ABNORMAL PSYCHOLOGY: PSY30010

WEEK 6 – CHAPTER THIRTEEN (pg. 483-527)

SCHIZOPHRENIA

- Describe the prevalence of schizophrenia and who is most affected

Schizophrenia: occurs in people from all cultures and is characterised by diverse symptoms, including oddities in perception, thinking, action, sense of self, and relating to others. The hall mark symptom is a significant loss of contact with reality AKA psychosis. Clinical presentation of schizophrenia differs from patient to patient.

HISTORY (pg. 484)

- 1810, John Haslam = the first detailed clinical description from Bethlem Hospital in London.
- 1860, Benedict Morel = Belgian psychiatrist who described a 13-year old boy. He used the term demence precoce (meaning mental deterioration at an early age) to distinguish him from dementing disorders associated with old age.
- 1856-1926, Emil Kraepelin = best known for his careful descriptions, using 'dementia praecox' to refer to a group of conditions that all seemed to feature mental deterioration early in life. He included descriptions such as "he becomes suspicious of those around him and sees poison in his food and is pursued by panic". He also noted hallucinations, apathy and indifference, withdrawn behaviour and an incapacity for normal work.
- 1857-1939, Eugen Bleuler = first to use the term Schizophrenia. He believed the condition was characterised by disorganisation of thought processes, lack of coherence between thought and emotion, and an inward orientation away from reality.

Schizophrenia originates from the Greek 'sxizo', meaning to 'split or crack', and 'phren' meaning the mind.

note, split does NOT refer to split personality – it instead refers to a split between intellect and emotion, and between the intellect and external reality.

TREATMENTS AND OUTCOMES (pg. 519)

- Describe the clinical outcome of schizophrenia and how it is treated, noting the advantages and disadvantages associated with the use of antipsychotic medications.

Dramatic improvement to the treatment of schizophrenics began in the 50's when antipsychotics were first introduced.

CLINICAL OUTCOME

Studies of clinical outcome show after 15-25 years of developing schizophrenia, 38% of patients have a generally favourable outcome and a 'recovered', meaning with the help of therapy and medications, patients can function quite well. Unfortunately for 12% permanent institutionalisation is required.
Also around 1/3 of patients display prominent negative symptoms. Also stringent recovery terms (i.e., lasting two years or more) lead to more modest recovery rates (around 14%).

*Patients in less industrialised countries tend to worse overall than patients from non-industrialised countries >>> It is believed that this is because EE is lower in lower-industrial countries (24%-41%) compared to higher0industiral countries (50%). This might explain differences related to location.

It is also sometimes possible that severely impaired patients will show considerable improvement late in the course of their illness. Spontaneous improvements even occurring when there is no change in the medications.

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WEEK 7 – CHAPTER NINE (pg. 327-365)

EATING DISORDERS AND OBESITY

- Identify the clinical aspects of eating disorders

Eating disorders (DSM-5): Characterised by a persistent disturbance in eating behaviour. Does include obesity which accounts for more mortality than all other eating disorders combined.

People with eating disorders show disturbed patterns of eating that impair their health or ability to function well.
- anorexia nervosa
- bulimia nervosa
- binge eating disorder

DSM-5 *Criteria for. . .*

Anorexia Nervosa

A. Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. *Significantly low weight* is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.

B. Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

ANOREXIA NERVOSA (pg. 328)

Anorexia nervosa literally means 'lack of appetite induces by nervousness' and at the heart of anorexia is the relentless pursuit for thinness. It has been around for centuries. The first medical account published in 1690 by Richard Morton, but was not named until 1873/

note **amenhorrea** = stopped periods. Which is no longer required for a diagnosis of anorexia. This was decidedd because it does not reflect mentality and also cannot be measured for men.

Patients with anorexia nervosa may be emaciated while still denying that they have any problems with their weight. They will go to great lengths to conceal their thinness by wearing baggy clothes, or by drinking massive amounts of water prior to being weighed (in a hospital setting, for instance).

There are TWO types of anorexia:

1. resricting – every effort is made to restict food intake. They may not like to eat in front of others, take a long time to consume food or just cut it into little pieces. They are also greatly admired by others with ED.

2. binge-eating/purging

Binge = out of control consumption of food, far greater than what most people would consume
Purge = efforts to remove food from the body. Communly including vomiting, laxatives, diuretics and enemas. They may also exercise excessively or fast. These strategies do not prevent all calories from the body.

Table 9.1 Distorted Thinking in Anorexia Nervosa

"I have a rule when I weigh myself. If I've gained then I starve the rest of the day. But if I've lost, then I starve too."
"Bones define who we really are, let them show."
"An imperfect body reflects an imperfect person."
"Anorexia is not a self-inflicted disease, it's a self-controlled lifestyle."
"It's not deprivation, it's liberation."

- Dancers are at especially high risk of ED.
(i.e., 20% of ballet dancers)

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WEEK 8 – CHAPTER ELEVEN (pg. 408-421 & 426-439)

ADDICTIVE DISORDERS

Most people have used alcohol at least once (82% of Australians over 18, only 9% have never).
Due to the high frequency of alcohol and tobacco use, they are not considered pathological, however when consumed in excessive amounts which lead to impairments and negative consequences, they are then considered disordered.

