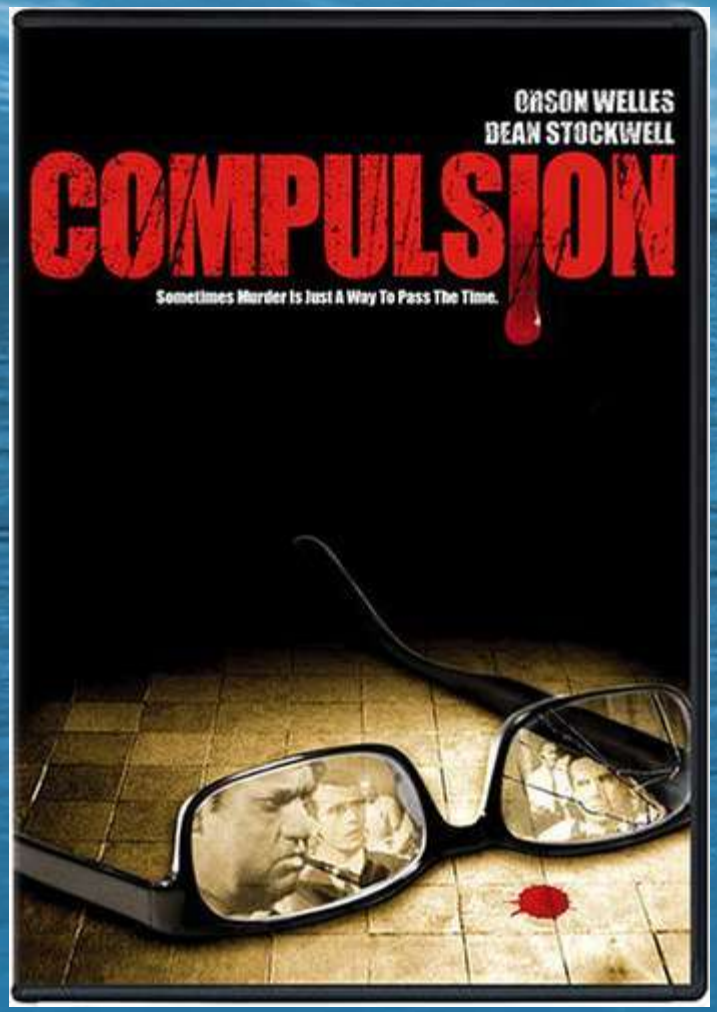
- **<u>Flooding</u>** – over stimulating the patient with the fearful object.
- This works for some patients but for others the systematic desensitization is much better.

Obsessive-Compulsive Disorder:

Obsessive-Compulsive Disorder

- unwanted repetitive thoughts (obsessions) and/or actions (compulsions)
- **Obsessions** – Persistent, intrusive, and unwanted thoughts that an individual cannot get out of his/her mind.
- These differ from worries
- They usually involve topics such as dirt or contamination, death, or aggression.

More About OCD:



- **Compulsions** – Ritualistic behaviors performed repeatedly, which the person does to reduce the tension created by the obsession.
- Common Compulsions include hand washing, counting, checking, and touching.

OCD – A Real Life Example:

OCD Background:

- In the United States, 1 in 50 adults have OCD
- Most people obsess about something
- One third to one half of adults with OCD report that it started during childhood.
- No specific genes for OCD have been identified
- When a parent has OCD, there is a slightly increased risk that a child will develop OCD, although the risk is still low
- There is no proven cause of OCD

Treatment of OCD

Discussion:

- 1. Are there certain things that you obsess about?
- 2. Would you say that any of these things are a continual problem for you?
- 3. Have you been able to overcome any of your obsessions or compulsions? How?

Lesson Four: PTSD and Causes of Anxiety Disorders

- By the end of this lesson, I will be able to:
- Discuss the major diagnostic categories, including anxiety and somatoform disorders, mood disorders, schizophrenia, organic disturbance, personality disorders, and dissociative disorders, and their corresponding symptoms.

Post Traumatic Stress Disorder:

- After a trauma or life threatening event a person suffering from PTSD may:
- 1. Have upsetting memories (flashbacks) of what happened
- 2. Have trouble sleeping
- 3. Feel jumpy (hyper alertness)
- 4. Lose interest in things you used to enjoy.
- 5. Have feelings of guilt
- **NOTE**: For some people these reactions do not go away on their own, or may even get worse over time.

Events That Can Cause PTSD:

- Combat or military exposure
- Child sexual or physical abuse
- Terrorist attacks – 9/11
- Sexual or physical assault
- Serious accidents, such as a car wreck.
- Natural disasters, such as a fire, tornado, hurricane, flood, or earthquake
- Why does this happen? – Flash bulb memory

Treatments:

- 1. Anti-anxiety medications
- 2. Removal from stressful stimuli (war, work, etc.)
- 3. Systematic desensitization

PTSD:

- Check This Out!
- http://www.pbs.org/wgbh/pages/frontline/shows/heart/view/

Video Discussion:

- 1. How should soldiers with PTSD be treated?
- 2. Do you think that people are more likely to seek help or talk about their problems compared to the past? Why?
- 3. What role should the military play in the recovery of their soldiers?
- 4. Should soldiers be prepared differently to combat the stress that is involved with their "job?"

Causes of Anxiety Disorders:

- **Behavioral** – Acquired through Classical conditioning, maintained through operant conditioning. (what does this mean?)
- **Cognitive** – misinterpretation of harmless situations as threatening (may selectively recall the bad instead of the good)
- **Biological** – Neurotransmitter imbalances – too little GABA (Valium, Xanum) – OCD is treated with anti-depressants (Prozac, Xoloft) – low levels of serotonin

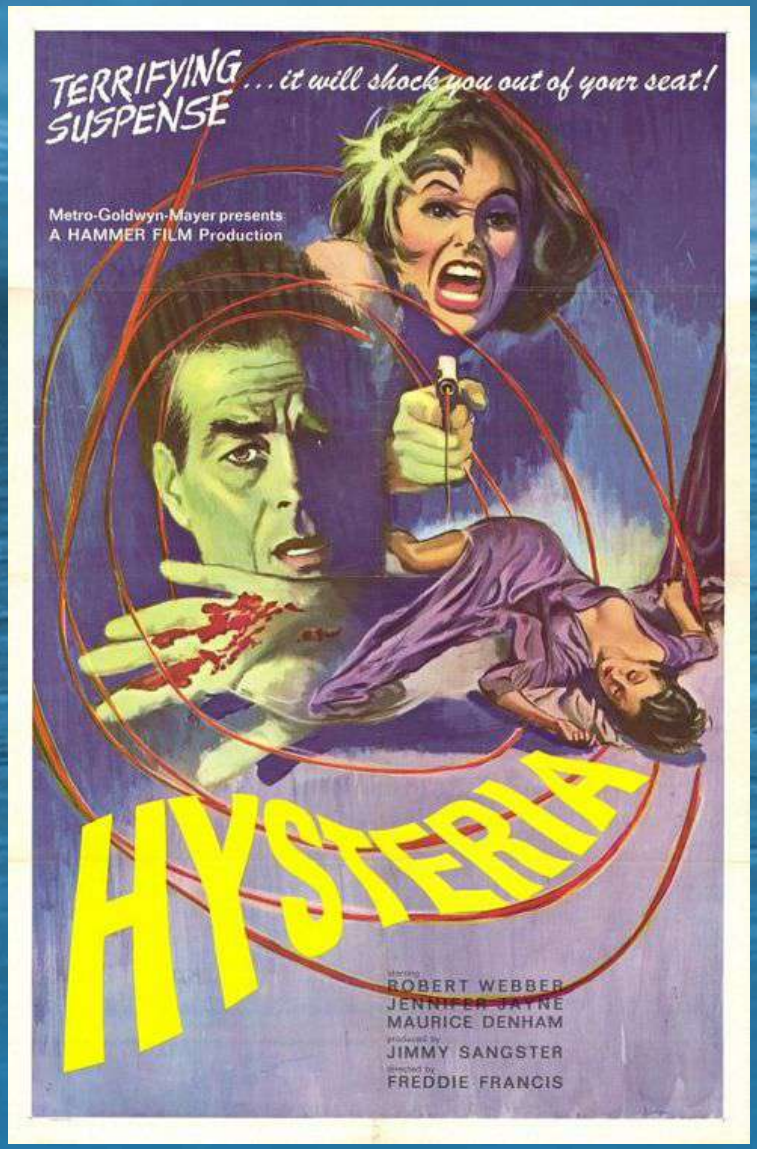
Lesson Five: Somatoform Disorders

- By the end of this lesson, I will be able to:
- 1. **Discuss the major diagnostic categories, including anxiety and somatoform disorders, mood disorders, schizophrenia, organic disturbance, personality disorders, and dissociative disorders, and their corresponding symptoms.**
- **But First… Let's Review!**

What are we going to talk about today?

- **<u>Somatoform Disorders</u>** – characterized by physical symptoms such as pain, paralysis, blindness, or deafness without any demonstrated physical cause.
- The symptoms are physical, while the causes are psychological.
- No physical damage is done.

