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Unit 6

Question 1.

Around 1% of the world's population suffers from schizophrenia, which is a complex and severe mental illness (Comer and Comer, 2019). The disease has many symptoms, which are both negative and positive. The negative symptoms of this disorder are events that detract from a person's mental state. Positive symptoms, on the other hand, are events that add to a person's mental state. Delusions, hallucinations, disorganized behavior, and disorganized speech are some of the positive symptoms of schizophrenia.

Perceptions that come about without any outside stimuli are called hallucinations. Auditory hallucinations, where people perceive sounds or other noises that are not there in the environment, are the most prevalent type of hallucination in schizophrenia (Comer and Comer, 2019). These voices may speak to the person or make comments about their actions or thoughts.

They may be positive, negative, or neutral. It is possible to experience visual hallucinations as well, albeit they are less frequent than auditory ones.

Delusions are ingrained unfounded false beliefs. Delusions of grandeur, in which patients of schizophrenia think they possess exceptional skills or powers, are common. According to Comer and Comer (2019), individuals could suffer from paranoid delusions, in which case they think people are out to get them or are spying on them. Those who have delusions may find it challenging to recover since they frequently hold these beliefs dearly and may be resistant to changing them.

Disorganized speech is a condition when a person speaks in a confusing, illogical, or unorganized manner. This can appear in a variety of forms, such as tangential speech—when a speaker deviates from the subject at hand and neologisms when a speaker invents new words or adapts existing ones in an unusual way (Comer and Comer, 2019). An indication of disorganized conduct is when someone behaves in an erratic, unpredictable, or improper way. This can appear in a variety of ways, such as catatonic conduct, in which a person may freeze in place for extended periods of time, and inappropriate affect, in which a person's emotional reactions are inappropriate for the circumstance.

Question 6.

Although the precise etiology of schizophrenia is not clearly defined, research indicates that a combination of hereditary, environmental, and neurobiological factors may be responsible (Comer and Comer, 2019). Schizophrenia is frequently linked to anomalies in how people absorb thoughts and perceive reality. In this situation, someone who starts to feel weird and unreal feelings may be in danger of developing the disease.

Delusions, hallucinations, social withdrawal, and disorganized thinking are just a few of the symptoms that schizophrenia exhibits from a cognitive point of view. These symptoms are frequently linked to disturbances in the normal operation of specific brain regions, especially those that control attention perception or executive function (Comer and Comer, 2019). For instance, a person with schizophrenia may have hallucinations as a result of the way their brain processes sensory data or fabricates reality. In this case, it can be the individual's first indicator of schizophrenia. It is possible for the person to begin hearing voices or perceiving objects that aren't actually there. In addition, they may start to have disordered thinking or trouble concentrating, which may make it difficult for them to make decisions and solve problems.

In addition, they could have trouble interacting with others and start to distance themselves from friends and family (Comer and Comer, 2019). They could experience fear or paranoia because they think people are looking at them or judging them. This can make their symptoms worse and set off a chain reaction of unfavorable ideas and actions. The person's everyday life may be significantly hampered as a result of these symptoms as they worsen and grow more incapacitating over time. A multitude of problems, such as substance misuse, self-harm, and suicide, can arise from schizophrenia if it is not treated effectively.

Question 9.

Two unique therapeutic methods that are frequently employed in the treatment of a mental illness are milieu therapy and token economy programs. Milieu therapy is an intervention strategy that concentrates on establishing a controlled and encouraging environment for people with mental health concerns. Token economy programs, on the other hand, use a behavioral strategy called positive reinforcement by employing tokens (rewards) to change behavior (Comer and Comer, 2019).

The fact that the two strategies both include a structured environment is one similarity between them. In milieu therapy, the setting is specifically created to offer a caring and supporting environment that fosters the development and growth of the person being treated. According to the usage of tokens, the environment is designed in token economy applications to reward good behavior and punish bad behavior (Comer and Comer, 2019). A group of specialists collaborating together to help the individual is also a similarity between the two strategies. This team in milieu therapy may consist of personnel from the mental health field, the medical field, and the support sector. The team may consist of behavioral analysts, therapists, and support personnel in token economy initiatives.

Notwithstanding these similarities, milieu therapy and token economy programs have a number of significant distinctions. Their emphasis is one key distinction. Whilst token economy programs concentrate on changing behavior with the use of positive behavior, milieu therapy concentrates on establishing an environment that supports human growth and development (Comer and Comer, 2019). The part that each patient plays in their treatment is another distinction between the two methods. In milieu therapy, the patient actively participates in their care and is urged to take charge of their personal development. In programs that use the token economy, the individual is frequently seen as passive, with an emphasis on changing their behavior through the usage of tokens. The two strategies' methods for measuring progress are the third distinction between them. In milieu therapy, the patient's capacity for independent functioning and general state of well-being serve as benchmarks for improvement (Comer and Comer, 2019). Progress in token economy initiatives is gauged by how well a participant meets predetermined behavioral objectives and accrues tokens.

