HISTORICAL PSYCHOLOGY

Different societies have constituted what abnormal behaviour means and what might cause them to occur.

CIRCA 8000 B.C

- Believed that peoples behaviours were caused by supernatural spirits
- Skulls of human beings have been found of man-made drilling indicating person was alive while this was occurring- a practice that exists today to rid of headaches and 'abnormal behaviours

Sympathetic Magic- belief that influencing things that are similar or once close to a person can influence that person
-Homeopathic Magic- involving the belief that doing something to the likeness of a person will influence a person i.e. black magic
-Contagious Magic- involves belief that what one does to something that a person once owned or was close to someone will influence someone
>> these are types of sympathetic methods

CIRCA 6000-5000 B.C.

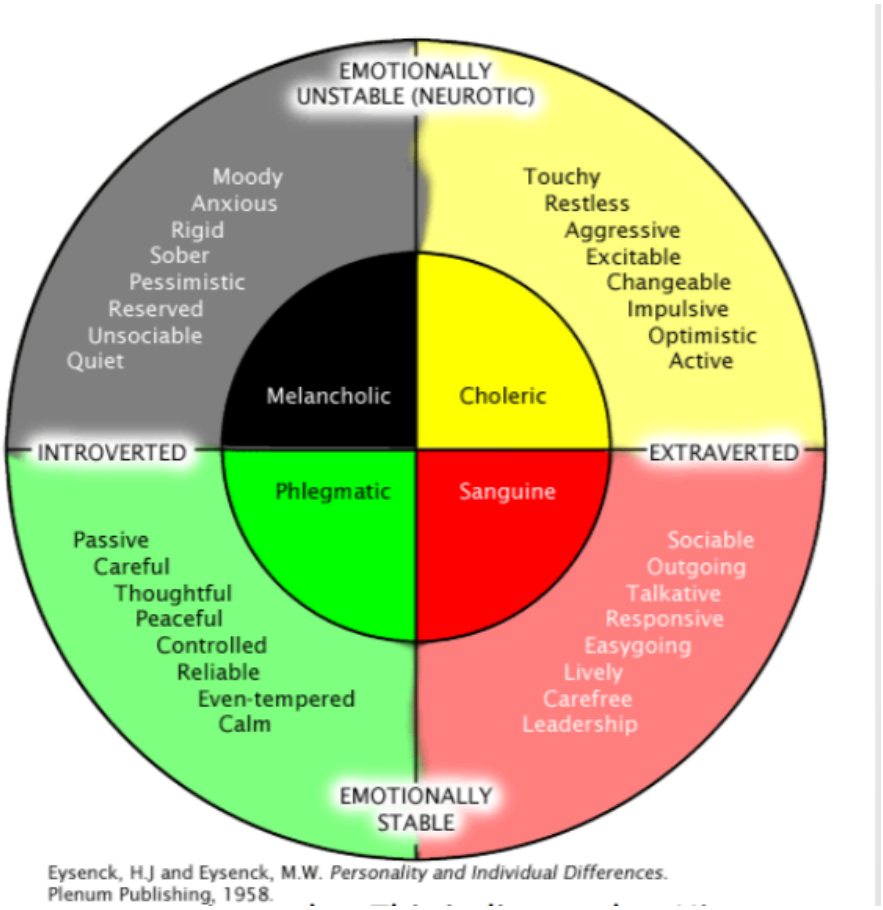
- Ancient Egypt
- Physical and mental illness were viewed as synonymous. The causes of mental illness were evil spirits and the wrath of Gods.
- Developed an empirical technique towards curing illness away from supernatural human beings.
- They relied on observations from the body and moved away from supernaturalism and focused on scientific methods

CIRCA 500 B.C.E- 400 C.E.

- ANCIENT GREECE AND ROME
- First western culture that believed in finding rational answers
- Gave rise to notion of modern scientific medicine and psychology
- Hippocrates (400 B.C.) proposed humourism (humor=fluid) meaning an excess or deficiency of any of the four humours (blood, yellow bile, black bile and phlegm) positing that if we had more or less of these four, it would change our behaviour.

The Greek physician **Hippocrates** (460–377 b.c) considered the brain to be the seat of wisdom, consciousness, intelligence, and emotion. Therefore, disorders involving these functions would logically be located in the brain. Hippocrates also recognized the importance of psychological and interpersonal contributions to psychopathology.