Conversion Disorder:



- This used to be called "hysteria" when Freud was researching.
- Patient will lose control of bodily functions such as: becoming blind, deaf, or paralyzed.
- This happens without any physical damage to affected organs or their neural connections.
- Anxiety will bring on these symptoms.

Hypochrondriasis:

- **Hypochrondriasis** - Patient unrealistically interprets physical signs – such as pain, lumps, and irritations – as evidence of serious illness.
- Headache = brain tumor
- They show excessive anxiety about one or two symptoms.

What causes hypochondriasis?

- Factors that might be involved in the development of the disorder include the following:
- 1. A history of physical or sexual abuse
- 2. A poor ability to express emotions
- 3. A parent or close relative with the disorder — Children might learn this behavior if a parent is overly concerned about disease and/or overreacts to even minor illnesses.

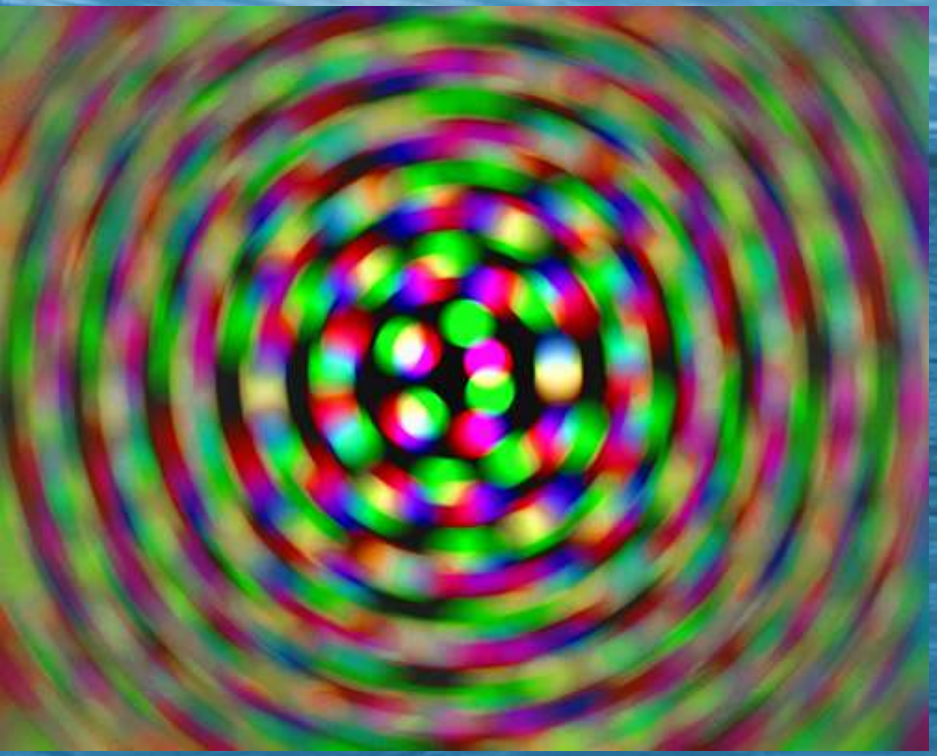
Warning signs that a person might have hypochondriasis:

- The person has a history of going to many doctors. He or she might even "shop around" for a doctor who will agree that he or she has a serious illness.
- The person recently experienced a loss or stressful event.
- The person is overly concerned about a specific organ or body system, such as the heart or the digestive system.
- The person's symptoms or area of concern might shift or change.
- A doctor's reassurance does not calm the person's fears. They believe the doctor is wrong or made a mistake.
- The person might have had a serious illness as a child.
- The person's concern about illness interferes with his or her work, family, and social life.
- The person might suffer from anxiety, nervousness, and/or depression.

Cleveland Clinic

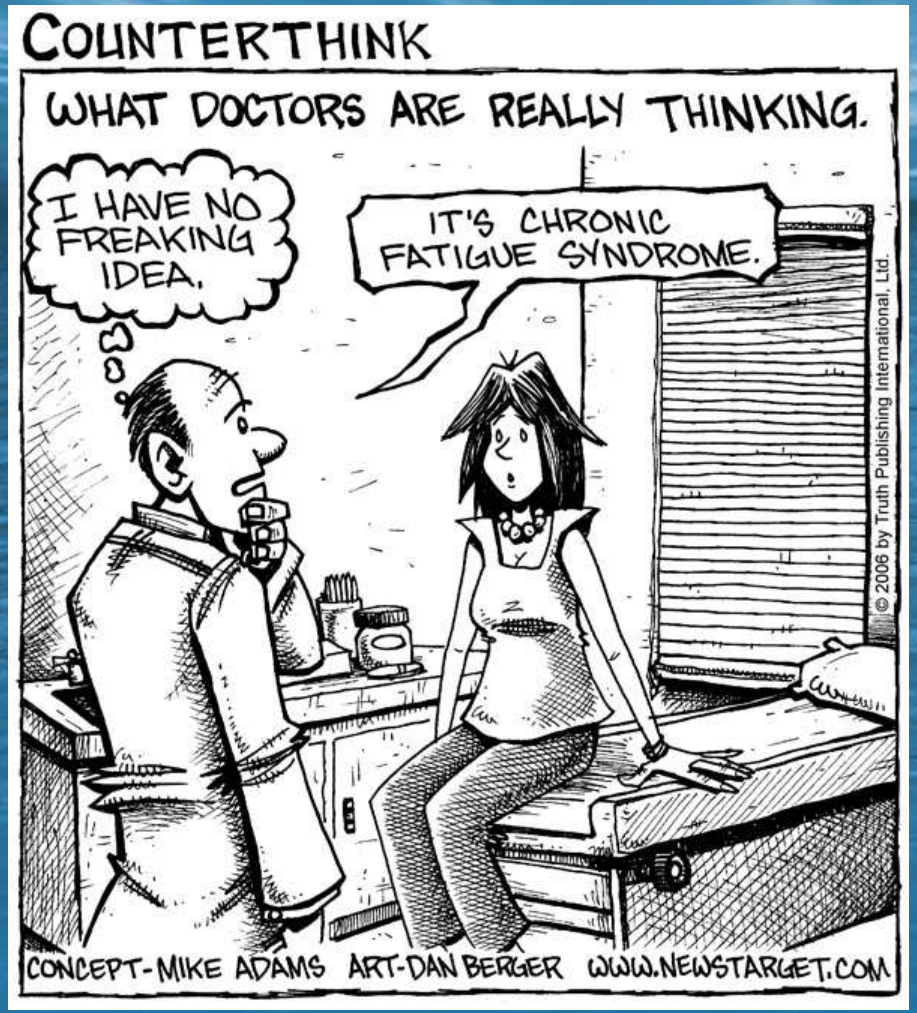
Video Clip –ABC News

Somatization Disorder:



- **Somatization Disorder**: Patient will complain about vague and unverifiable medical conditions such as: dizziness, heart palpitations, and nausea.
- No physical cause
- To be classified with this disorder the patient must be “suffering” from multiple symptoms.

More about somatization disorder:



- The disorder usually begins before the age of 30 and occurs more often in women than in men.
- Patients are often dismissed by their physicians as having problems that are "all in your head.“
- Doctors will often think these patients are making up their symptoms.

MASS HYSTERIA!!!

- Pg. 520 – Regular Psychology book
- Orson Welles – War of the Worlds
- Self Test – on my website

So, Where Do These Disorders Come From? (cont.)

- **Behavioral Approach** – Acquired through classical conditioning and maintained through operant conditioning.
- **Cognitive Approach** – Misinterpretation of harmless situations as threatening.
- **Biological Approach** – Neurotransmitter imbalances.

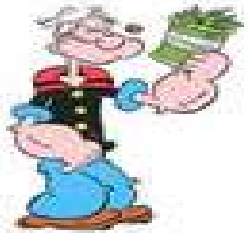
Medical Afflictions
OF THE
Cartoon World

Parkinson's Disease

Anorexia

Amphetamine Addiction

A.D.D.



