Chapter 11 – Schizophrenia

Schizophrenia

- Psychotic Disorder
- DSM: Must experience two or more of these symptoms (acute episode) for at least 1 month with disturbances for 6 months
  - Delusions
  - Hallucinations
  - Disorganized Speech
  - Disorganize or Catatonic Behavior
  - Negative Symptoms
  - Must also have decline in social or occupational functioning
- Acute Schizophrenic episode ("active" phase)
  - Generally positive symptoms
  - Patient continues to experience negative symptoms outside of active phase
- **Symptoms**
  - Major disturbances
    - Thought
    - Emotion
    - Behavior
  - Disordered thinking
  - Disturbances in movement and behavior
  - **Positive Symptoms (Added behaviors)**
    - Delusions
      - Often persecutory delusions (CIA implanting thoughts in head)
      - Can include grandiose delusions (Belief one is Jesus Christ)
    - Hallucinations
      - Audible (Hearing things that are not there) – Often manifests as voices in head
      - Visible (See things not there)
      - Increased activity in Broca's area during hallucinations
  - **Negative Symptoms (Removed behaviors)**
    - Avolition – Lack of interest
    - Alogia – Reduction in speech
    - Anhendonia – Cannot experience pleasure
      - Includes anticipatory (pleasure derived from excitement of future event)

            - Includes consummatory (pleasure derived from participating in an activity)
        - Flat Affect – Little emotion in face or voice
        - Asociality – Unable to form personal relationships
    - **Disorganized Symptoms**
        - Disorganized Speech
            - Incoherence – Inability to organize and articulate ideas
            - Loose associations – Goes off on tangents, difficulty in staying on one topic
        - Disorganized Behavior
            - Odd behavior
                - Silliness, easily agitated, strange clothing choices
    - **Other**
        - Catatonia
            - Motor abnormalities
                - Repetitive, complex gestures
                    - Generally of fingers and hands
                - Excitable, wild flailing of limbs
            - Catatonic immobility
                - Maintain odd positions for long periods of time
            - Waxy Flexibility
                - Other people can move and pose the person's limbs
        - Inappropriate affect
            - Reacts emotionally to events opposite of social norms
                - i.e. laughing at a funeral
- **Subtypes**
    - Disorganized – Disorganized/Flat Affect
    - Catatonic – Prolonged immobility
    - Paranoid – Delusions, hallucinations, ideas of reference (weatherman giving person signs)
    - Undifferentiated – Meet criteria for schizophrenia, not for subtype
    - Residual – No longer meets criteria but still shows signs of schizophrenia
    - Poor predictive validity – much overlap among subtypes

Other Psychotic Disorders

- Schizophreniform – Symptoms last greater than 1 month but last than 6
- Brief Psychotic Disorder – Symptoms last 1 day to 1 month
    - Often triggered by extreme stress (i.e. death of a loved one)
- Schizoaffective Disorder – Symptoms of both mood disorder and schizophrenia
- Delusional Disorder – Have delusions but no other symptoms of schizophrenia

Etiology of Schizophrenia

- Genetic
    - Not likely caused by single gene
    - Studies have been done but need to be replicated (some results inconsistent)
    - Genes identified – DTNGP1 and NGR1
- Diathesis-Stress Model
    - May have heritable parts – though it is not known which parts
        - DZ twin studies – 12%
        - MZ twin studies – 44%
- Neurotransmitters
    - Dopamine Theory
        - Disorder due to too much dopamine
        - Drugs that reduce dopamine alleviate symptoms
            - Help symptoms of schizophrenia
            - Can cause similar symptoms to Parkinson's
        - Amphetamines increase dopamine – can cause psychosis
        - Dopamine mainly related to positive symptoms
        - Does not completely explain the disorder
    - Serotonin, GABA, and Glutamate also involved
- Brain Structure
    - Enlarged Ventricles
        - Indicate loss of brain cells
        - Connected to poor performance on cognitive tests
    - Reduced activity in Prefrontal Cortex
        - Behaviors affected by schizophrenia are governed by prefrontal cortex (speech, decision making)
    - Congenital factors could be factors
        - Reduced supply of oxygen during delivery
        - Viral damage to fetal brain – Flu study (higher rates of schizophrenia in women who had flu in third trimester)
- Socioeconomic Status
    - Highest rates among urban poor
        - Sociogenic Hypothesis (poverty first)
            - Disorder caused by stress of poverty
        - Social Selection Theory (disorder first)
            - Disorder causes person to drift down in Socioeconomic Status
- Family Factors
    - Schizophrenogenic Mother Theory
        - Cold, domineering mother causes child to develop schizophrenia
    - Family environment affects relapse
        - Expressed Emotion – Hostility and over involvement in patient can lead to rehospitilization