- These terms even exist today: the term melancholier, which means black bile, is still used today in its derivative form melancholy to refer to aspects of depression
- A phlegmatic personality (from the humor phlegm) indicates apathy and sluggishness but can also mean being calm under stress. A choleric person (from yellow bile or choler) is hot tempered
- Excesses of one or more humor's were treated by regulating the environment to increase or decrease heat, dryness, moisture, or cold, depending on which humor was out of balance.



Eysenck, H.J and Eysenck, M.W. *Personality and Individual Differences.* Plenum Publishing, 1958.

CIRCA 400-1400s

- Medieval or Middle Ages
- Superstition made a return, essentially mental illness and odd behaviour was demonised
- Strange and abnormal behaviours treated by prayer, exorcism, beatings, burning

CIRCA 1400's- 1700's

- The Renaissance
- Period of intellectual expansion
- Looking at bodies for scientific and artwork purposes providing insight
- Copernicus- earth turning on an axis and is not the centre of the universe
- Descartes- body (matter, physical) and mind (spirit) were two separate things
- Leoanardo Da Vinci- drawings of foetus in utero, of the heart, vascular system, sex organs etc.

Late 15th and 16th centuries

- Housing (asylums) mentally ill people (lack of compassion) no translation of treatment but was for observation-to understand
- Main purpose to protect society from abnormal behaviour of the inmates, socially undesirable
- Bethlem Royal Hospital- starvation and chaining of mentally ill individuals
- Witch hunts: enacted for financial gain or individuals displaying socially undesirable behaviour

18th and 19th Centuries

- Moral treatment movement: founding of asylums and retreats with the goal of curing patients, offered reading to patients, good diet, recreation, restricted physical restraint- more like a rehab centre

Mass hysteria may simply describe the phenomenon of emotion contagion, in which the experience of an emotion seems to spread to those around

20th and 21st Century

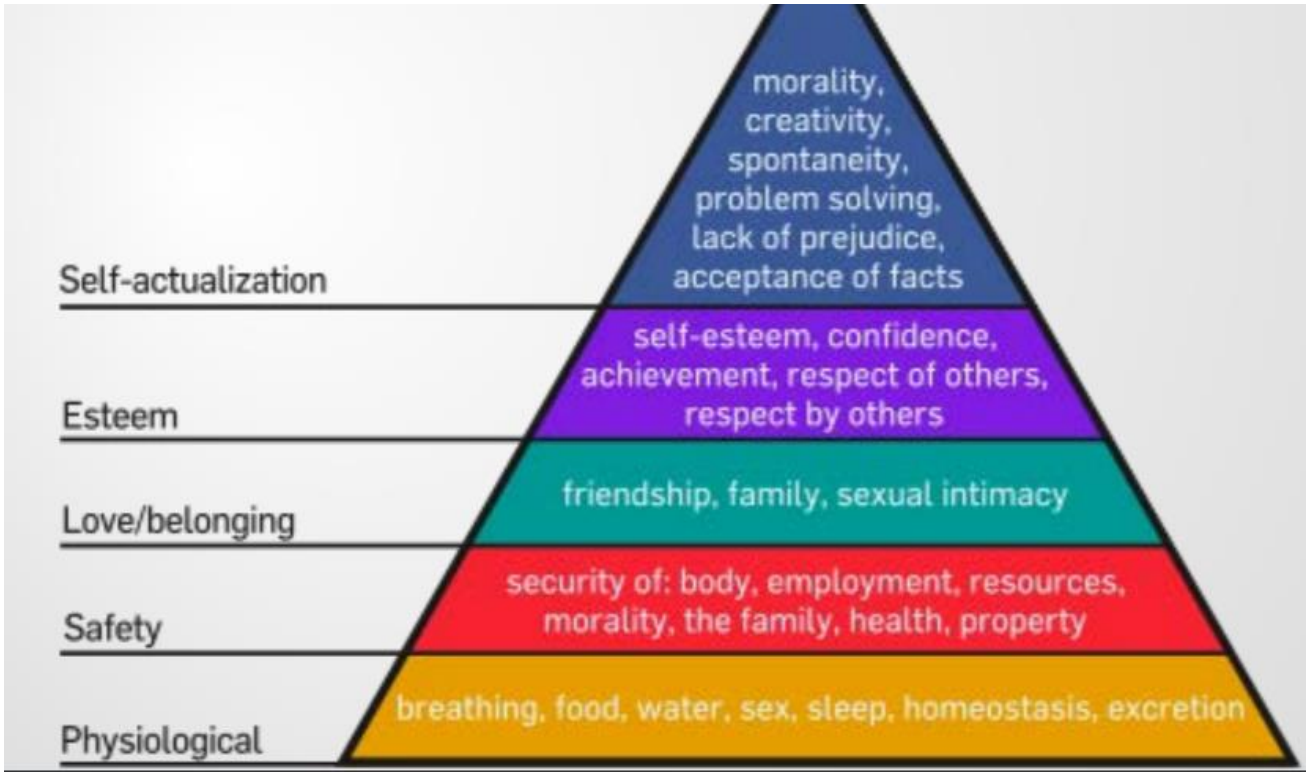
- Further development of institutions intended to serve those unwell
- Reduce stigma around mental illness
- Development of different treatments for mental illness such as pharmacotherapy, behaviour therapy, cognitive therapy (successful), acceptance and commitment therapy
- Electro-convulsive shock therapy for depression