Gigantism

Senile Agitation

Narcolepsy

Sexual Addiction

Violent Mood Swings

Napoleon Complex

Severe Lisp

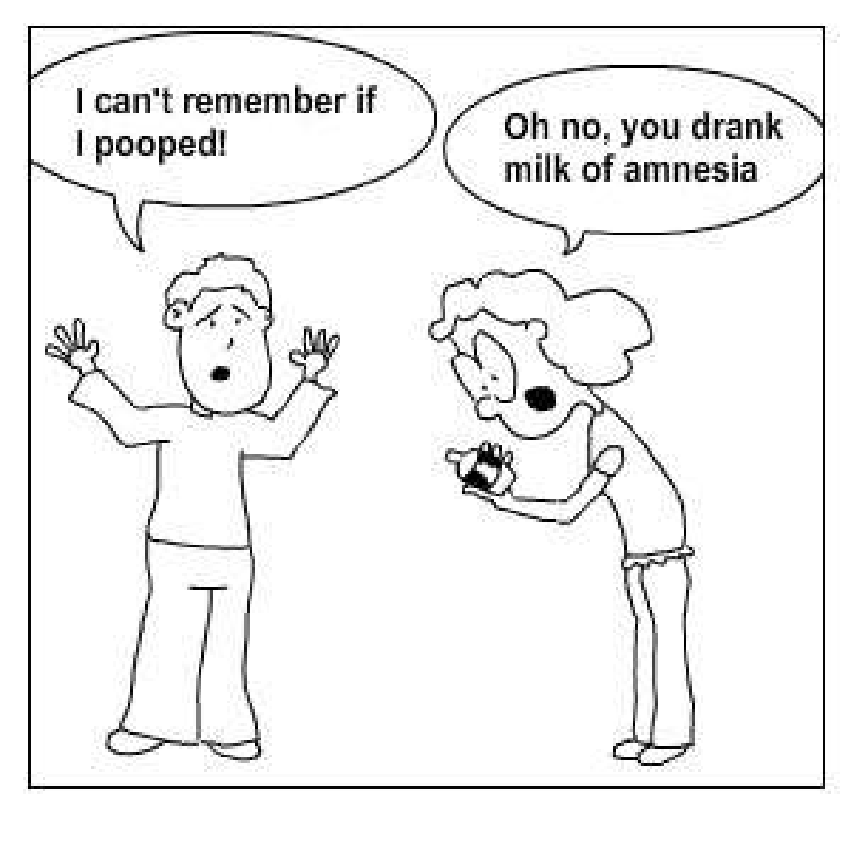
Lesson Six – Dissociative Disorders

- **By the end of this lesson, I will be able to:**
- 1. **Discuss the major diagnostic categories, including anxiety and somatoform disorders, mood disorders, schizophrenia, organic disturbance, personality disorders, and dissociative disorders, and their corresponding symptoms.**

What are Dissociative Disorders?

- **Dissociative Disorder** - Disorders in which conscious awareness becomes separated (dissociated) from previous memories, thoughts and feelings.

Which Disorders Will We Be Talking About Today?



- Dissociative Amnesia
- Dissociative Fugue
- Dissociative Identity Disorder - Intro

Dissociative Amnesia

- This disorder is characterized by a blocking out of critical personal information, usually of a traumatic or stressful nature.
- Dissociative amnesia, unlike other types of amnesia, does NOT result from other medical trauma (a blow to the head).

Localized Amnesia:

- **Localized amnesia** is present in an individual who has no memory of specific events that took place, usually traumatic.
- **Example**: a survivor of a car wreck who has no memory of the experience until two days later is experiencing localized amnesia.

Selective Amnesia:

- **Selective amnesia** happens when a person can recall only small parts of events that took place in a defined period of time.
- **Example**: An abuse victim may recall only some parts of the series of events around the abuse.

Generalized Amnesia:

- **Generalized amnesia** is diagnosed when a person's amnesia encompasses his or her entire life.
- **Example**: I don’t know who I am.

Systematized amnesia

- **Systematized amnesia** is characterized by a loss of memory for a specific category of information.
- **Example**: A person with this disorder might be missing all memories about one specific family member.

Dissociative Fugue:

- **Dissociative Fugue** - An individual with dissociative fugue suddenly and unexpectedly takes physical leave of his or her surroundings and sets off on a journey of some kind.
- These journeys can last hours, or even several days or months.
- Affects .2% of the population

More about Dissociative Fugue:

- Individuals experiencing a dissociative fugue have traveled over thousands of miles.
- An individual in a fugue state is unaware of or confused about his identity, and in some cases will assume a new identity (although this is the exception).
- Article - http://www.msnbc.msn.com/id/15373503/

So…How Does This Happen?

- Often associated with stress (stressful event)
- Traumatic experiences (war, or natural disasters) - increase the incidence of the disorder.
- Death of a loved one
- Serious work or home pressures (avoidance)

Dissociative Identity Disorder:

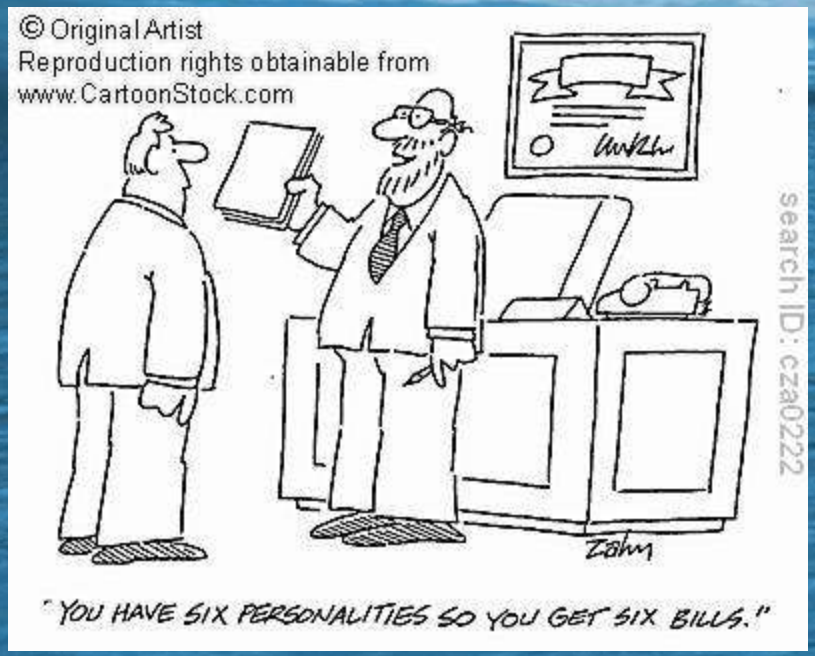
Click on the picture for a link to a great video on Dissociative Identity Disorder.

- DID - A rare dissociative disorder in which a person exhibits two or more distinct and alternating personalities.
- Also known as multiple personality disorder.
- Additional Link:

Conditions:

- **Four conditions for diagnosis:**
  - Presence of two or more distinct personalities
  - At least two take control of persons behavior
  - Inability to recall important personal information
  - Not related to drugs or medical condition

More about DID:



- Generally individuals who have this disorder are identified initially because they complained of having lost periods of time during which they apparently were doing something but have no recollection of what.
- Long-term psychotherapy is the treatment of choice.
- Therapy consists in attempt to uncover trauma.
- Article: http://www.cbsnews.com/stories/2009/03/08/sunday/main4852177.shtml

Key Facts About DID:

- This disorder is RARE
- Each personality may have it's own name, memories, traits, and physical mannerisms.
- May also be different in age, race, gender, and sexual orientation.
- Alters are commonly quite different from one another.
- The alters can come on suddenly

Causes:

- Little is known
- Stress
- Intentional role playing (stemming from inferiority)
- Media reinforcement (Before *Sybil*, 1973 (2 or 3 alters, now 15 or more)
- Most common cause: Severe physical, sexual, emotional abuse, or rejection (usually during childhood)
- More likely to occur in females

Controversy:

- **Controversy**
  - Only 200 cases before 1970
  - Now may run as high as 5% of inpatient hospital admissions
  - Some Psychologists think this is becoming a “cultural phenomenon”

Lesson Seven: Personality Disorders

- **By the end of this lesson, I will be able to:**
- **Discuss the major diagnostic categories, including anxiety and somatoform disorders, mood disorders, schizophrenia, organic disturbance, personality disorders, and dissociative disorders, and their corresponding symptoms.**

Personality Disorders:

- **Personality disorder** – person has longstanding, maladaptive thought and behavior patterns that are troublesome to others, harmful, or illegal.
- **Key Fact** – these patterns may impair a person's social functioning BUT they usually do not create anxiety, depression, or delusions.
- **Three clusters** – odd/eccentric, dramatic/emotionally problematic, chronic fearfulness / avoidant

Odd / Eccentric

- **Paranoid** – Unwarranted suspiciousness and mistrust, overly sensitive, often envious
- **Schizoid** – Shy, withdrawn behavior, poor capacity for forming social relationships
- **Schizotypal** – Odd thinking, often suspicious and hostile

Dramatic / Emotionally Problematic

- **Histrionic** – Excessively dramatic; seeking attention and tending to overreact, egocentric
- **Narcissistic** – Unrealistically self-important, expects special treatment, can't take criticism
- **Borderline** – Emotionally unstable, impulsive, unpredictable, irritable
- **Antisocial** – Used to be called sociopaths or psychopaths, violate other people's rights without guilt or remorse, can commit many violent crimes