Treatment

- Effective treatment can differ based on stage of disease
  - I.e therapy may not be effective for a patient having an acute episode as they will be distracted
- Medication
  - 1st Generation – Thorazine
    - Reduced agitation
    - Lowered dopamine levels
    - Little effect on negative symptoms
    - Could cause tardive dyskinesia (develop tics)
  - Second Generation – Clozapine
    - Fewer side effects
    - Can cause a lowering of white blood cells
      - Patient needs blood checked regularly
- Psychological
  - Medication plus psychosocial intervention
    - Social skills training – learn how to get a job, bus schedule, etc.
  - Family Therapy
    - Help reduce expressed emotion
    - Educate family about Schizophrenia
  - CBT
    - Recognize delusional thoughts
    - Recognize and challenge negative behaviors
- Psychoanalytic
  - Freud did not really deal with
    - Thought they could not be treated as they could develop a close bond with the therapist

Chapter 13 – Gender and Identity Disorders

Gender and Sex Cycle

- Views on human sexuality have changed over time
  - Victorian era, individuals wore high collars/ hid sexuality
  - Inhibition of sexuality is now considered to cause problems
- Men
  - Think more about sex, want more sex, have more partners

    - More dysfunction as they age
- Women
    - Desire sex based on relationship status and social norms
    - No more dysfunction found in older women than younger
- Sexual Response Cycle
    - Appetitive/Desire Phase
        - Sexual interest or desire, often associated with fantasies
    - Excitement Phase
        - Men and women experience pleasure and increase blood flow to the genitalia
    - Orgasm Phase
        - Sexual pleasure peeks
    - Resolution Phase
        - Relaxation and wellbeing, usually follow orgasm

Sexual Desire Disorders

- Must be pervasive and lasting
- Hypoactive Sexual Disorder
    - Deficient or absent sexual fantasies or urges
        - Low sex drive
        - Can differ among cultures
- Sexual Aversion Disorder
    - Individual actively avoids genital contact with another person

Sexual Arousal Disorders

- Female Sexual Arousal Disorder
    - Consistently inadequate vaginal lubrication that hinders sexual intercourse
- Male Erectile Disorder
    - Failure to maintain an erection during the course of sexual intercourse
    - Can often be physiological

Orgasmic Disorders

- Female Orgasmic Disorder
    - Consistent absence of orgasm after sexual excitement
- Male Orgasmic Disorder
    - Consistent difficulty in ejaculating
- Premature Ejaculation
    - Ejaculation too quickly

Sexual Pain Disorders

- Dyspareunia
  - Persistent or recurrent pain during sexual intercourse
- Vaginismus
  - Involuntary spasms of outer third of vagina that makes intercourse impossible

Etiology of Sexual Dysfunctions

- Psychoanalytic
  - Repressed conflicts
    - i.e. premature ejaculation is due to hostility against partner who reminds individual of his mother
- Masters and Johnson
  - Historical Causes
    - Religious orthodoxy
    - Sexual trauma
    - Homosexual inclination
  - Current Causes
    - Performance fears
    - Spectator role
- Biological
  - Disease
  - Low hormone levels
  - Alcohol and tobacco
- Psychosocial
  - Rape
  - Early childhood sexual trauma
  - Relationship problems
  - Psychological disorders
  - Stress

Treatment

- Anxiety Reduction
- Directed masturbation
- Change thought and attitudes
- Sexual skills training
- Communication training
- Couples therapy
- Medication and physical treatment
  - “squeeze” technique for premature ejaculation
- Masters and Johnson

    - Progression from only touching (no genitalia), called sensate focus, to gradually becoming more and more intimate

Gender Identity Disorder

- Formerly known as transsexualism
- Feel as though they are the opposite sex
- May seek surgery to alter body
- Must cause distress
- May be attracted to same or opposite sex
- Controversial diagnosis – pathologizes natural diversity?
- Often diagnosed in children
    - Cross-gender behavior can be common in children, but does not indicate GID in adulthood

