PSYCHOLOGICAL DISORDERS

AND TREATMENTS

Terms for Flashcards Unit 10:

Mental Illness

Attention Deficit/Hyperactivity disorder	Major depressive disorder	Personality disorders
Medical model	Mania	Illness anxiety disorder
DSM-5	Bipolar disorder	Mood disorders
Anxiety disorders	Schizophrenia	Post- traumatic stress disorder
Generalized anxiety disorder	Psychosis	Conversion disorder
Panic disorder	Delusions	Obsessive-compulsive disorder
Phobia	Hallucinations	Somatic symptom disorder
Social anxiety disorder		

Pick 15 terms from the above list that you are least familiar/comfortable with and construct a flash card including the following information:

1. **Define** the term IN YOUR OWN WORDS. Try and keep the definition short, meaningful, and something that you can remember.

2. **Draw** a picture that demonstrates the term OR describe a personal example.

Rosenhan Study – AP Psychology

Question: Suppose someone were committed to a psychiatric hospital by accident. Would the staff notice? Would the person be able to get out?

David Rosenhan of Stanford University set out to answer these questions and another "How accurately to psychiatric hospitals distinguish between people who are psychotic and those who are healthy?"

To find out, Rosenhan and several colleagues had themselves committed (Rosenhan, 1973). Entrance to mental hospitals was gained by faking only one symptom. Rosenhan and the others complained of hearing voices, which said "empty," "hollow," and "thud." In 11 out of 12 tries, the were admitted with a diagnosis of "schizophrenia."

Pseudo-patients After being admitted these "pseudo-patients" dropped all pretense of mental illness. Yet, even though they acted completely normal, none of the researchers was ever recognized by the hospital staff as a phony patient. Other patients were not so easily fooled. It was not unusual for a real patient to say to one of the researchers "You're not crazy, you're checking up on the hospital!" or "You're a journalist."

Rosenhan and the others spent from one to seven weeks in hospitals before being discharged. The hospitals ranged from very modern and plush to ancient and shoddy. No matter how good the facilities or how good the hospital's reputation, Rosenhan found some disturbing conditions.

Contact between staff and a patient was very limited and sometimes marked by fear or hostility. It was found that attendants and staff only spent an average of 11.3 percent of their time out of the "cage," the glassed-in central compartment in the ward.

It was not unusual for the morning attendants to wake patients with a hostile call of: "Come on you m----- f-----s, out of bed!" When patients tried to talk with staff, they were often ignored or received strange replies. One pseudo – patient approached a psychiatrist and politely asked when he might get grounds privileges. The doctor's reply was, "Good morning Dave. How are you today?"

Rosenhan found that therapy other than drugs was very limited. Daily contact of patients with psychiatrists, psychologists, or physicians averaged about 7 minutes. On the other hand, the researchers were given a total of 2,100 pills to swallow. (Only 2 of these were actually taken, the rest being pocketed or flushed down the toilet.)

Nonpersons Patients tended to be treated as nonpersons. A nurse unbuttoned her uniform to adjust her bra in front of a room of male patients. She was not being sexy, she just didn't consider the patients as men. Patients would often be discussed by the staff while the patient was standing near by. It was as if patients were invisible.

A situation that sums up Rosenhan's findings better than any other is his note – taking. Rosenhan began taking notes by carefully jotting things on a small piece of paper hidden in his hand. He learned quickly that hiding was totally unnecessary. He was soon walking around with a clipboard and note pads, recording observations and collecting data.

No one questioned this behavior. Note – taking was simply seen as a symptom of his "illness". As a matter of fact Rosenhan found that anything he did was ignored. When a staff member manhandles a patient (as happened occasionally) Rosenhan would be right there – taking notes on the whole incident.

Labels These observations clarify the failure of staff members to detect the fake patients. Because they were seen in the context of a mental ward and because they had been labeled schizophrenic, anything the pseudo – patients did was seen as a symptom of their "illness."

To return to the original hypothetical question about talking your way out of an accidental commitment, it should be clear that it would be quite futile to say, “Look, this is all a mistake. I’m not crazy. You’ve got to let me out.” The response might very well be, “Have you had these paranoid delusions for long?’