Chronic Fearfulness / Avoidant

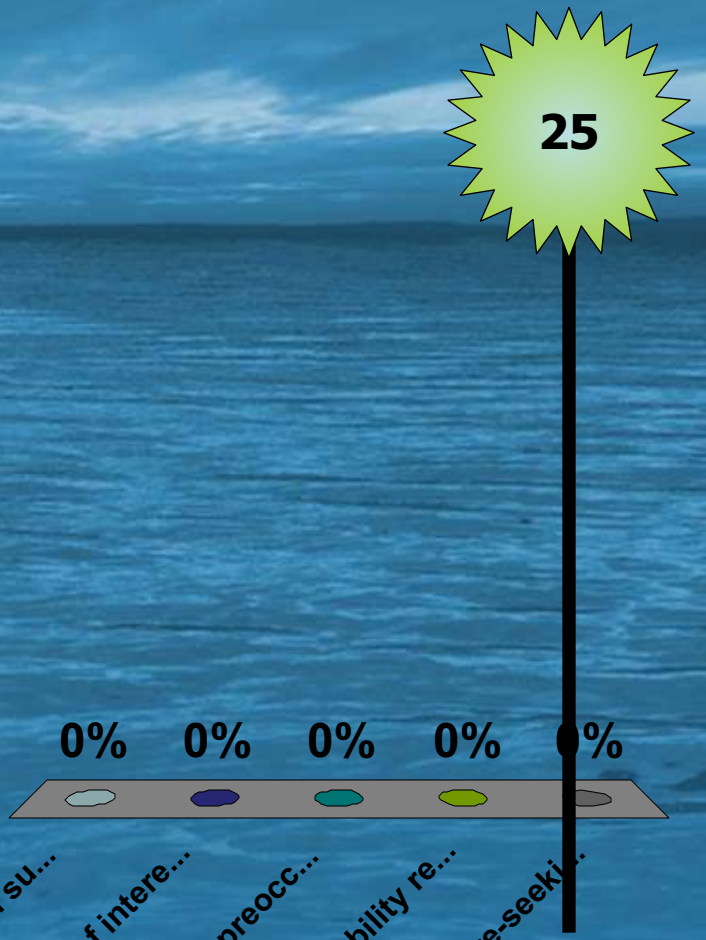
- **Avoidant** – Excessively sensitive to potential rejection, desires acceptance but is socially withdrawn
- **Dependent** – excessively lacking in self-confidence, allows others to make all decisions
- **Obsessive-compulsive** – usually preoccupied with rules, schedules, and details

Lesson Eight - Objectives

- **By the end of this lesson you will be able to:**
- 1. Describe the symptoms and causes of Bipolar Disorder.
- 2. Identify the symptoms of major depressive disorder and season affective disorder.

Paranoid personality disorder is characterized by:

1. Unwarranted suspiciousness and mistrust of other people
2. Lack of interest in social relationships
3. Unusual preoccupation with rules and schedules
4. Instability revolving around problems of mood and thought processes
5. Pleasure-seeking, shallow feelings, lack on conscience



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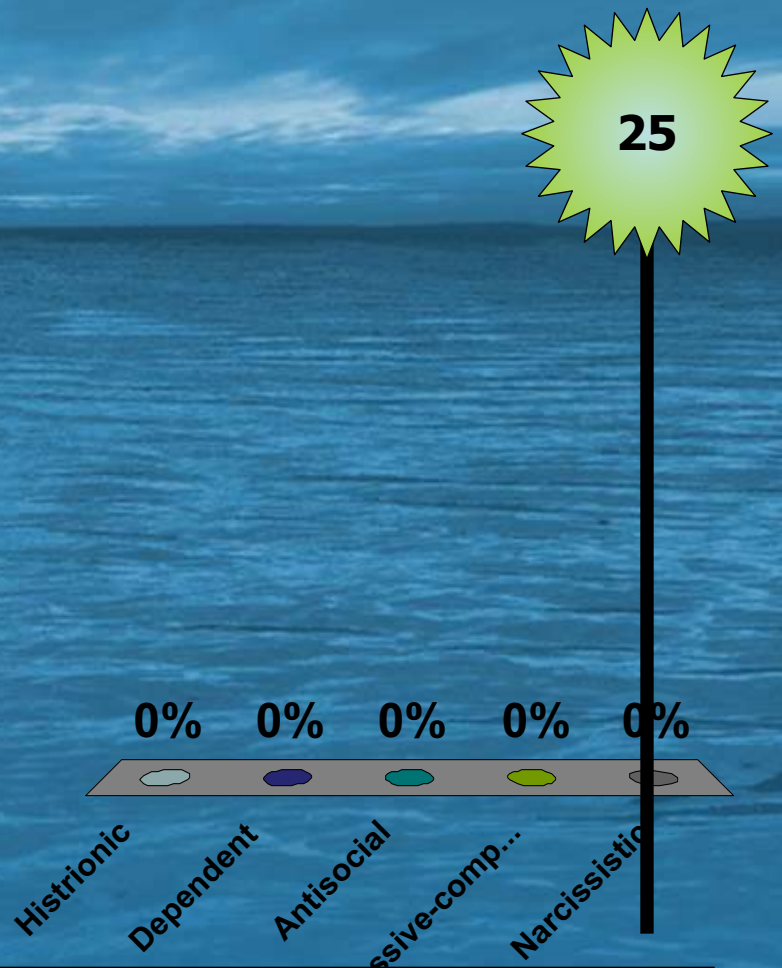
Kim always goes shopping with Maria. Because she has no confidence in her own decisions, she lets Maria decide what she should buy, and pays for clothes for Maria with money she was saving for a haircut. Kim shows signs of which of the following personality disorders?

1. Histrionic
2. Dependent
3. Antisocial
4. Obsessive-compulsive
5. Narcissistic



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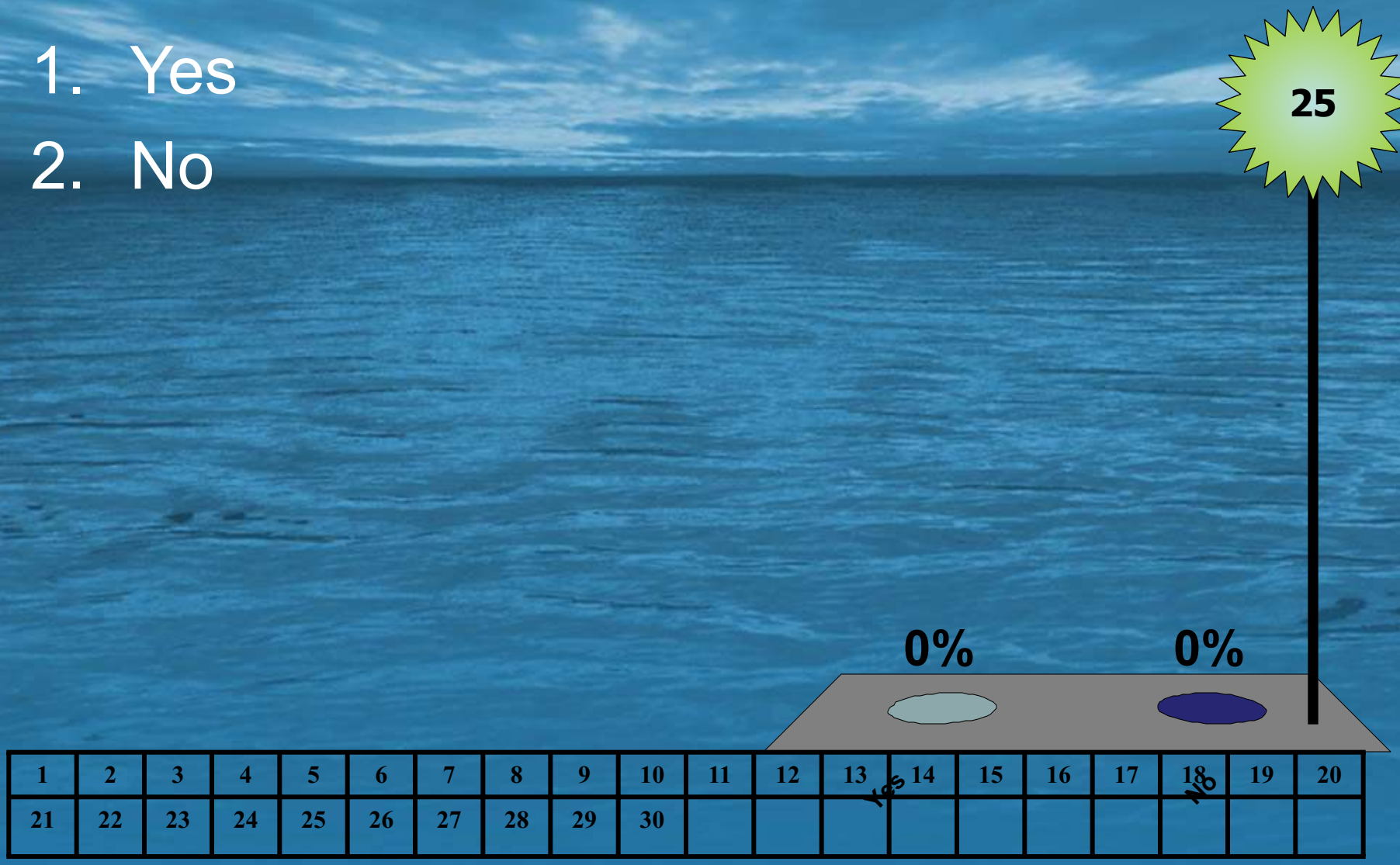
How many of you have signed up for the AP Psychology Test?

1. Yes
2. No



Bipolar Disorder: Key Facts

- Used to be called Manic-depressive disorder
- Two extremes: Mania ← → Depression
- Affects 1-2% of the population
- Equal in males and females
- Peak vulnerability (20-29.)
- Remember the Robert the Dentist story?

What is “Mania?”