Etiology

- Genetic
    - At least moderately heritable
- Neurobiological
    - High levels of sex hormones in utero
- Social and Psychological
    - Reinforcement of cross gender behaviors

Treatment

- Sex reassignment surgery
    - Recommended to live 1 year as opposite sex before surgery
- Behavior treatment
    - Shaping of more masculine behaviors
    - Only affective for those who desire this treatment

Paraphilia

- Fetishism
    - Arousal from inanimate object
    - Attraction irresistible and involuntary
    - Tranvestism
        - Arousal from cross dressing
        - No desire to be opposite sex
- Pedophilia
    - Sexually arousing urges, fantasies, or behaviors involving sexual contact with prepubescent children

- Victims usually known to pedophile
    - Usually not violent, uses coercion
- Incest
    - Most common is brother and sister, father and daughter less common but more pathological
- Voyeurism
    - Arousal from observing unclothed people or sexual behavior while victim(s) is unaware
- Exhibitionism
    - Arousal from exposing genitals to unsuspecting victim
- Frotteurism
    - Rubbing genitals on nonconsenting person
- Sexual Sadism
    - Sexual arousal from humiliating/inflicting pain on another
- Sexual masochism
    - Sexual arousal from being the recipient of pain or humiliation
    - Masochism and sadism can occur in both heterosexual and homosexual individuals/couples

Etiology

- Neurobiological
    - Male hormones
    - Dysfunctional temporal lobe
- Psychodynamic Factors
    - Fixation at pregenital stage of development
    - Paraphilia could be a defense against repressed fears and conflicts
        - Castration anxiety
        - Fear of heterosexual relationships
- Psychological Factors
    - Classical Conditioning
        - Not supported
    - Operant Conditioning
        - Poor social skills
    - History of childhood abuse and sexual abuse
    - Cognitive distortions
        - Misattributing blame – “she said no but her body said yes”
        - Minimizing consequences – “I never touched her so couldn’t have hurt her”
        - Justifying cause – “I wouldn’t have don’t this if I wasn’t molested as a kid”

Treatment

- Treatment is difficult
    - Lack of motivation

    - May blame victim
- Aversion therapy
    - Shock while looking at pictures of their desire
- Cognitive therapy
    - Counter distorted thinking
    - Combine with skills and empathy training
- Biological
    - Castration in the past
    - Hormone medication to reduce androgens

Prevention

- Megan's Law was put into effect after she was murdered by a sex offender who had been convicted multiple times
    - Members of community must be notified with convicted sex offender is released and going to live in that community
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Rape

- Forced
    - Sexual assault on unwilling partner
- Statutory
    - Intercourse with a minor
- Most rapists known to victim
- Many times not reported
    - May believe rape is a private matter
    - Fear of reprisal
    - Belief that police will be ineffective
- Rapists often hostile towards women
- Treatment focuses on anger management, empathy training and may give medications to lower sex drive

Chapter 14 – Childhood Disorders

- Externalizing Disorders
    - Outward behaviors
    - Includes ADHD, Oppositional Defiant Disorder, and Conduct Disorder
    - More common in boys
- Internalizing Disorders
    - Inward behaviors
        - Depression, anxiety, social withdrawal

    - Includes childhood anxiety and mood disorders
    - More common in girls

ADHD

- Excessive levels of activity
- Distractibility and difficulty concentrating
- Must be sever and persistent
- Predominantly Inattentive
    - Quiet and dreamy
    - Sometimes mistaken as lazy
    - Poor grades
- Predominantly hyperactive and impulsive type
    - Bouncing of the walls
- Combined
    - Combines both types

Etiology

- Genetic
    - Adoption and twin studies – heritability as high as 70-80%
    - Genes can be at risk if alcohol or nicotine are present during prenatal
- Neurobiological
    - Poor performance on tests of frontal lobe function
- Prenatal factors
    - Low birth weight
        - Later maternal warmth can mitigate
    - Mother using tobacco or alcohol
- Parent-child relationship
    - More negative relationship
    - Family factors
        - Can contribute to ADHD but do not cause

Treatment

- Stimulant medications
    - Reduce disruptive behavior
    - Reduce aggression
- Therapy with meds
    - Improve social skills that meds alone cannot
- Psychological Treatment
    - Parental training
    - Change in classroom management

