Key Dates

- TH Mar 2 Units 12-13; MW Ch 4 Anna, Ch 14 Temple
- TU Mar 7 Begin Dimensions-Physical, Units IID and Unit 14; MW Ch 5 Alix, Pam ; Term Paper Step 1
- TH Mar 9 Units 15-16; MW Ch 8 Tim, Marilyn
- SPRING BREAK!
- TU Mar 21 Begin Explanations and Treatments, review Unit 3, plus Unit 17
- TH Mar 23 Unit 18; “Loss of control drinking in alcoholics” (on course website)

Interested graduate programs related to Psychology?

Get advice on which grad programs might be a good match for you!

Get information about how to apply, GREs, letters of recommendation, and more!

Psychology Grad School Workshop

Monday March 6th

5:30pm

HSS 165

This workshop is sponsored and presented by the Department of Psychology. All are welcome.

Goal: To recognize and differentiate different forms of psychopathology that involve disordered thinking and reasoning and distorted perception

UNIT 11: THINKING, REASONING, AND PERCEIVING

Learning Outcomes

- By the end of this class, you should be able to:
  - Define “psychotic” and explain how it is key to understanding many different severe mental disorders
  - Define the following key symptoms of psychosis: delusions, hallucinations, loose associations, catatonia, anhedonia
  - Identify and define the key characteristics of what the *DSM* requires for a diagnosis of schizophrenia
  - Explain how the *DSM* distinguishes between schizophrenia, schizophreniform disorder, and brief psychotic disorder
  - Identify the Cluster A personality disorders and their relationship to the schizophrenia spectrum

Thinking, Reasoning, and Perceiving

- Psychotic disorders, or psychoses (singular = psychosis), are among the most serious of all mental disorders
- They involve significantly disordered thinking and a breakdown in contact with reality
- Day-to-day functioning is severely impaired, to the point that psychotic disorders account for the majority of psychiatric hospitalizations

Thinking, Reasoning, and Perceiving

- Most basic to psychotic disorders are disturbances of language, thought and perception:
  - Loose associations (derailment) and incoherence, seen in the “word salad” style of speech
  - Neologisms, clanging, echolalia
  - Impoverished speech: alogia
  - Delusions (jealousy, grandiosity, persecution, identity), often bizarre
  - Disturbances in perception: hallucinations, illusions (usually auditory)

Thinking, Reasoning, and Perceiving

- More psychotic symptomatology
  - Disturbances in motor behavior: catatonic immobility or excitement, mutism, impaired self-care (dressing, feeding, hygiene, etc.)
  - Emotional disturbances: flat affect, anhedonia, inappropriate or childish affect
  - Social withdrawal, identity confusion, diminished goal-directed activity (avolition)

Thinking, Reasoning, and Perceiving

- Classification of psychotic disorders
  - The schizophrenia spectrum:
    - Schizophrenia (6 months or more)
    - Schizophreniform disorder (1-6 months)
    - Brief psychotic disorder (1 day to 1 month)
    - Cluster A personality disorders--paranoid, schizoid, schizotypal (non-psychotic, but on the spectrum; early onset, usually chronic)
  - Schizoaffective disorder
  - Delusional disorder
  - Psychotic disorder due to another medical condition
  - Substance/medication induced psychotic disorder

Thinking, Reasoning, and Perceiving

- Schizophrenia
  - Relatively uncommon (<1%) but a major focus for researchers, and responsible for ~50% of all mental health spending in U.S.
  - Kraepelin and the distinction between thought disorder (dementia praecox) and mood disorder (manic-depression)
  - Bleuler and the meaning of “schizo”..”phrenia” (splitting/fragmented mind—*not* “split personality”)
  - Broad versus narrow usage: over-diagnosed in past, but now more narrowly-defined in terms of symptoms and required duration

Thinking, Reasoning, and Perceiving

- Positive versus negative symptoms
  - "Positive" symptoms are those that involve something abnormal or inappropriate being *added* (e.g., delusions, hallucinations)
  - "Negative" symptoms are when a normal characteristic is *subtracted* or absent (e.g., diminished emotional expression, absence of goal-oriented activities)

Thinking, Reasoning, and Perceiving

- Diagnostic criteria for schizophrenia
  - Delusions, hallucinations (usually auditory), and/or disorganized speech (the “cardinal” symptoms): one must be present
  - As well as disorganized or catatonic behavior, and/or
  - Negative symptoms such as affective flattening, alogia, avolition
  - All required symptoms present together during at least a 1-month period, with some of the symptoms present for at least 6 months
  - Level of functioning drops below what it was before onset
  - Symptoms are not exclusively connected to a mood disturbance, nor to any drug or medical condition

Thinking, Reasoning, and Perceiving

- Course might be continuous or episodic (and remission between episodes might be partial or full)
- Onset is usually in late adolescence to early adulthood
- Male:female ratio about equal, but men tend to have earlier onset, women tend to have better outcome
- Substance use disorders (“dual diagnosis”) are common, as are suicide attempts and self-injuring behavior
- While danger to oneself is common, danger to others not as common as media would suggest–violent criminality, though not unknown, is uncommon, and schizophrenia is rarely diagnosed in serial murderers, rapists, or child molesters

Thinking, Reasoning, and Perceiving

- Sub-types of schizophrenia
  - Many have been proposed:
    - DSM-IV had paranoid, disorganized, catatonic, undifferentiated, and residual
    - Process-reactive/Chronic-acute
    - Good pre-morbid adjustment-poor pre-morbid adjustment
  - But *none* has been shown to be diagnostically reliable
  - Though some evidence that good pre-morbid adjustment combined with acute onset predicts better outcome

Thinking, Reasoning, and Perceiving

- Schizophreniform disorder and brief psychotic disorder share symptoms with schizophrenia but are of shorter duration
- The former is often a precursor of schizophrenia, but BPD usually is not, though it might entail one or more relapses
- Schizoaffective requires co-occurrence of major depressive or manic episode with cardinal symptoms of schizophrenia, plus symptoms of schizophrenia *in absence of* mood disturbance
- Delusional disorder: non-bizarre delusions (i.e., they "almost" could be true), without other symptoms of schizophrenia, and day-to-day functioning is much less impaired
- Prevalence of all except BPD <0.5%; prevalence of BPD harder to estimate but more common

Thinking, Reasoning, and Perceiving

- Cluster A personality disorders
  - Seem to share psychotic qualities, but to a lesser extent, not fully psychotic (but transient psychotic periods might occur)
  - Some evidence to suggest common etiology for Cluster A and schizophrenia spectrum
  - Overall prevalence of any Cluster A disorder is reported to be 5.7%
  - All are thought to be somewhat more common in males

Thinking, Reasoning, and Perceiving

- Paranoid personality disorder: distrust of others, suspiciousness, perception of others as malevolent
- Schizoid personality disorder: detachment from social relationships and a restricted range of emotional expression
- Schizotypal personality disorder: discomfort in close relationships combined with odd or unusual ideas, beliefs, emotional reactions, and/or behaviors

Thinking, Reasoning, and Perceiving

- Differential and co-morbid considerations
  - Substance intoxication and substance withdrawal often involve hallucinations—intoxication often visual, withdrawal often tactile
  - Dementias and brain injury often associated with olfactory hallucinations
  - All these psychotic disorders overlap with each other, and differential diagnosis can be tricky, with diagnosis often changed over time
  - Psychotic qualities are seen in many other areas of psychopathology: depressive and bipolar disorders, autism spectrum disorders