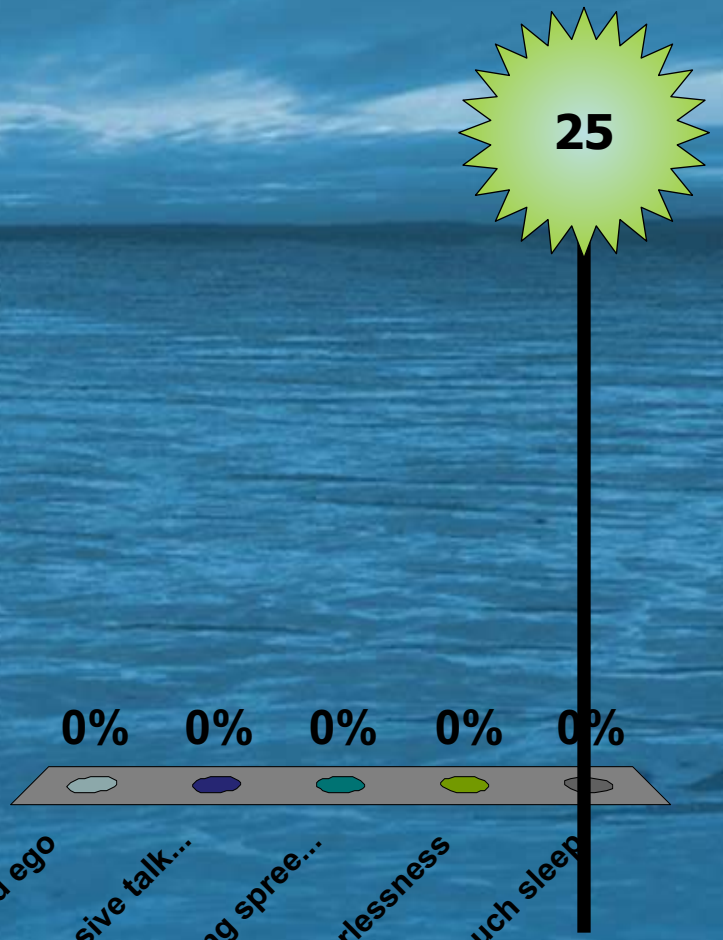
- High Self-Esteem
- Euphoria
- High Energy
- No Sleep
- Extravagant Plans
- Optimism
- Hyperactive
- Rapid Talking
- Impaired Judgment
- Excessive Gambling
- Excessive Spending
- Sexually Reckless
- Excessive Drug and Alcohol Use

Depression:

- Inability to think clearly
- Suicidal thoughts
- Excessive sleep (Why?)
- Lethargic
- Social withdrawal

Which of the following is NOT characteristic of the manic state of bipolar disorder?

1. Inflated ego
2. Excessive talking
3. Shopping sprees
4. Fearlessness
5. Too much sleep



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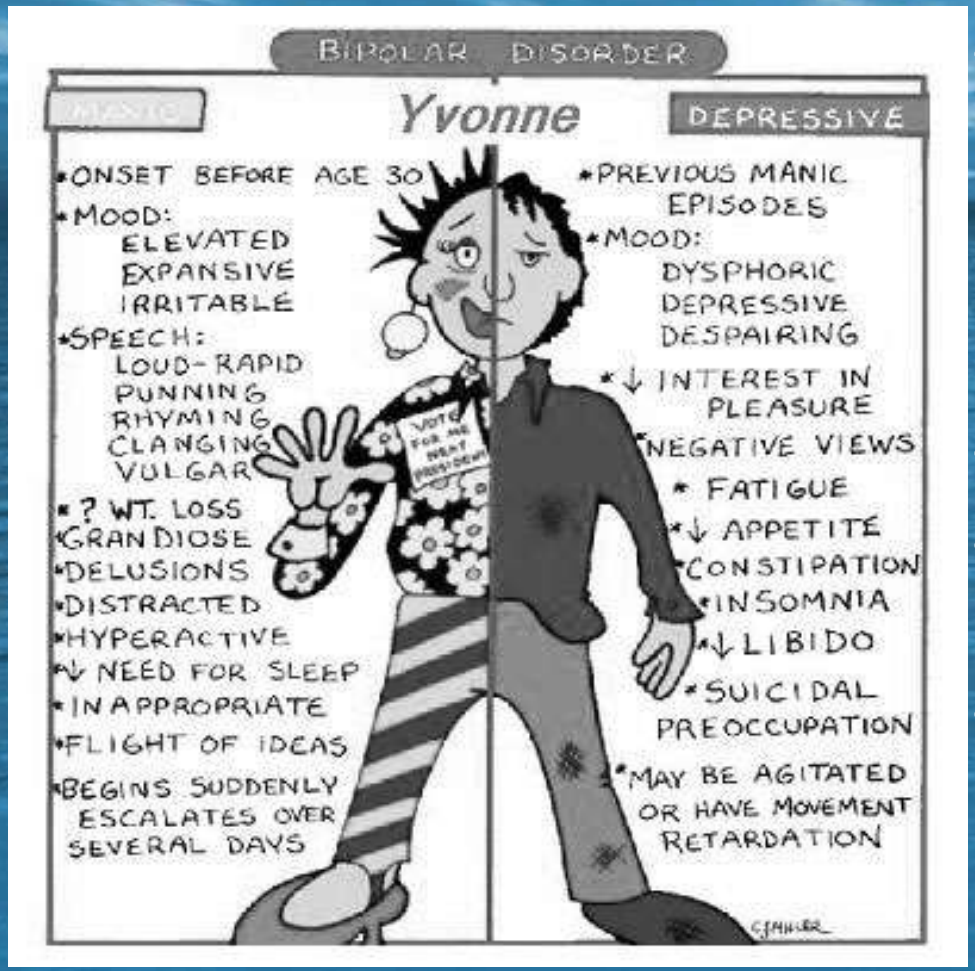
Interesting Side Note:

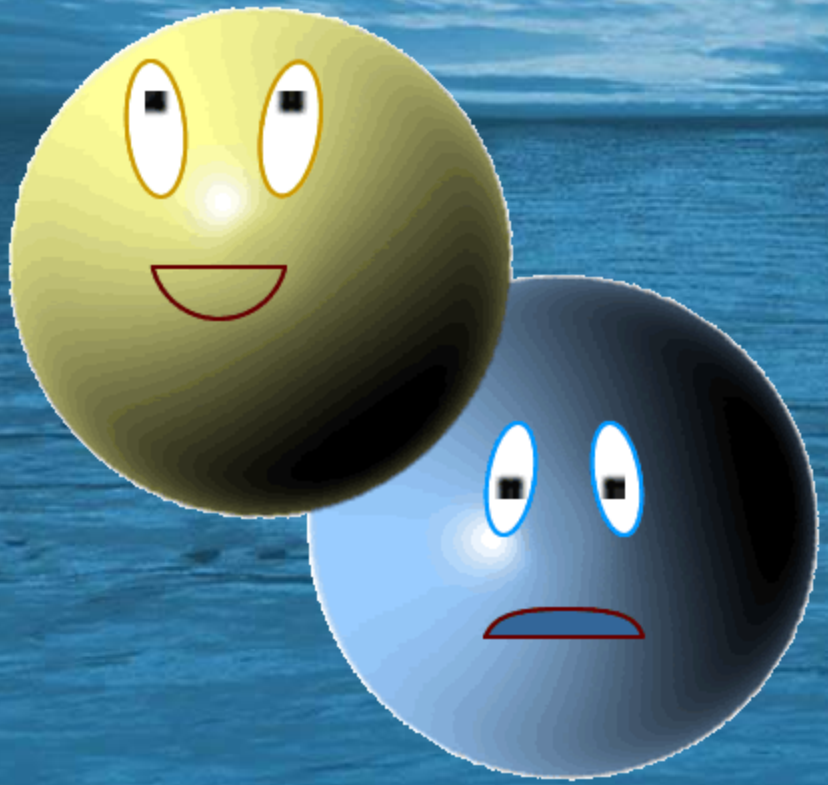


- The majority of those suffering from Bipolar Disorder at some level **enjoy** their periods of mania.
- Why?
- 1. Traits are seen as attractive
- 2. Surges of productivity and creativity

Causes of Bipolar Disorder:

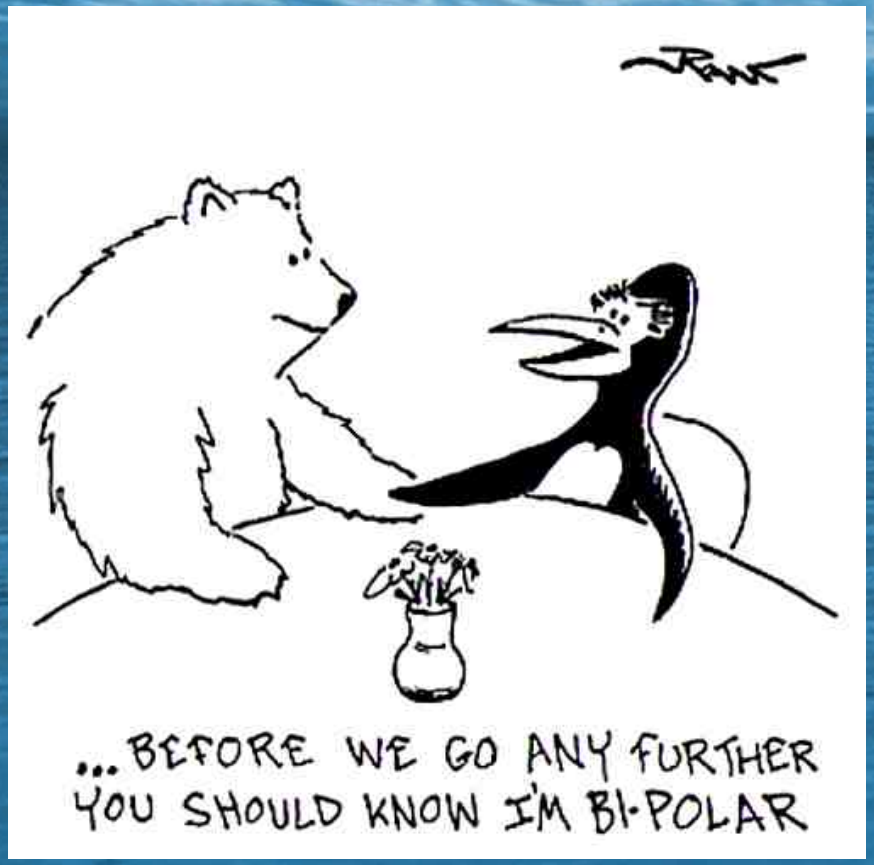
- Genetics
- Neuro-chemical
- Cognitive
- Interpersonal