- **Sigmund Freud**: **Psychodynamic Psychology**
  Mental illness is caused by maladaptive thoughts and behaviours which occur because of conflict occurring between conscious and unconscious processes. The psychologist facilitates the patient to come to realisations in order to cure their affliction.
- Many believe that this theory is unscientific because there is no way to approve or disapprove that. i.e you have depression because of unconscious memories from childhood… how can this be confirmed???

- **Edward Thorndike 1911**
- Behaviour therapy or Behaviour Modification
  All our behaviours and our personality is learnt by **experience**. He suggested we learn to act in certain ways and think certain things because of associations we form between important objects (animals, people, places) and important events (fun, being fearful, receiving an award/punishment).
- A person develops a mental illness because of unhelpful or maladaptive learning experiences i.e. being bitten by a dog leads to dog phobia.
- A person can overcome their afflictions by changing the associations they have in their minds by typically facing their fears i.e. exposure therapy.

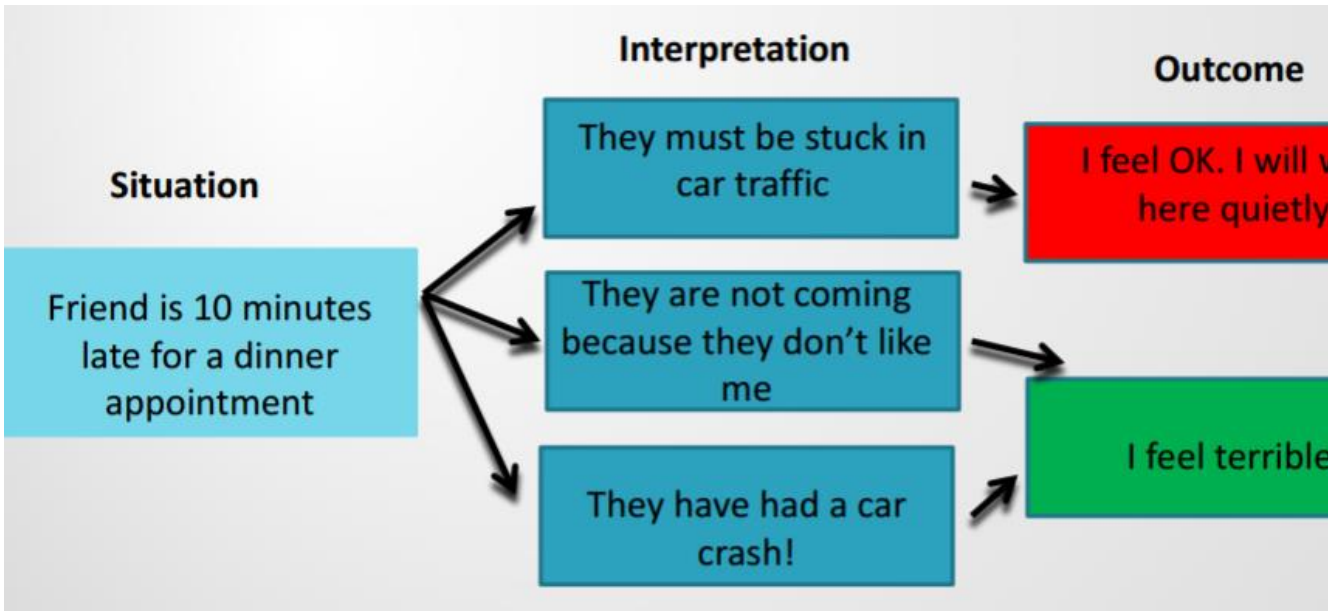
- **Abraham Maslow: Humanist Psychology**
  A desire to focus on what it is that is good about human beings as opposed to what is it that makes us bad
  What makes a person resilient in the face of extreme adversity i.e. Post WWII.
  Ego dystonic- can become depressed due to becoming something you do not want to become.
  When you are behaving in a way you believe is not the way to behave; seed of mental illness which is the theory of humanist psychology.