Question 20.

A new drug or treatment must go through several stages of clinical trials, including phases I, II, and III before it is made available to the public. The drug or treatment is examined during these trials for security, effectiveness, and any possible negative effects (Comer and Comer, 2019). Phase I testing involves evaluating the safety of the medication or treatment on a limited number of healthy volunteers and looking for any potential side effects.

Establishing the correct dosage range and confirming that the medicine is secure enough to move on to the next step are the main objectives of this phase (Comer and Comer, 2019). In phase II, a larger population of individuals with the condition the treatment or medication is intended to treat is used to test the medicine or treatment. In addition to further evaluating the treatment's safety and adverse effects, this is done to determine whether it is effective, that is, whether it achieves its desired results. Phase III is the testing phase where a larger number of patients are exposed to the medication or treatment to ensure its efficacy and safety (Comer and Comer, 2019). In a randomized controlled study, some people get the new treatment during this phase, while others receive control or standard care for comparison. The goal of this phase is to offer unmistakable proof that the therapy is both secure and efficient. The regulatory authorities approve the drug or treatment and release it onto the market if it successfully completes all three clinical trial phases.

Psychotherapy, social skills coaching, and cognitive therapy are some alternatives to drug therapy for schizophrenia. To help schizophrenic patients perform better overall, these treatments may be used alone or in conjunction with medication (Comer and Comer, 2019). Treatments for schizophrenia symptoms include psychotherapy, family therapy, cognitive-behavioral therapy, and social skills coaching. These therapies support patients' problem-solving abilities, interpersonal relationships, and learning of coping mechanisms. However, it is significant to

remember that from patient to patient, the efficacy of various therapies varies, and some individuals may need medication in addition to therapy.

According to Comer and Comer (2019), making decisions about the choice of treatment should involve the schizophrenia patient extensively. The patient is the most significant stakeholder in any medical condition, and treatment choices should be based on their preferences and goals. Engaging patients in their own care can also result in better results and higher patient satisfaction. Patients with schizophrenia should be frequently given the power to decide how they will be treated. Patients' families or legal guardians, on the other hand, might participate in the decision-making exercise in some instances where it is determined that the patient is incapable of making an informed choice (Comer and Comer, 2019). However, patients may encounter obstacles to receiving therapy, such as logistical or financial difficulties, which may restrict their ability to decide on their course of treatment.

Question 22.

A person's personality is the distinctive collection of traits, sentiments, emotions, and actions that define them as a person. It is a multifaceted and complicated construct that is influenced by a variety of cultural, genetic, and environmental factors (Comer and Comer, 2019). Contrarily, personality disorders are a class of mental health issues marked by pervasive and rigid ways of thinking, emotion, and behavior that diverge from cultural standards and significantly disturb people or impede their ability to function in social, professional, or other areas.

Conscientiousness, Openness, neuroticism, extraversion, and agreeableness are some of the five dimensions or attributes that make up personality. These attributes are patterns of conduct that are dependable and persistent throughout time and across contexts. For instance, a

person with a high openness quotient may be innovative, curious, and creative, whereas a person with a high neuroticism quotient may be agitated, moody, and sensitive to stress.

On the other hand, the traits of personality disorders are rigid, severe, and change-resistant maladaptive patterns of behavior (Comer and Comer, 2019). These tendencies may include a chronic lack of regard for other people's rights, a continuous craving for attention and adoration, or a persistent mistrust and suspicion of everybody else (paranoid personality disorder) (antisocial personality disorder). The fact that personality traits are often considered as occurring on a continuum, with individuals ranging in their level of expression of each attribute, is another important distinction between the elements of personality and personality disorders. Contrarily, personality disorders are thought to be categorical, which means that a person must either fit the criteria for a diagnosis of a specific disorder or they do not.

Question 24.

Three clusters of "personality disorders" are recognized by the DSM-5, and they are odd/eccentric, dramatic/erratic, and anxious/fearful. Paranoid, schizoid, and schizotypal personality disorders are examples of odd/eccentric personality disorders (Comer and Comer, 2019). These diseases are characterized by unique ideas or perceptions, a tendency toward social withdrawal, and communication and emotional expression challenges. Those with schizoid personality disorder typically have a narrow range of emotional expression and a propensity for solitary pursuits, whereas those with paranoid personality disorder have a deeply embedded distrust and suspicion of others (Comer and Comer, 2019). Moreover, those who have schizotypal personality disorder may have distorted perceptions, strange ideas or magical thinking, and trouble establishing close connections.