Genetics:



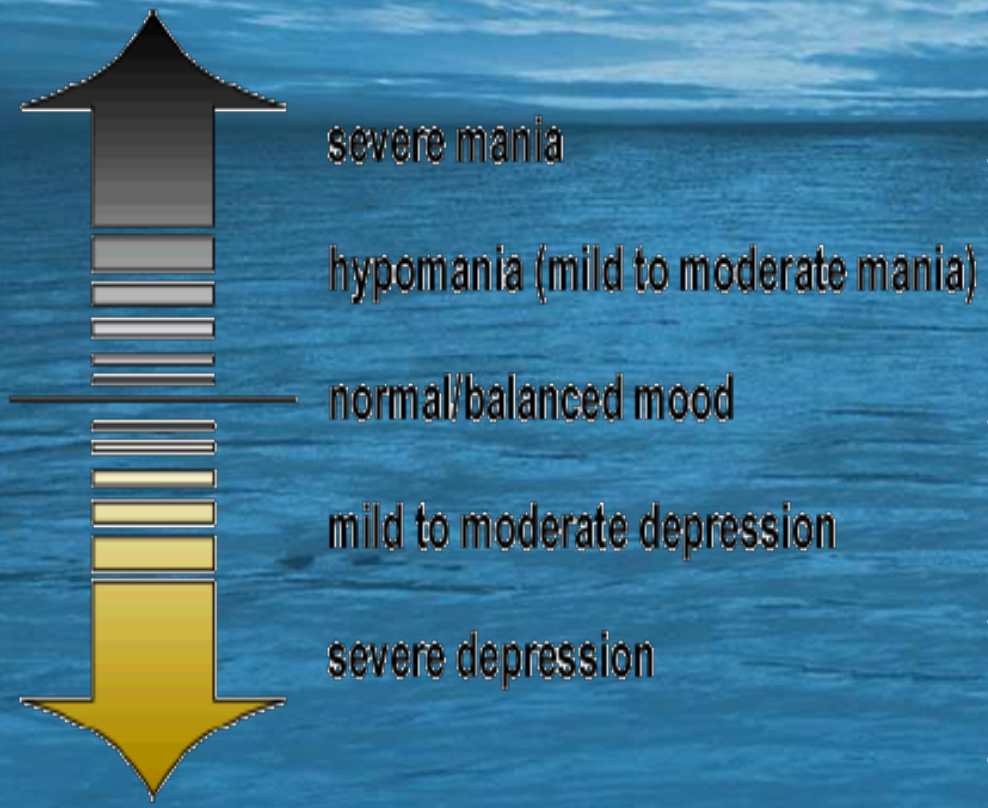
- Strong evidence
- There is a huge difference between the concordance rates between identical and fraternal twins.
- So.. There may be some predisposition here with environmental factors precipitating the symptoms.

Neuro-chemical:



- Abnormal levels of norepinephrine and serotonin. (low and high levels)
- This may be hereditary
- Drug therapy is very effective

Cognitive:



- Negative thinking = Depression ---- or is it the other way around?
- Depression may be cause by “learned helplessness.” = passive giving up
- How do people handle setbacks? (Do you take things personal?)
- Pessimistic people = increased depression
- Rumination = increase depression (m/f)

Interpersonal:

- “Misery
  you insist that the weight of the world
  should be on your shoulders
  Misery
  there's much more to life than what you see
  my friend of misery”
-

- No one wants to hang out with a “Debbie Downer” or a “Negative Nancy.”
- So….they may have a lack of social support
- So…they may gravitate towards other negative people. (Misery loves company)


Discovery
EDUCATION

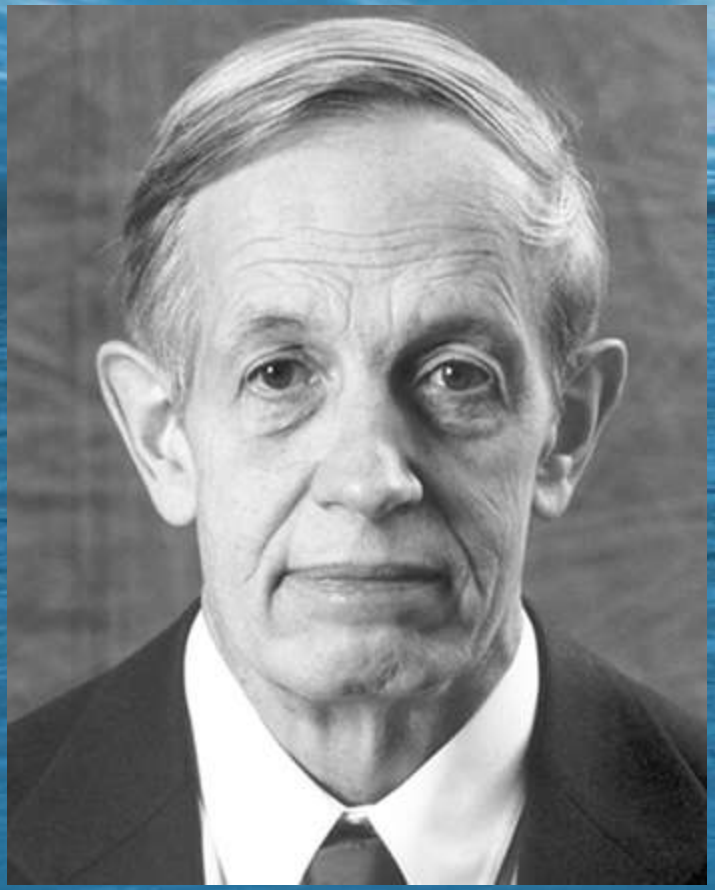
Major Depressive Disorder / SAD

- **Major Depressive Disorder** – intense depressed mood, reduced interest or pleasure in activities, and loss of energy for a min. of 2 weeks.
- **Seasonal Affective Disorder** – seasonal depression that recurs usually during the winter months (usually in northern latitudes)
- Treatment – UV lamps

Lesson Nine: Objectives:

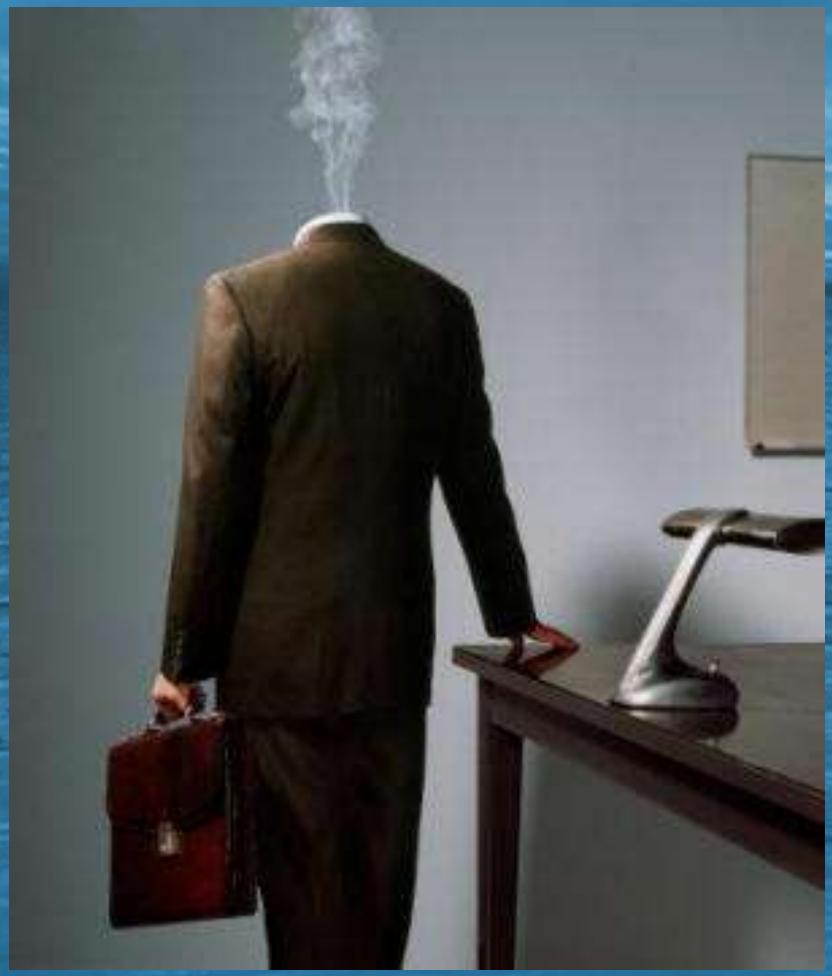
- **By the end of this lesson I will be able to:**
- 1. Describe the general symptoms, types, treatments, and possible causes of schizophrenia.