Substance related disorders: Are seen all around us – high rates of alcohol abuse and drug scandals with sport athletes and movie stars.

Addictive behaviour: based on the pathological need for a substance. Could involve nicotine, alcohol, ecstasy, cocaine. It is one of the most prevalent and difficult to treat health problems of society today.

The most commonly used substances are Psychoactive Substances – which target the CNS.

- Alcohol
- nicotine
- barbiturates
- tranquillizers
- amphetamines
- heroin
- ecstasy
- marijuana

Some are legal, others illegal and the remainder can be purchased under medical supervision (i.e., barbiturates or pain medications like oxytocin).

THERE IS A DISTINCTION BETWEEN SUBSTANCE ABUSE (using too much) AND SUBSTANCE DEPENDENCE (needing it)

- Substance abuse: excessive use of a substance, resulting in either;
(1) hazardous behaviour (i.e., drunk driving)
(2) continued use despite social, psychological, occupational or health problems.

Substance dependence: (more severe) involves a marked psychological need for increasing amounts of a substance to achieve the desired affects. The individual will show a tolerance for the drug and have withdrawals when it's removed.

Tolerance: Results from biochemical changes in the body that affect the rate of metabolism and elimination of the substance from the body – leads to an increase in dose needed to achieve desired effects.

Withdrawal: physical symptoms (i.e., sweating, tremors, tension) from abstinence from a drug.

ALCOHOL RELATED DISORDERS (pg. 309)

- Describe the characteristics of alcohol abuse and dependence

'The harmful use of alcohol' (used by the WHO instead of alcoholic or alcoholism)

>>> Drinking that causes detrimental health and social consequences for the drinker, the people around that person and society as a whole. The patterns of drinking are associated with increased risk of adverse health outcomes.

> 6 alcoholic drinks at least once per month = heavy episodic drinking (WHO)

Beer was first made in Egypt, 3000BC. Wine 800BC. And abuse began almost as early as the availability did.

THE PREVELENCE, COMORBIDITY AND DEMOGRAPHICS OF ALCOHOL ABUSE AND DEPENDENCE (pg.310)

Alcohol is one of the major, most destructive psychiatric disorders around the world.

13% of people in the US meet the DSM criteria for alcohol abuse at some point in their life.
5% meet the criteria for alcohol dependence at some point in their life.

Currently drinking alcohol = in the past 30 days >>> 52.2% of Americans >12 years old.
Binge drinking = >5 drinks on one occasion in the past month >>> 22.9%
Heavy drinking = having at least five drinks more than 5 times in the past month >>> 6.3%

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WEEK 11 – CHAPTER TEN (pg.365-408)

PERSONALITY DISORDERS

A person's characteristic traits, coping styles and ways of interacting in the social environment emerge during childhood and normally crystalize into established patterns by the end of adolescence or early adulthood.

Five basic personality trait dimensions can be used to characterise normal personality which are the centre of the five-factor model of personality being:

- Neuroticism (emotional instability)
- Extraversion/introversion
- Openness to experience (unconventionality)
- Agreeableness/antagonism
- Conscientiousness

CLINICAL FEATURES OF PERSONALITY DISORDERS (pg. 366)

- Describe the general features of personality disorders

Personality disorders: occur when a person has certain traits that are so inflexible and maladaptive that they are unable to function effectively or meet the demands of their society.

The general characteristics of personality disorders are:

- Chronic interpersonal difficulties - problems with one's identity or sense of self
- Inability to function in society

To be diagnosed with a personality disorder, the person's behaviour must be

- Pervasive - Inflexible - stable - have a long duration

The behaviour also must cause - clinically significant stress and impairment in functioning. It must also be manifested in *at least two of the following areas*:

- Cognition
- Affectivity
- Interpersonal functioning
- Impulse control

Outsiders often view the behaviour of people with personality disorders as confusing, exasperating, unpredictable and unacceptable.

The disorders stem largely from the gradual development of inflexible and distorted personality and behavioural patterns that result in persistently maintaining maladaptive ways of perceiving, thinking about and relating to the world. These patterns colour the disordered person's reactions to each new situation to match previous reactions, as they fail to learn from previous mistakes or troubles.

The DMS-5 personality disorders are grouped into three clusters (based on similarities):

(1) Cluster A, paranoid, schizoid and schizotypal personality disorders: often seem odd or eccentric, with behaviour ranging from distrust and suspicion to social detachment. *prevalence of 4%*

(2) Cluster B, histrionic, narcissistic, antisocial and borderline PD: these people share a tendency to be dramatic, emotional and erratic. *least common, with a prevalence of 3.5-4%*

(3) Cluster C, avoidant, dependent and OCD disorders: these people can show anxiety and fearfulness. *the most common, with a prevalence of 7%*

About ¾ of people diagnosed with personality disorder also have another disorder as well; personality disorders are often associated with anxiety, mood disorders, substance use problems and sexual difficulties disorders.