WEEK 1 – Classification, diagnosis and an integrative approach to psychopathology

1. Define the key elements in the current conceptualisation of abnormality or psychological disorder

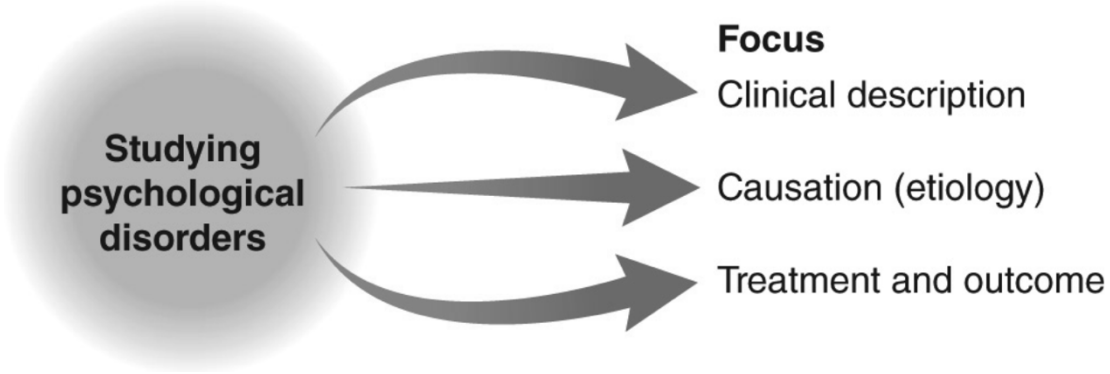
A psychological disorder is conceptualised as being a behavioural, cognitive or emotional dysfunction. It is unexpected in a cultural context, causes personal distress and/or impairment in social or occupational functioning, or increased risk of suffering, death, pain or impairment. Most disorders exist on a dimensional perspective.

General criteria include:
- The disorder is not due to the direct effects of a substance
- The disorder is not due to the direct effects of a general medical condition
- The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

2. Describe the scientist-practitioner approach to psychopathology

Research informs what interventions psychologists use; they take a scientific approach to their clinical work. Science is not only consumed, it also evaluated with clients in determining the effectiveness of the practice. Psychologists also conduct new research that leads to new procedures useful in practice.

3. Describe the three major categories of focus underlying the study and discussion of psychological disorders



Clinical description:
Course:
- Episodic; individual will recover within a few months, only to suffer again at a later time
- Time-limited; disorder will improve without treatment within a relatively short period of time with little/no risk of reoccurrence
- Chronic; disorder tends to last a long time/lifetime

Onset:
- Acute; disorder begins suddenly
- Insidious; disorder presents itself gradually over an extended period

Treatment:

Clinicians agree that victims of PTSD should face the original trauma, process the intense emotions, and develop effective coping procedures in order to overcome the debilitating effects.

Some drugs, such as SSRIs, that are effective for anxiety disorders in general have shown to be helpful for PTSD, perhaps because they relieve the severe anxiety and panic attacks that accompany PSTD.

8. Describe the clinical features, causes, and treatment of **OCD**

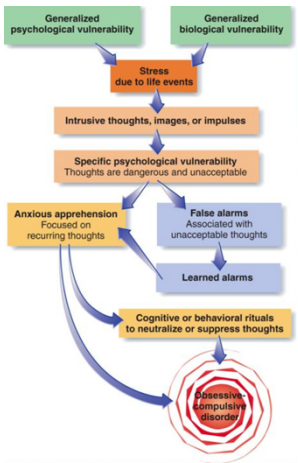
OCD is the devastating result of the anxiety disorders. One with OCD may experience severe generalised anxiety, recurrent panic attacks, debilitating avoidance and major depression, all occurring simultaneously with OCD symptoms.

The danger is usually in an external object or situation/memory of one. In OCD the dangerous event is a thought, image, or impulse that the sufferer attempts to avoid like someone with a snake phobia.

Obsessions are the intrusive and nonsensical thoughts, images, or urges that one tried to resist or eliminate.
Compulsions are the thoughts or actions used to suppress the obsessions and provide relief.

Causes:

- Generalised biological/psychological vulnerabilities must be present for OCD to develop.
- Believing some thoughts are unacceptable and must be suppressed may put people at greater risk of OCD.



Treatment:

SSRIs are most effective and benefit up to 60% of OCD sufferers. Relapse often occurs when the drug is discontinued. Psychological treatment is found to be some-what better than drug treatment.

The most effective psychological treatment is exposure and ritual prevention. It is a process whereby rituals are actively prevented and the patient is systematically and gradually exposed to feared thoughts or situations.

Psychosurgery is also one of the more radical treatments for OCD.

9. Describe the clinical features, causes, and treatment of **BODY DYSMORPHIC DISORDER**

Relatively normal looking people think they are so ugly that they refuse to interact with others or otherwise function normally for fear that people will laugh at their ugliness.

OCD often occurs with BDD and is found among family member who have BDD. People with BDD complain of horrible, intrusive thoughts about their appearance, and so engage in compulsive behaviours like repeatedly looking in the mirror to check their physical features. People with BDD often have 5-7 body parts of concern. Great focus can be on hair, skin, nose, stomach, teeth and weight for example. Some people completely avoid mirrors as if it is a phobia, and others often check to see if their appearance has changed. Suicidal thoughts and attempts are common consequences of BDD.