Introduction:



- Schizophrenia translates to “split mind.”
- This is not to be confused with “split personality.”
- **Definition of Schizophrenic Disorders** – A class of disorders marked by delusions, hallucinations, disorganized speech, and deterioration of adaptive behavior.

How Common is the Disorder?



- 1% of the population suffers from this disorder.
- Average onset – 20-29 yrs. of age
- There have been earlier cases reported
- It is a very costly illness to treat.
- Often times, it will require extensive hospital care.
- Medications are also quite expensive

Childhood Schizophrenia Cases:

- Part 1
- Part 2
- Part 3
- Part 4
- Part 5

General Symptoms:

- **Symptoms**: (we will break each one down)
- 1. Irrational Thought
- 2. Deterioration of Adaptive Behavior
- 3. Distorted Perception
- 4. Disturbed Emotion

Irrational Thought:

- Disturbed, irrational thoughts are the hallmark of schizophrenia.
- **Delusions** – false beliefs that are maintained even though they clearly are out of touch with reality.
- Example: They feel that their private thoughts are being “broadcasted” to other people.

More about Delusions:

- Many schizophrenics will also have delusions of grandeur.
- **Delusions of Grandeur** – People maintain that they are famous or important.
- They may think they are God or possibly the Devil.

More about Delusions (cont.)

- The person's train of thought deteriorates.
- Thinking becomes chaotic rather than logical.
- Might say wild things that have nothing to do with each other.
- "word salad" – dinglehopper – Little Mermaid

Deterioration of Adaptive Behavior:

- Routines get thrown out the window. (work, social relationships, etc.)
- The ability to get up for work, shower, eat breakfast, etc. would be difficult for a schizophrenic.
- Personal hygiene is also often neglected.

Distorted Perception:

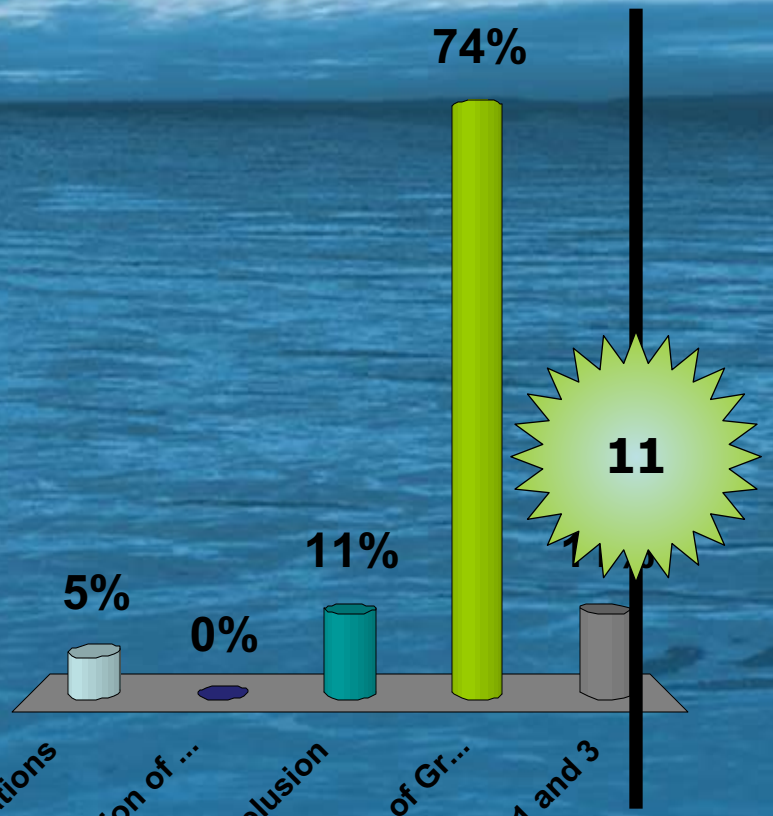
- Hallucinations are the most common.
- **Hallucination** – occur in the absence of a real, external stimulus or are distortions of perception.
- Hearing voices – sometimes from famous people.
- “seeing” other people, smells
- These voices often make rude comments or can even be in the form of a running commentary on their lives.

Disturbed Emotions:

- Some patients show a flattening of emotions – no response
- Others show inappropriate emotional responses – these may not fit with the situation or with what they are saying.
- They may also become emotionally volatile. (erratic or unpredictable)

A schizophrenic patient believes that they are the smartest person in the world. This false belief would be considered a:

1. Hallucinations
2. Distortion of perception
3. Delusion
4. Delusion of Grandeur
5. Both 1 and 3



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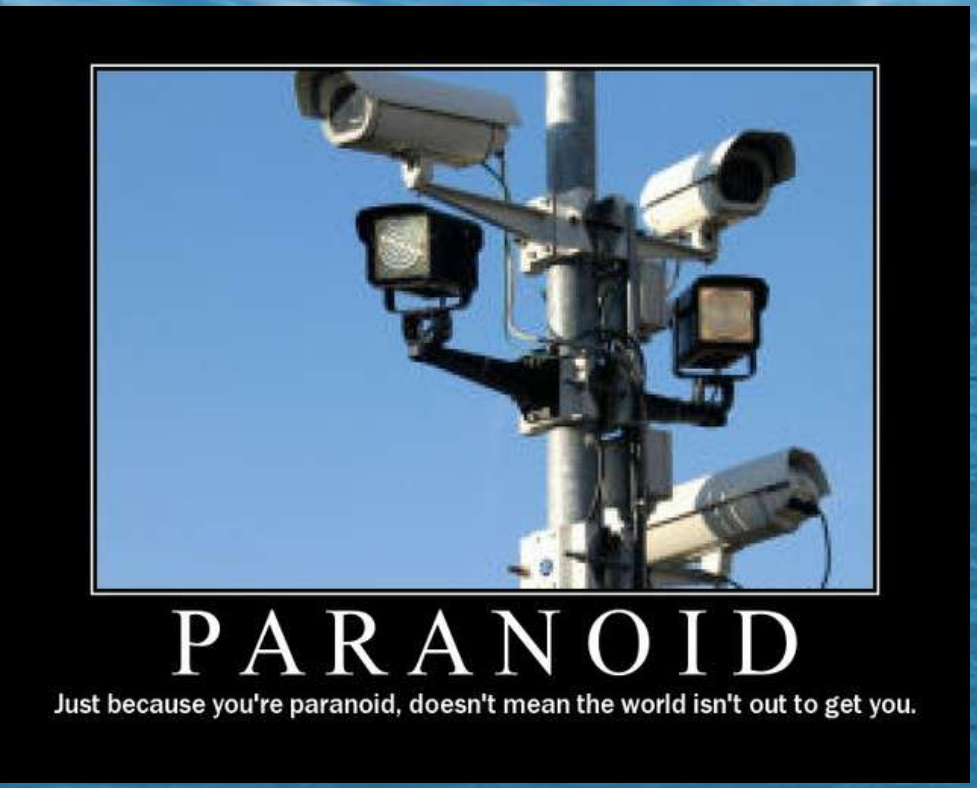
Paranoid Schizophrenia:



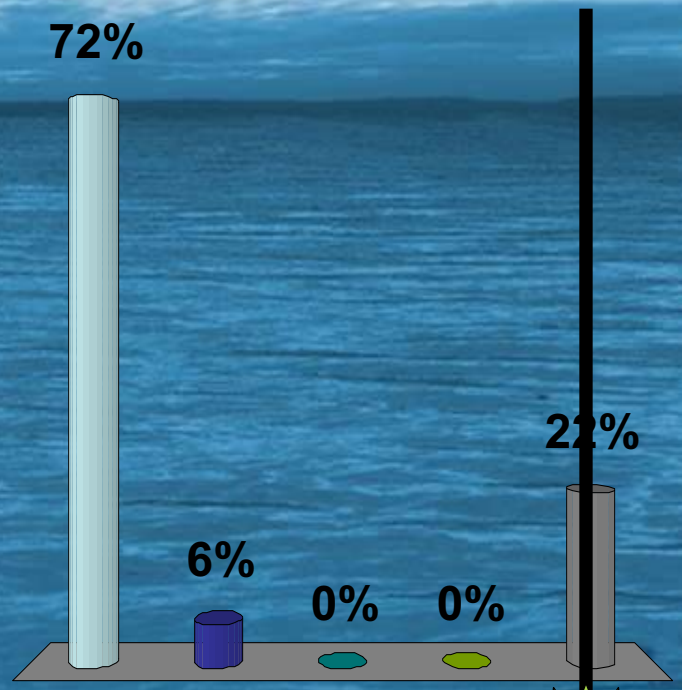
- Dominated by delusions of persecution, along with delusions of grandeur.
- Believe they have many enemies who will harass and oppress them.
- They become suspicious of friends and family. (being watched)

Paranoid Schizophrenia: Cont.