  Hierarchy of Needs: you must satisfy the requirements at a lower level before you may effectively progress to the next.



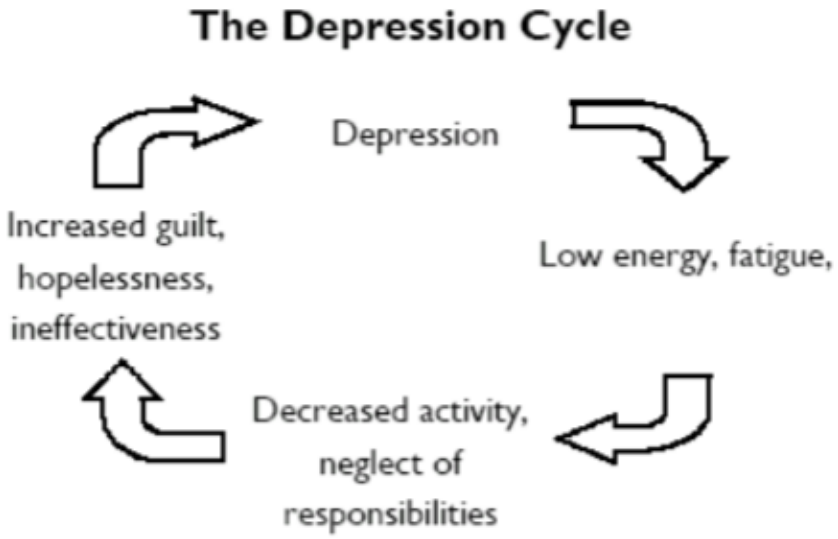
Displays the importance of various things for each person.
Views what might be important to people and how this can affect their level of stress, emotions, happiness etc.

- **Aaron T. Beck: Cognitive Therapy**
  Events are ambiguous; the interpretation of the event is what makes people feel bad. i.e. everything happening to me is horrible-nothing good is in the future. These are examples of negative interpretations about the past.
- Therapist works with client to challenge core negative beliefs about the world and the self.



- Interpretative style based on negative beliefs is NEGATIVE not positive. Changing core beliefs about the world and self (cognitive therapy).

- Peter Lewinsohn: Behavioural Activation
  Inactivity leads to depression as there is less chance for positive reinforcement from positive experiences and more time to reflect on negative experiences impacts much more negatively.
- Therapist is like a coach- gradually increasing positive activities (being social, achieving goals) and reducing negative behaviours (being inactive, negative thinking).



CHAPTER 1 NOTES

Psychological Disorder (abnormal behaviour) - a psychological dysfunction within an individual associated with distress or impairment in functioning and a response that is not typical or culturally expected
Phobia- a psychological disorder characterized by marked and persistent fear of an object or situations.

psychopathology-Psychopathology is the scientific study of psychological disorders. Clinical and counselling psychologists receive the Ph.D. degree (or sometimes an Ed.D., doctor of education, or Psy.D., doctor of psychology) and follow a course of graduate-level study, lasting approximately 5 years, that prepares them to conduct research into the causes and treatment of psychological disorders and to diagnose, assess, and treat these disorders.