Conduct Disorder

- Pattern of behaviors that are violate social norms, others' rights, and are often illegal
- Substance abuse common
- Etiology
  - Genetic factors possible
  - Generally have low iq
  - Do not develop morals fully – lack empathy
- Treatment
  - Family intervention
  - Teach parents to reward pro social behavior
    - One of the more effective treatments
  - Anger management training
  - Programs started such as Head Start
    - Help children of families with low income to get a head start in school
    - Also provide mental health services
- Oppositional Defiant Disorder
  - Child displays pattern of defiant behavior but not conduct disorder
  - More deliberate in behavior than ADHD
- Adolescent-limited conduct problems
  - Normal childhood then have CD-like symptoms bur grow out of it

Depression

- Comorbid with adhd and cd
- Depression is recurrent
- Adolescent rates of depression are similar to adult rates
- Twice as prevalent in girls
- Etiology
  - Genetic predisposition
  - Depressed parents
  - Children and parent have more negative interactions – vicious cycle
  - Negative perceptions
- Treatment
  - SSRI more effective than tricyclics
  - CBT
  - Interpersonal therapy

Anxiety

- Sever worrying
- Must interfere with functioning

- Social Phobia
    - Separation anxiety
        - Worry about parents or self while at school
    - Fear of school
        - Fears specific aspect of school
    - Extreme shyness and withdrawal
    - May express selective mutism
        - A Refusal to speak in an unfamiliar setting
- PTSD
    - Trauma, natural disaster
- OCD
    - Similar to OCD in adults
- Etiology
    - Genetics – heritability 29-50%
    - Overestimation of threat
    - Poor social skills
- Treatment
    - Exposure to feared object
    - Cognitive restructuring
    - Skills training

Learning Disability

- Inadequate development in specific academic area (reading, writing, etc.)
- Not due to mental retardation, autism, physical disorder, or lack of educational opportunity
- Individual usually average or above average intelligence
- Etiology
    - Genetic factors
    - Problems in language processing (i.e. dyslexia)
- Treatment
    - Multisensory instruction in listening, speaking, and writing kills
    - Phonics instruction
    - Fast forWord
        - Computer games and audiotapes that slow speech sounds

Mental Retardation

- Significantly below average intellectual functioning
    - IQ less than 70
- Deficits in adaptive functioning
- Onset before age 18
- Mild mental retardation – 50-55 - 70

- Moderate mental retardation – 34-50 – 50-55
- Severe mental retardation – 20-25 – 35-40
- Profound mental retardation – below 20 – 25
- Etiology
    - Neurological
        - Down's Syndrome
        - Fragile X Syndrome
        - Recessive-gene syndrome
            - Phenylketonuria (PKU)
                - Deficiency of liver enzyme
                - Must be put on special diet in order to prevent toxins from injuring the brain
        - Maternal infectious diseases
        - Brain injury's
        - Lead or mercury poisoning
- Treatment
    - Residential treatment
    - Behavioral treatment
    - Cognitive treatment
    - Computer assisted instruction

Autistic Disorder

- Impairment in social interactions (at least 2 of the following)
    - Deficient use of nonverbal behaviors
    - Poorly developed peer relations
    - Lack of social or emotional reciprocity
- Impairments in communication (at least 1)
    - Delay in or lack of spoken communication
    - Difficulty initiating or sustaining conversation
        - Repetitious or idiosyncratic language
        - Echolalia
            - Repeating a phrase back
        - Pronoun reversal
            - Using incorrect pronoun
                - Instead of "I want that" they say "He wants that"
- Repetitious or stereotyped behaviors (at least 1 of the following)
        - Abnormal preoccupation with objects
        - Ritualized behaviors
        - Stereotyped mannerisms
        - Abnormal preoccupation with parts of an object
- Etiology

    - Psychoanalytic theory
        - Rejecting and unresponsive parent
        - Child withdraws into their own world
    - Genetic factors
        - Twin studies
            - 60 – 91% concordance rates
        - Genetic flaw
            - Deletion on chromosome 16
    - Neurobiological factors
        - Brain size
            - Brains of autistic children and adult are larger than normal
- Asperger's Disorder
    - Less severe form of autism
    - Language and intelligence intact
    - Poor social relationships
    - Recently recognized more in adult population