- To make sense of this persecution they often develop delusions of grandeur.
- They may see themselves as great inventors, or great religious or political leaders.
- “I am the President of the USA!” (Sylvia)

Why do many schizophrenics become paranoid?

1. Because they have distorted perceptions of their own abilities
2. They have been told they are important by their therapists
3. They have not received treatment
4. Paranoia is a byproduct of drug therapy
5. They do not trust their own judgment



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Catatonic Schizophrenia:

People with catatonic schizophrenia display extreme **inactivity** or **activity** that's disconnected from their environment or encounters with other people (catatonic behavior).

- These episodes can last for only minutes or up to hours.
- Excessive mobility (excitement), Physical immobility (stupor) peculiar movements, Extreme resistance, mimicking speech (echolalia, and echopraxia)

Disorganized Schizophrenia:

- Describes a severe deterioration of adaptive behavior.
- Person may become emotionless – social withdrawal.
- They may also exhibit excessive babbling and giggling.
- Delusions often center around bodily functions – “My brain is melting out of my ears.”

Undifferentiated Schizophrenia:

- Occurs when a patient cannot fit into any separate category.
- This is very common because many schizophrenics display multiple “types” of schizophrenia.

Positive vs. Negative Symptoms:

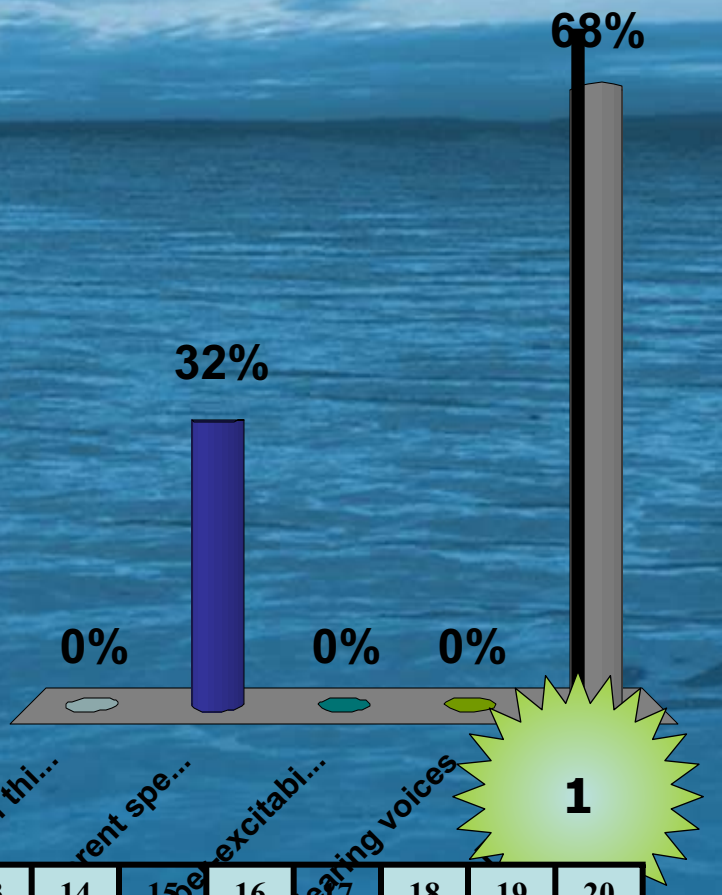
- **Positive Symptoms** – Involve behavioral excesses or peculiarities (hallucinations, delusions, bizarre behavior, and wild ideas)
- **Negative Symptoms** – Flattened emotions, social withdrawal, apathy, impaired intention, and poverty of speech.

Why Positive and Negative?

- A patient that has more positive symptoms before treatment will usually respond to treatment better than a patient with more negative symptoms. (Cuesta, 1994)
- Some researchers classify schizophrenics by positive and negative rather than by type.

Which of the following is a negative symptom of schizophrenia?

1. Delusional thinking
2. Incoherent speech
3. Hyper-excitability
4. Hearing voices
5. Flat affect



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Dealing with Schizophrenic Patients:

- A patient has a relatively favorable prognosis when:
- 1. The onset of the disorder is sudden and not gradual.
- 2. The onset has occurred at a later age.
- 3. The patient was going to work or school before the diagnosis.
- 4.The proportion of negative symptoms is low.
- 5. The patient has a relatively healthy and supportive family network.

What Causes Schizophrenia?

- The exact cause of schizophrenia is not yet known
- It is not the result of bad parenting or personal weakness
- **The Big Three:**
- 1. Genetics
- 2. Brain Chemistry
- 3. Environmental Factors

Genetics

- Schizophrenia tends to run in families
- Parents don’t have schizophrenia =1% chance
- 1 parent has schizophrenia = 14%
- Both parents have schizophrenia = 46%

Brain Chemistry:

- Dopamine imbalance
- They may be either very sensitive to or produce too much of a brain chemical called dopamine
- An imbalance of dopamine affects the way the brain reacts to certain stimuli, such as sounds, smells and sights, and can lead to hallucinations and delusions.

Environmental Factors:

- Stress can bring out schizophrenic symptoms such as delusions and hallucinations
- Schizophrenia more often surfaces when the body is undergoing hormonal and physical changes, such as those that occur during the teen and young adult years.

Discussion Questions: Turn and Talk – 3 minutes

- 1. Do you think that the two girls that have schizophrenia should play together?
- 2. What are the possible positive and negative outcomes?
- 3. Do you agree with how the family is dealing with the issue? (apartments)
- 4. What do you think the future looks like for both of these girls?

Lesson Ten: Treatment

- **By the end of this lesson, I will be able to:**
- 1. **Describe major treatment orientations used in therapy (e.g., behavioral, cognitive, humanistic) and how those orientations influence therapeutic planning.**

Mental Health Practitioners:

- **Psychiatrist** – Medical doctor who can prescribe medication – they generally focus on biological approach to treatment
- **Clinical psychologist** – Ph.D.'s who use a variety of treatment approaches because they don't prescribe drugs (work in conjuncture with psychiatrists)
- **Counseling psychologist** – Deal with less severe mental problems (college setting, marital)
- **Psychoanalysts** – Follow Freudian techniques to uncover sources of distress

Therapy Types: Group Therapy

- **<u>Group Therapy</u>** – Helps people because they realize that others have similar problems.
- Get information from therapist and other group members
- Cheaper than individual therapy

Therapy Types: Couples and Family Therapy

- **Couples and Family Therapy** – Therapist acts as a mediator between the couples
- The focus is to improve their relationships

Therapy Types: Self-Help Groups

- **Self-help groups** – groups themselves lead the group, not a therapist
  - Tend to have a spiritual focus
- **Alcoholics Anonymous** – acts as a peer support and outlet

Deinstitutionalization:

- Serious overcrowding became a problem in the 1950's (neglect)
- With creation of better meds, less hostile patients were placed back in regular communities.
- **Drawback** – people can't make it on their own → they can't afford meds or treatment

Treatment Approaches:

- No approach is ideal
- Psychoanalysis
- Behavioral
- Humanistic
- Cognitive
- Biological

Psychoanalysis Terms:

- **Old terms:**
- Free association, manifest content, latent content, Hypnosis
- **New terms:**
- **Resistance** – Blocking of anxiety-provoking feelings, coming late for sessions – (problem)
- **Transference** – Client learns to see therapist as significant person in their life (open up)
- **Catharsis** – The release of emotional tension after reliving an emotionally charged experience from the past.

Behavioral Terms:

- **Old terms:**
- Behavioral therapy, systematic desensitization, flooding, token economy, primary/secondary reinforcers, behavior modification, aversive conditioning
- **New terms:**
- **Anxiety hierarchy** – Create a hierarchy of fears from least feared to most (start small and work up)
- **Social skills training** – Treat patients using modeling, rehearsal, and shaping
- **Biofeedback** – Giving immediate physiological feedback when treating a patient – this can lesson arousal (heart rate, blood pressure)

Humanistic Terms: Client Chooses Direction of Therapy

- **Old terms**:
- Unconditional positive regard, self-actualization, ideal self, real self
- **New terms:**
- **Active listening** – Involves echoing, restating, and seeking clarification of what the client says and does
- **Gestalt therapy** – Allows client to decide whether they will allow past conflicts to control their future or whether they will control their destiny

Cognitive Approach:

- **New Terms:**
- **Cognitive restructuring** – Turning the distorted thoughts into more realistic thoughts
- **Rational emotive therapy** – aims at eliminating self-defeating thoughts. (Albert Ellis)
- **Cognitive triad** – Looks at what a person thinks about his self / world / future (Aaron Beck)

Biological Terms:

- **Old Terms:**
- Tolerance, stimulants
- **New Terms:**
- **Psycho pharmacotherapy** – The use of psychotropic to treat mental disorders
- **Electroconvulsive shock treatment** – is given to treat mental disorders (shocks impaired region of the brain to get it to work more or less efficiently)
- **Psychosurgery** – the removal of brain tissue