Many mental health professionals found Rosenhan’s findings hard to believe. This led to a follow - up study in which the staff of another hospital was warned that 1 or more pseudo – patients were going to try to gain admission over the next 3 months. Thus alerted, the staff at this hospital tried to identify fake incoming patients. Among 193 candidates, 41 were labeled fakes by at least 1 staff member, and 19 more were labeled “suspicious.” This only serves to confirm Rosenhan’s original findings since he never sent any patients – fake or otherwise – to this hospital!

It is an important final note that all of the normal people who served as pseudo – patients in the original studies were discharged as schizophrenics “in remission” (temporarily free of symptoms). In other words, the label that prevented hospital staff from seeing the normality of the researchers stayed with them when they left. Psychiatrist Karl Menninger (1964) has commented on a similar situation:

A label can blight the life of a person even after his recovery from mental illness. A young doctor I knew suffered for a time from some anxiety and indecision. He consulted a psychiatrist and soon recovered. Unfortunately, a “tentative” diagnosis of schizophrenia got abroad – I don’t know how – and the young doctor’s professional career was seriously impaired. He was injured, not by mental illness but by a word.

Observations such as these are not a total condemnation of psychiatrist hospitals. Many of the conditions Rosenhan encountered will be found in any hospital or other large institution. But Rosenhan’s findings do carry an important message for professionals and nonprofessionals alike: labels can be dangerous. As Stoller (1967) said,

“When a person is labeled – neurotic, psychotic, executive, teacher, salesman, psychologist – either by himself or by others. He restricts his behavior to the role and even may rely upon the role for security. This diminishes the kind of experiences he is likely to have. Indeed, it is those groups whose members have shared labels – be it schizophrenic or executive – which are hardest to help move into intimate contact.

Implications The terms in the Rosenhan Study can cause problems. If used carelessly, they may do great damage. Everyone has felt or acted “crazy” during brief periods of stress or high emotion. The person whose adjustment problems extend over a longer period of time is different from you or me only is the severity of his or her difficulty.

It is therefore more productive to label problems than to label people. Think of the difference in impact between saying, “He is experiencing a serious emotional disturbance” and saying “He is a psychotic.” Which statement would you choose to have said about yourself.

It is also important to realize that a severely disturbed person will appreciate being treated normally. Rosenhan’s research makes it clear that the person is not helped by being thrust into the role of a “patient.” One former patient’s comments clarify this last point:

“After I got back from the hospital, my friends tried to act like nothing had changed. But I could tell they weren’t being honest. For instance, a friend invited me to dinner and everything went fine until I dropped my fork. Both my friend and his wife jumped up and stared at me like they thought I might explode. I was quite embarrassed.”

Name:_____

MOOD, ANXIETY, & DISSOCIATIVE DISORDERS

DISORDER	CLASSIFICATION	SYMPTOMS	POSSIBLE CAUSES
Dissociative Amnesia			
Dissociative Identity Disorder			
Major Depression			
Dysthymia			
Bipolar Disorder			
Panic Disorder			
Phobia			
Agoraphobia			
Generalized Anxiety Disorder			
Obsessive-Compulsive Disorder			
Posttraumatic Stress Disorder (PTSD)			

Personality Disorders Party

Ian decided to throw a party for his birthday and invited some of his new coworkers. . .

Hillary arrived early to the party; she tried to impress the host by being very helpful. She insisted on staying to help clean up after the host told her that it would be better for her to leave because it was late. She also asked the host if she could return at another time so she could get to know him better. She and her ex-fiancé' just broke off their engagement two days prior to the party.

Annie danced into the party and immediately became the center of attention. With sweeping gestures of her arms and dramatic displays of emotion, she boated about her career as an actress in a local theater. During a private conversation, a friend inquired about the rumors that she was having some difficulties in her marriage. In an outburst of anger, she denied any problems and claimed her marriage was "as wonderful and charming as ever". Shortly thereafter, while drinking her second martini, she fainted and had to be taken home.

Vincent wandered into the party, but didn't stay long. The "negative forces" in the room were unsettling and to his "psychic soul-spot". The few guests he spoke to felt somewhat uneasy being with this aloof "space cadet".

Jean paraded into the party drunk and continued to drink throughout the night. Laughing and giggling, she flirted with many of the men and to two of them expressed her "deep affection". Twice during th evening she disappeared for almost half an hour, each time with a different man. After a violent argument with one of them, because he took "too long" to get her a drink, she locked herself into the bathroom and attempted to swallow a bottle of aspirin. Her friends encouraged her to go home, but she was afraid to be alone in her apartment.

