1. What is a clinical disorder? [provide the detailed definition you learned in class]

   A constellation of symptoms that significantly impairs an individual’s ability to function, and is characterized by a particular symptom picture with a specifiable onset, course, duration, outcome, and response to treatment, and associated familial, psychosocial, and biological correlates.

2. What are secondary symptoms (i.e., define them and provide an example of secondary symptoms of a clinical child disorder – and explain why it might be a secondary symptom)?

   Secondary symptoms are behavioral, psychological, social, or physiological phenomenon that may arise as a result of the primary symptoms of a disorder but are not required to diagnose the disorder. For example, a child with ADHD may experience extensive academic difficulties, however academic difficulties are not necessary for a diagnosis of ADHD and are likely to arise as a result of the primary symptoms of the disorder, i.e., inattention, impulsivity, hyperactivity, and working memory deficits.

3. Name four core positive symptoms of schizophrenia.

   a. Delusions
   b. Hallucinations
   c. Disorganized speech
   d. Disorganized or catatonic behavior.

4. Name three core negative symptoms of schizophrenia.

   a. Flat affect (a lack of emotional reactivity on the part of an individual. It is manifest as a failure to express feelings either verbally or non-verbally, especially when talking about issues that would normally be expected to engage the emotions);
   b. Alogia (a general lack of additional, unprompted content seen in normal speech);
   c. Avolition (a psychological state characterized by general lack of drive, or motivation to pursue meaningful goal).

5. Briefly explain the primary differences between positive and negative symptoms.

   Positive symptoms are an excess or distortion of normal functioning such as delusions, hallucinations, disorganized speech, and disorganized or catatonic behavior.

   Negative symptoms are a diminution or lack of normally occurring behaviors such as flat affect, alogia, and avolition.
6. Delusions are: \textit{idiosyncratic beliefs or impressions that are firmly maintained despite being contradicted by what is generally accepted as reality or rational argument; typically a symptom of a mental disorder.}

7. Thought disorder is: \textit{a disorder of cognitive organization, characteristic of psychotic mental illness, in which thoughts and conversation appear illogical and lacking in sequence and may be delusional or bizarre in content.}

8. Before treating enuresis with behavioral techniques, it is important to rule out \textit{medical causes} such as \textit{lack of normal nocturnal increases in antidiuretic hormone (ADH)} and \textit{bladder infections.}

9. List 3 differences between nightmare and night terror disorders.

\textbf{Nightmare Disorder:}

a. Nightmares involve impairing and repeated sleep awakenings; the child is usually able to recall the content of the extended and frightening dream upon awakening.

b. Nightmares are associated with rapid reorientation upon awakening (easy to arouse; responsive to environment).

c. Occurs during REM sleep.

d. Mild to moderate physiological arousal.

e. Occurs commonly among children.

\textbf{Sleep Terror Disorder:}

f. Involves impairing sleep awakenings, usually with a panicky scream, intense fear, and intense physiological arousal (rapid heart rate, sweating, dilated pupils).

g. Individual is relatively unresponsive to comforting, is slow to orient upon awakening, and has little or no recall of the dream.

h. Occurs during non-REM sleep.

i. Occurs rarely among children.

10. ADHD and Childhood Onset Bipolar Disorder

What are the behavioral, cognitive, and clinical symptom similarities and differences between children with ADHD and children with bipolar disorder? Describe the similarities first under a heading, then the differences under a separate heading. What other information would you require to ensure an accurate clinical diagnosis?

a. Similarities: [know at least of the 10 of the 14]

- Concentration difficulties
- Higher than normal gross activity level (but chronic in ADHD vs limited to manic episodes in bipolar disorder)
• Emotional lability
• Irritability
• Disruptive behavior
• Impulsivity
• Denial of problems
• Poor judgment
• Low frustration tolerance
• Poor school achievement (but chronic in ADHD & limited to episodes in bipolar disorder)
• Decreased need for sleep (again, chronic in ADHD, limited to episodes in bipolar disorder)
• Restlessness
• Talkativeness (chronic in ADHD; episodic in bipolar disorder)
• Psychopathology in family members (in ADHD…high rate of ADHD, CD, substance abuse…in bipolar, higher rates of affective disorders)

b. Differences: [know the first 5 and at least 5 other differences]
• Onset of disorder is a distinct change in the child’s behavior
• Delusions/hallucinations limited to children with bipolar disorder
• Requires relative little sleep whereas usually sleeps for age appropriate time intervals
• Strong family history of affective disorders
• Poor response to MPH and other stimulants
• Poor response to antidepressants (TCA, SSRIs)
• Extremes of emotional lability
• More garrulous, intrusive, silly, and disinhibited behavior
• Strong early sexual interest and behavior
• Explosive anger (rages) and vindictiveness
• Bullying
• Focus on emotions rather than novelty
• Long lasting tantrums as a toddler
• Mood disturbance in bipolar (50% present with an elevated mood; 50% present with depressed mood; can occur in ADHD, but will occur much later in life usually as a reaction to chronic school/relationship failures

c. Other information needed to ensure an accurate diagnosis:

Age of onset, what type of course the symptoms followed (e.g., in ADHD, we would expect to see an early onset with a gradual worsening course as the child proceeds in school. In contrast, in childhood bipolar disorder we would expect to see a moderate to rapid change in behavior from a previously normal level of functioning and the behavioral changes are time limited (i.e., the child eventually returns to the pre-morbid level of functioning). We would also need to know which disorders are present in the child’s immediate and extended family because ADHD and the affective class of disorders are known to be highly heritable.
10. The primary differences between childhood major depression disorder and childhood dysthymia are:

a. Childhood dysthymia lasts longer—an average of one year or more

b. Childhood depression is associated with more severe symptomatology and higher rates of attempted and completed suicide

11. Vocabulary:

a. **Obsessions**: a persistent, irrational idea, impulse, or feeling that continually forces its way into consciousness, often associated with anxiety and mental illness. For example, excessive preoccupation with and extreme anxiety related to germs in the environment.

b. **Prodromal**: The “prodromal syndrome” is not a diagnosis, but a technical term used by mental health professionals to describe a specific group of symptoms that may precede the onset of a clinical disorder. For example, the prodromal phase of psychosis may last anywhere from a couple of days to a couple of years. During this time, individuals experience symptoms of psychosis at mild or moderate levels of intensity, or for short periods of time. Individuals and their families may also notice changes in functioning, such as trouble with school or work and social withdrawal or anxiety.

c. **Compulsions**: irresistible persistent impulses to perform an act (e.g., excessive hand washing) to avoid or escape from the increasing anxiety associated with obsessional thinking; often associated with mental illness.

12. What are the primary differences between social anxiety disorder and phobic disorder?

a. Children with Social Anxiety Disorder are persistently fearful of and attempt to avoid being in social situations in which they may be evaluated, humiliated, and embarrassed based on their behavior and/or performance; a small subset of them are selectively mute. Onset is usually in the mid-teens.

b. In simple Phobic Disorder, excessive and impairing fearfulness and accompanying escape/avoidance behavior is associated with specific places (e.g., heights, bridges), events (injections, dentist visits), animals (dogs, snakes, insects), environmental (e.g., lightning/thunder storms, hurricanes), and other specific things (e.g., clowns, number patterns). Simple phobias can develop at any time in life and they are the most common anxiety disorder in children.

13. What are the two primary causes (contributing factors) of enuresis?
Two physical functions prevent bedwetting. The first ability is a **hormone cycle that reduces the body's urine production**. At about sunset each day, the body releases a minute burst of antidiuretic hormone (also known as arginine vasopressin or AVP). This hormone burst reduces the kidney's urine output well into the night so that the bladder does not get full until morning. This hormone cycle is not present at birth. Many children develop it between the ages of two and six years old, others between six and the end of puberty, and some not at all. The second ability that helps people stay dry is **waking when the bladder is full**. This ability develops in the same age range as the vasopressin hormone, but is separate from that hormone cycle. Most children develop the ability to stay dry as they grow older. The typical development process begins with one- and two-year-old children developing larger bladders and beginning to sense bladder fullness. Two- and three-year-old children begin to stay dry during the day. Four- and five-year-olds develop an adult pattern of urinary control and begin to stay dry at night.

14. What are the two primary categories of sleep disorders?

**Dyssomnias**: Difficulties initiating and maintaining sleep, or excessive sleepiness; and

**Parasomnias**: Disorders of arousal, partial arousal, or sleep-stage transitions

15. Explain how the nighttime urine alarm system works (i.e., what type of conditioning does the system rely on and what are the basic assumptions of this type of conditioning that pertain to enuresis?) Draw a diagram, label the UCS, the UCR, the newly trained CR, and what it now elicits.

The nighttime alarm was designed based on the assumption that some children have not followed the typical development process wherein sensing bladder fullness results in a wake-up response while asleep—this phenomenon is based on classical conditioning wherein the unconditioned stimulus (i.e., bladder fullness/pressure) elicits an unconditioned response (wake-up response) without any training (i.e., occurs naturally). Children with nocturnal enuresis, however, must be trained to wake up in response to bladder pressure while asleep.
In Alarm Training the goal is to train the full bladder to elicit a wake-up response.

UCS: conditioned Stimulus (loud alarm) → UCS elicits UCR

Neutral stimulus = full bladder (becomes a conditioned stimulus (CS) through repeated pairings)

UCR: unconditioned Response (wake-up response); the UCR becomes a conditioned response (CR) to what was previously a neutral stimulus & is now a CS.

16. Label 4 courses of major mood disorders immediately below: (see diagram)
Blue = manic depressive disorder…mood fluctuates between extremes of severe depression and manic states…severe depression episodes last much longer than manic episodes
Brown = mania…mood becomes extremely elevated during manic states and returns to normal in between episodes…if only slightly elevated during manic episodes it is termed hypomania
Green = normal fluctuations in mood by most people
Orange = dysthymia…mood is depressed but not to the extent observed in severe depression, but is more chronic and does not return to a normal mood state for many years
Red = severe depression…mood fluctuates between severe depressive states lasting 9 to 14 months and returns to a normal mood state in between episodes