- Many mental health professionals take a scientific approach to their clinical work and therefore are called **scientist-practitioners**

Clinical Description
One important function of the clinical description is to specify what makes the disorder different from normal behaviour and from other disorders.
Prevalence: is how many people in the population as a whole have the disorder
Incidence: statistics on how many new cases occur during a given period i.e. a year of the disorder. Other stats can include sex, age etc.

Some disorders follow a chronic course (lifetime) or an episodic course (i.e. A seizure , gone for a few months to reoccur soon). Some have an acute onset (suddenly beginning) and some may have an insidious onset (developing gradually over time).

The anticipated course of a disorder is called **prognosis.**
Etiology is the study of why a disorder begins and what causes it including biological, psychological and social dimensions.

19th Century:
Syphilis- Behavioural and cognitive symptoms of what we now know as advanced syphilis, a sexually transmitted disease caused by a bacterial microorganism entering the brain, include believing that everyone is plotting against you (delusion of persecution) or that you are God. Patients were injected with malaria as this was seen effective- obviously not an ethical practice today.

Psychosocial treatment- The best treatment was to re-educate the individual through rational discussion so that the power of reason would predominate

Moral therapy- treating patients as normally as possible in a setting that encouraged and reinforced normal social interaction. Moral really meant emotional or psychological rather than a code of conduct. Originated with the well-known French psychiatrist Philippe Pinel (1745–1826) and his close associate Jean-Baptiste Pussin

Psychoanalysis-elaborate theory of the structure of the mind based on Freuds ego, id and superego; and the role of these unconscious processes in determining behaviour

Psychanalytic theory focuses on hypnosis, psychoanalysis-like free association and dream analysis as well as the balance of the id, ego and superego.

- The structure of the mind and the distinct functions of personality that sometimes clash with one another
- The defence mechanisms with which the mind defends itself from these clashes or conflicts.
- The stages of early psychosexual development that provide grist for the mill of our inner conflicts.

Freud teamed up with Josef **Breuer** (1842–1925), who had experimented with a somewhat different hypnotic procedures. While his patients were in the highly suggestible state of hypnosis, Breuer asked them to describe their problems, conflicts, and fears in as much detail as they could. Breuer observed two extremely important phenomena during this process. First, patients often became extremely emotional as they talked and felt quite relieved and improved after emerging from the hypnotic state. Second, seldom would they have gained an understanding of the relationship between their emotional problems and their psychological disorder. In fact, it was difficult or impossible for them to recall some details they had described under hypnosis. In other words, **the material seemed to be beyond the awareness of the patient. EVIDENCE OF THE UNCONSCIOUS PROCESSES.** With this observation, Breuer and Freud had discovered the unconscious mind and its apparent influence on psychological disorders

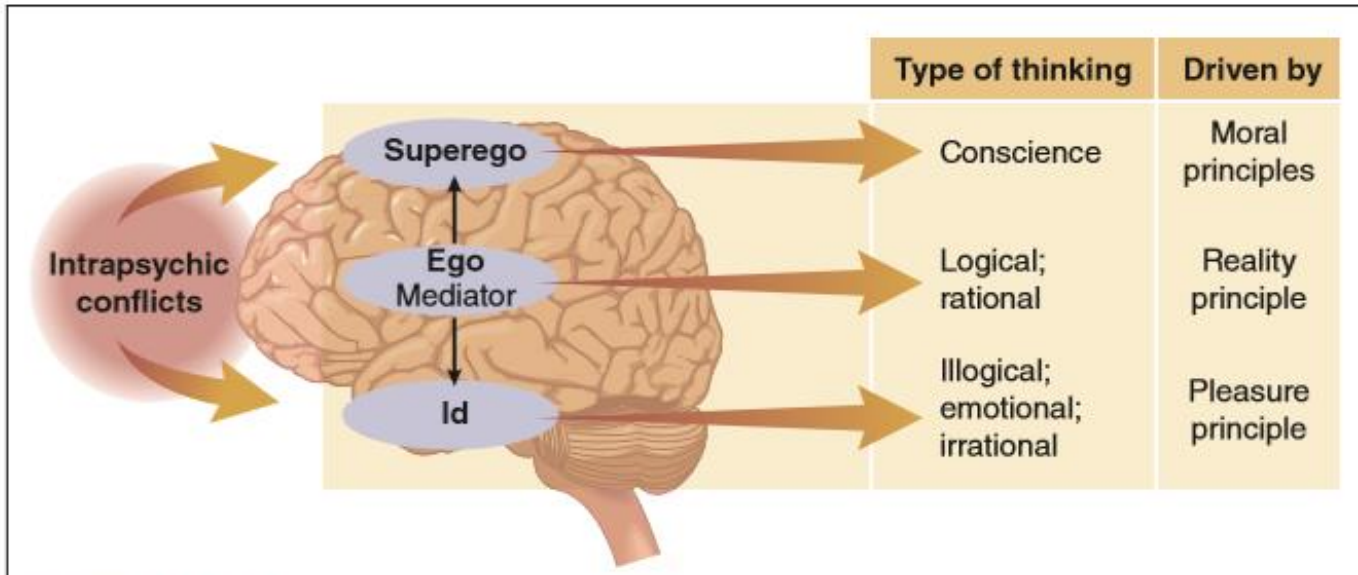
Behaviourism- which focuses on how learning and adaptation affect the development of psychopathology