Mac spends most of the time talking about his trip to Europe, his new Mercedes, and his favorite French restaurants. People seemed bored being around him, but he kept right on talking. When he made a critical remark about how one of the women was dressed – hurt her feelings – he could not apologize for his obvious blunder. He tried to talk his way around it, and even seemed to be blaming her for being upset.

Sam arrived at the party exactly on time. He made a point of speaking to every guest for five minutes. He talked mostly about technology and finance, and avoided any inquiries about his feelings or personal life. He left precisely at 10 PM because he had work to do at home.

Sue watched the party for several minutes from outside through the window before entering. Once she went in, she seemed very uncomfortable. When people tried to be nice to her, she looked guarded and distrustful. People quickly became uncomfortable with her habit of finding fault with every little thing you said or did. She seemed to be picking fights with people. She didn't stay very long at the party.

Ulysses wasn't invited to the party. No one really knows him very well because he rarely talks. In fact, he spends most of his time alone at home reading.

Ericka didn't come to the party, even though she received an invitation and told the host she really wanted to attend. The host did not know why she failed to attend.

Antisocial Personality Disorder:
- Be able to act witty and charming
- Be good at flattery and manipulating other people's emotions
- Break the law repeatedly
- Disregard the safety of self and others
- Have problems with substance abuse
- Lie, steal, and fight often
- Not show guilt or remorse
- Often be angry or arrogant

Obsessive-Compulsive Personality Disorder:
- Excess devotion to work
- Inability to throw things away, even when the objects have no value
- Lack of flexibility and generosity
- Not wanting to allow other people to do things
- Not willing to show affection
- Preoccupation with details, rules, and lists

Dependent Personality Disorder:
- Avoiding being alone
- Avoiding personal responsibility
- Becoming easily hurt by criticism or disapproval
- Becoming overly focused on fears of being abandoned
- Becoming very passive in relationships
- Feeling very upset or helpless when relationships end
- Having difficulty making decisions without support
- Having problems expressing disagreements

Avoidant Personality Disorder:
- Be easily hurt when people criticize or disapprove of them
- Hold back too much in intimate relationships
- Be reluctant to become involved with people
- Avoid activities or jobs that involve contact with others
- Be shy in social situations out of fear of doing something wrong
- Make potential difficulties seem worse than they are
- Hold the view they are not good socially, not as good as other people, or unappealing

Borderline Personality Disorder:
- Frantic efforts to avoid real or imagined abandonment
- Unstable, intense interpersonal relationships
- Recurrent suicidal behavior
- Emotional instability
- Impulsivity
- Transient, stress-related paranoid thoughts

Paranoid Personality Disorder:
- Concern that other people have hidden motives
- Expectation that they will be exploited by others
- Inability to work together with others
- Social isolation
- Detachment
- Hostility

Schizoid Personality Disorder:
- Appears aloof and detached
- Avoids social activities that involve emotional intimacy with other people
- Does not want or enjoy close relationships, even with family members

Schizotypal Personality Disorder:
- Discomfort in social situations
- Inappropriate displays of feelings
- No close friends
- Odd behavior or appearance
- Odd beliefs, fantasies, or preoccupations
- Odd speech

Histrionic Personality Disorder:
- Acting or looking overly seductive
- Being easily influenced by other people
- Being overly concerned with their looks
- Being overly dramatic and emotional
- Being overly sensitive to criticism or disapproval
- Believing that relationships are more intimate than they actually are
- Blaming failure or disappointment on others
- Constantly seeking reassurance or approval
- Having a low tolerance for frustration or delayed gratification
- Needing to be the center of attention
- Quickly changing emotions, which may seem shallow to others

Narcissistic Personality Disorder:
- React to criticism with rage, shame, or humiliation
- Take advantage of other people to achieve his or her own goals
- Have excessive feelings of self-importance
- Exaggerate achievements and talents
- Be preoccupied with fantasies of success, power, beauty, intelligence, or ideal love
- Have unreasonable expectations of favorable treatment
- Need constant attention and admiration
- Disregard the feelings of others, and have little ability to feel empathy
- Have obsessive self-interest
- Pursue mainly selfish goals

Name:_____

CHILDHOOD DISORDERS

Fill out the information in the chart for each of the childhood disorders included in the articles.