Contrarily, narcissistic, borderline, antisocial, and histrionic personality disorders are examples of dramatic/erratic personality disorders (Comer and Comer, 2019). Those who suffer from these diseases frequently exhibit strong emotions, impulsivity, and interpersonal relationship issues. People with borderline personality disorder frequently engage in self-destructive or suicidal conduct as a result of their powerful and erratic emotions. A grandiose sense of self-worth, a lack of compassion for others, and a desire for praise are traits of a narcissistic personality disorder (Comer and Comer, 2019). Those with an antisocial personality disorder tend to disrespect other people's rights, engage in impulsive and risky activity, and lack regret for their deeds, whereas those with a histrionic personality disorder are characterized by attention-seeking behaviors and dramatic emotional expression.

One significant distinction between the two clusters is that people with odd/eccentric personality disorders frequently struggle to establish deep relationships, whereas people with dramatic/erratic personality disorders may experience intense, erratic, and frequently turbulent relationships (Comer and Comer, 2019). Moreover, those with eccentric or strange personality disorders may be more likely to have strange beliefs or perceptual difficulties, whereas people with erratic or dramatic personality disorders are more inclined to act impulsively and take risks.

Question 34.

An excessive desire for attention, a fear of abandonment, and the incapacity to make decisions or act autonomously are all characteristics of dependent personality disorder (DPD), a psychological illness. People with DPD have a systematic and ongoing pattern of demanding acceptance and encouragement from other individuals to the extent that they may forego their own desires and needs in order to appease the people around them (Comer and Comer, 2019).

Despite the fact that the precise origins of DPD are not entirely understood, various speculative ideas have been put forth.

Psychodynamic Theory: In accordance with the psychodynamic hypothesis, unresolved tensions throughout infancy development, especially during the oral period, are the root cause of DPD (birth to 18 months). Infants at this period like sucking, and they are largely attached to their caregivers because they can offer them food and nutrients (Comer and Comer, 2019). A child can develop an unsafe emotional competence and have a lifelong need for assurance and support if they do not receive appropriate care throughout this stage.

Behavioral Theory: According to behavioral theory, DPD develops as a result of acquired behavioral patterns that are maintained by rewards and penalties. Those with DPD might have discovered that depending on others leads to favorable outcomes like care and attention while being independent results in unfavorable outcomes like rejection or criticism (Comer and Comer, 2019). This strengthens their reliance on others and establishes a pattern of behavior that is challenging to break.

Cognitive Theory: This cognitive approach assert that DPD is a result of negative thought processes and beliefs. People with DPD could have poor self and the conviction that they are unable to manage their own life, which makes them dependent on others for guidance and assistance (Comer and Comer, 2019). A dread of abandonment and the conviction that they are undeserving of affection and love may also result from this poor self-image.

Attachment Theory: This theory maintains that DPD is the consequence of an interrupted attachment style, frequently as a result of inconsistent or careless parenting during childhood. With a constant need for assurance and a fear of rejection, people with DPD may exhibit a

preoccupied attachment style. Because of their potential issues with intimacy and trust, people with this attachment style may find it challenging to develop close relationships as adults.

Question 35.

In contrast to flexibility, openness, and efficiency, obsessive-compulsive personality disorder (OCPD) is characterized by a continuous trend of obsession with orderliness, perfectionism, and control. People with OCPD may be too preoccupied with details and rituals and frequently have a tremendous need for order and standards (Comer and Comer, 2019). They could also think rigidly and have trouble adjusting to change.

An extreme obsession with control and order is one of the defining traits of OCPD. Those who have this disorder might feel driven to maintain their surroundings immaculately planned and organized and could find it challenging to assign work to others (Comer and Comer, 2019). They might also face challenges with feelings of rage or unhappiness when things don't go as planned. They might also have strict expectations for both themselves and other people.

The OCPD also has perfectionism as a significant characteristic. Those who have this illness may have unrealistic standards for themselves and may be excessively critical of both themselves and other people. Also, they could have trouble appreciating their successes and may suffer from emotions of insecurity and self-doubt (Comer and Comer, 2019). A predisposition toward inflexibility and rigidity is another trait of OCPD. Those who have this illness may find it difficult to adjust to novel circumstances or concepts and may be reluctant to change. They might also find it difficult to act or make decisions since they think they need to collect all the information first.

Finally, people with OCPD may have trouble forming and maintaining relationships. They might find it difficult to convey their feelings, which could make them appear aloof or cold

to others. They might also fail to build strong relationships with others and have a narrow set of

interests and hobbies.

Reference

Ronald Comer and Jonathan Comer (2019). Fundamentals of Abnormal Psychology (9th Edition).

New York. Worth Publishers.