WEEK 4 – Somatic Symptom and Dissociative Disorders

1. Describe the clinical features, causes and treatment of **somatic symptom disorder** and **illness anxiety disorder**

Clinical features of SSD:

- One or more somatic symptoms that are distressing and/or result in significant disruption of daily life
- Excessive thoughts, feelings, and behaviours related to the somatic symptoms or associated health concerns as manifested by at least one of the following:

1. disproportionate and persistent thoughts about the seriousness of one's symptoms
2. high level of health related anxiety
3. excessive time and energy devoted to these symptoms or health concerns

- Although any one symptom may not be continuously present, the state of being symptomatic is persistent (more than 6 months)

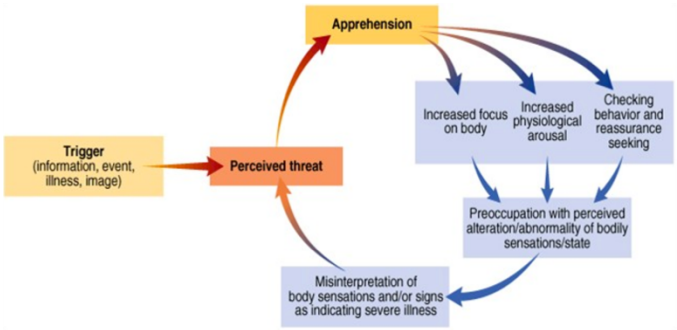
Clinical features of IAD:

- Preoccupation with fears of having a serious illness
- Somatic symptoms are not present or, if present, are only mild in intensity. If a medical condition is present, or there is a high risk for developing medical condition, the preoccupation is excessive or disproportionate
- High level of anxiety about health and the individual is easily alarmed for personal health
- The individual performs excessive health-related behaviours or exhibits maladaptive
- Illness preoccupation has been present for at least 6 months, but the specificity may change over time
- The illness-related preoccupation is not better explained by another mental disorder

Causes:

Faulty interpretation of physical signs and sensations as evidence of physical illness is central – basically it is a disorder of cognitive perception with strong emotional contributions

- Patients with these disorders show enhanced perceptual sensitivity to illness cues who also interpret ambiguous stimuli as threatening
- Hyper-responsivity might combine with a tendency to view negative life events as unpredictable and uncontrollable and, therefore, to be guarded against at all times
- These disorders seem to develop in the light of stressful life situations (death/illness)
- People who develop these disorders seem to have disproportionate incidence of disease in their family when they were children
- Important social and interpersonal influence may be involved – some people who come from families where illness is a major issue may have learned that ill people get a lot of attention. Therefore, the 'benefits' of being sick may contribute to the development of the disorder.



Treatment:

Reassurance and education can be effective as with CBT.

An educational framework was associated with a significant reduction in fears and beliefs about somatic symptoms and decrease in health-care usage and this was maintained at the follow-up assessment.

WEEK 10 – Neurodevelopmental Disorders

1. Outline the features of **attention deficit/hyperactivity disorder**.

- Difficulty sustaining their attention on a task or activity; appear to not be listening, not pay enough attention to details, making careless mistakes
- Motor hyperactivity; fidgeting, not able to sit still, always being on the go
- Impulsivity; blurting out answers before questions are completed, trouble waiting turns
- Academic performance generally suffers
- Unpopularity and rejected by peers

2. Discuss the biological and psychological factors thought to cause attention deficit/hyperactivity disorder.

BIOLOGICAL –

- Relatives of children with ADHD have been found to be more likely to have ADHD themselves as well as psychopathology in general
- Multiple genes are thought to be responsible for ADHD. That is that some genes may be 'turned off' (not making proteins) when they should be 'on'. It is also thought that mutations occur to create extra copies of genes on one chromosome or others are deleted.
- There is strong evidence that ADHD is associated with the dopamine transporter gene and receptor gene.
- Maternal smoking is thought to increase the chance that a child will have a genetic predisposition to ADHD
- The brain of children with ADHD is slightly smaller (3-4%) than those without it.

PSYCHOSOCIAL –

- Negative responses by parents, teachers, and peers to the affected child's impulsivity and hyperactivity may contribute to feelings of low self-esteem. Years of reminds to sit still and listen may create a negative self-image in these children which may negatively affect their ability to make friends which can last into adulthood.

3. Describe the biological and psychosocial treatment of attention deficit/hyperactivity disorder.

BIOLOGICAL –

- Ritalin and Adderall (stimulant drugs) are the most common drugs prescribed to children and adults with ADHD. They are helpful in reducing symptoms of hyperactivity and impulsivity while helping the person to concentrate. They reinforce the brain's ability to focus attention during problem-solving tasks. They are recommended temporarily in conjunction with psychological intervention.
- Some children do not respond to medications, and most that do show improvement are not able to show improvement in academia or social skills.
- Medication can have some unpleasant side effects such as insomnia, drowsiness or irritability.

PSYCHOLOGICAL –

- Setting goals like increasing the amount of time the child can stay seated, how many maths questions they can complete, or appropriate play with peers
- Reinforcement programs; reward good behaviour, misbehavior will result in a loss of rewards
- Parent education on constructive responses to their child's behaviours