DISORDER	SYMPTOMS	FREQUENCY OF DIAGNOSIS	OTHER IMPORTANT INFORMATION
ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)			
AUTISM			
CONDUCT DISORDER			
OPPOSITIONAL DEFIANT DISORDER			

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Diagnostic and Treatment Protocol

Congratulations on your new position as a clinical psychologist intern! Your first client has a specific problem and has come to **you** for your help. As a psychologist, you and your team must diagnose and treat the individual with an eclectic approach appropriate to your client's diagnosis.

DIAGNOSTICS:

1. Read the history of your client.
2. Discuss the client's problem in your group. Identify the category of disorders in which your patient's symptoms might best fit (i.e. mood, anxiety, personality, etc.).
3. Narrow your diagnosis to one specific disorder.
4. Detail your patient's diagnosis using specific symptoms to back up your diagnosis.

DEVELOPING A TREATMENT PLAN:

1. Together, you must decide on an ending goal for the therapeutic process.
   - Do you want an absence of symptoms?
   - If that's not realistic, what would give your client the best quality of life?
   - It **MUST** be measurable/observable!!
2. Decide on an eclectic approach that includes at least **two treatment options** from different psychological perspectives (i.e. cognitive, humanistic, psychoanalytic, behavioral, biological, etc.)

PRESENTATION TO YOUR CLINIC REVIEW BOARD:

1. Design a typed report (in ***outline form***- with only small paragraphs) that addresses the following:
   a. Introduction to client – name, demographics, symptoms
   b. Diagnosis – **briefly** explain the disorder
   c. Rationale – you must provide at least three pieces of evidence from their history to support your diagnostic claim
   d. Describe your treatment approach with the board – what is your overall goal?
   e. Define **&** describe the two different methods you will be using to treat your patient. Be sure to explain how each technique would apply to your client's situation.
2. The review board will be evaluating your diagnosis and treatment plan.

CHANGE MY CLIENT RUBRIC

/ 5	**Client Introduction & History** – name, demographics, symptoms
/ 4	**Diagnosis Explanation**
/ 6	**Diagnosis Rationale** - must include 3 pieces of evidence from history to support diagnosis
/ 3	**Treatment Approach #1** - definition
/ 7	**Treatment Approach #1** - application
/ 3	**Treatment Approach #2** - definition
/ 7	**Treatment Approach #2** - application
/ 35	**Total**

THERAPUTIC TECHNIQUES

BIOLOGICAL THERAPY TECHNIQUES

Drug Therapy

Goal:

How it works:

Which drug options/categories are available for the following disorders? Underline the most effective.

Schizophrenia

Depression

Bipolar Disorder

Anxiety Disorders

Electroconvulsive Therapy

Goal:

How it works:

Best for treating:

COGNITIVE THERAPY TECHNIQUES

Cognitive Therapy

Theorist:

Goal:

How it works:

Best for treating:

Rational-Emotive Therapy

Theorist:

Goal:

How it works:

Best for treating:

Cognitive-Behavioral Therapy

Goal:

How it works:

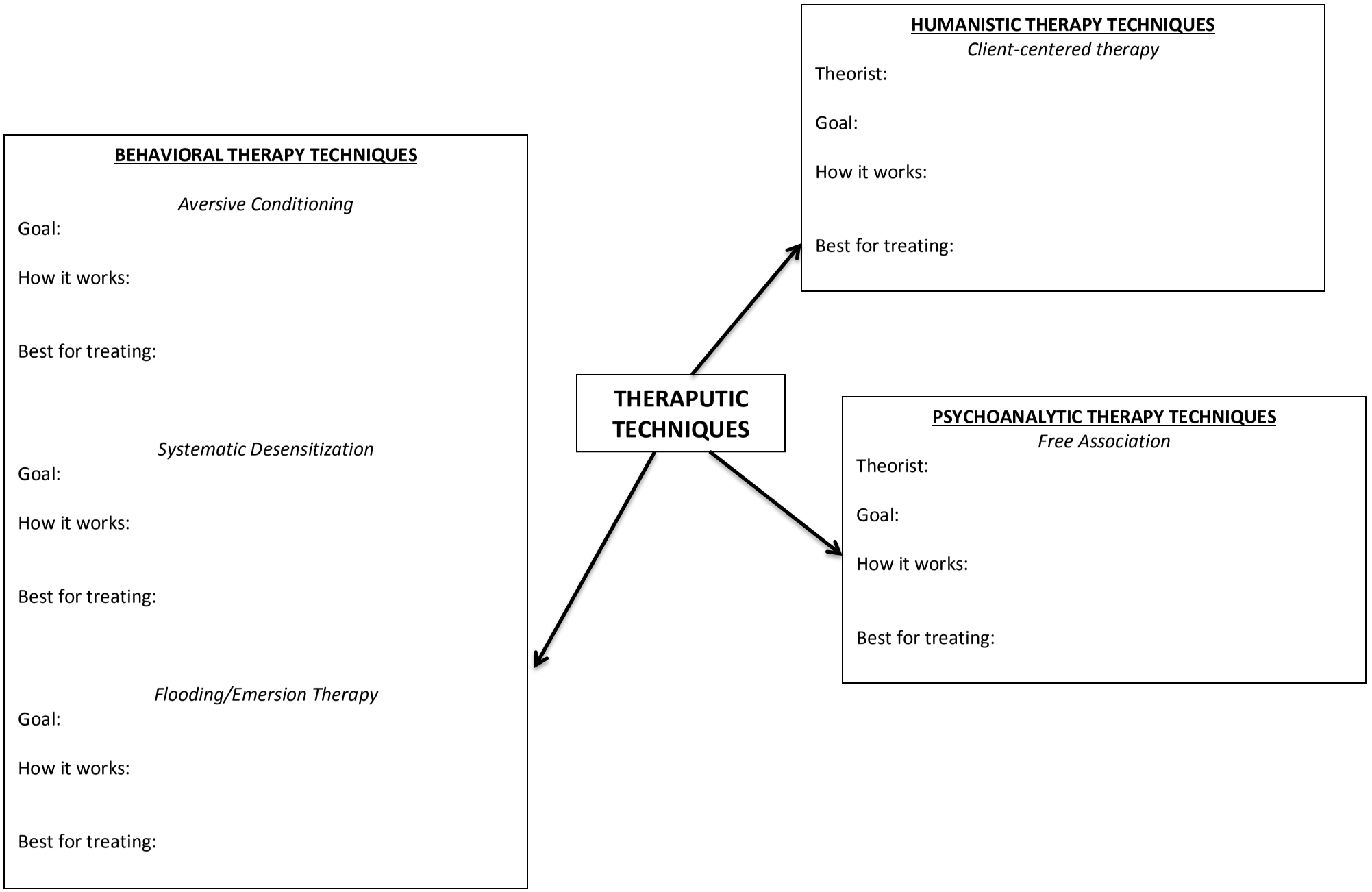
Best for treating:

GROUP & FAMILY THERAPY TECHNIQUES

Goal:

How it works:

Best for treating:


THERAPUTIC TECHNIQUES
BEHAVIORAL THERAPY TECHNIQUES
Aversive Conditioning
Goal:
How it works:
Best for treating:
Systematic Desensitization
Goal:
How it works:
Best for treating:
Flooding/Emersion Therapy
Goal:
How it works:
Best for treating:
HUMANISTIC THERAPY TECHNIQUES
Client-centered therapy
Theorist:
Goal:
How it works:
Best for treating:
PSYCHOANALYTIC THERAPY TECHNIQUES
Free Association
Theorist:
Goal:
How it works:
Best for treating:

CLINICAL REVIEW BOARD

Team up for review:	
Diagnosis evaluation: *(Accuracy? Possible other diagnoses?)*	
Why do you agree or disagree with diagnosis? *(refer to specific symptoms)*	
Treatment plan evaluation: *(Do you agree their plan would be most effective? Why or why not?)*	
Third treatment option: create a third plan using a different perspective	

Team up for review:	
Diagnosis evaluation: *(Accuracy? Possible other diagnoses?)*	
Why do you agree or disagree with diagnosis? *(refer to specific symptoms)*	
Treatment plan evaluation: *(Do you agree their plan would be most effective? Why or why not?)*	
Third treatment option: create a third plan using a different perspective	