Sigmund Freud has three major parts or functions:

- **Id**: source of our strong sexual and aggressive feelings or energies; basically the animal within us- and if unchecked, we would be killers/rapists. The id operates according to the pleasure principle with an **overriding goal of maximising pleasure** and eliminating any associated tension or conflicts.

- **Ego**: the part of our mind that ensures we act realistically. It operates according to the reality principle instead of pleasure principle. To mediate conflict between the id and the superego, juggling their demands within the realities of the world. If unsuccessful, this is where the id and superego become strong and is the beginning of psychological disorders. These conflicts within the mind are referred to as intrapsychic conflicts.

- **Superego**: is what our conscience is representing the moral principles instilled in us by our parents/our culture. It is the voice inside our head that is constantly talking back or talking us through a process that, to you is wrong.



■ **FIGURE 1.4** Freud's structure of the mind.

Defence mechanisms (coping styles): unconscious protective processes that keep primitive emotions associated with conflicts in check so that the ego can continue its coordinating function

- displacement. The ego adaptively decides that expressing primitive anger at your professor might not be in your best interest. Because your brother and your dog don't have the authority to affect you in an adverse way, your anger is displaced to one of them.
- Some people may redirect energy from conflict or underlying anxiety into a more constructive outlet such as work where they may be more efficient because of the redirection. This is called sublimation.
- Denial: Refuses to acknowledge some aspect of objective reality or subjective experience that is apparent to others.
- Projection: Falsely attributes own unacceptable feelings, impulses, or thoughts to another individual or object
- Rationalization: Conceals the true motivations for actions, thoughts, or feelings through elaborate reassuring or self-serving but incorrect explanations
- Reaction formation: Substitutes behaviour, thoughts, or feelings that are the direct opposite of unacceptable ones
- Repression: Blocks disturbing wishes, thoughts, or experiences from conscious awareness

Freud developed techniques of **free association**, in which patients are instructed to say whatever comes to mind without the usual socially-required censoring. Free association is intended to

reveal emotionally charged material that may be repressed because it is too **painful** or threatening to bring into consciousness.

Psychosexual stages of development:

- Freud hypothesized that if we did not receive appropriate gratification during a specific stage or if a specific stage left a particularly strong impression (which he termed fixation), an individual's personality would reflect the stage throughout adult life. For example, **fixation** at the oral stage might result in excessive thumb sucking and emphasis on oral stimulation through eating, chewing pencils, or biting fingernails. Adult personality characteristics theoretically associated with oral fixation include dependency and passivity or, in reaction to these tendencies, rebelliousness and cynicism.

Cartharsis: discovery that it is therapeutic to recall and relive emotional trauma that has been made unconscious and to release the accompanying tension. This release of emotional material became known as catharsis. This can be evident in free association technique.

Humanistic Theory

- **Self-actualising** the assumption that all of us could reach out highest potential in all areas of functioning
- **Person-centred therapy** with unconditioned positive regard

The **Behavioural Model** is known as the cognitive-behavioural model or social learning model which brought the systematic development of a more scientific approach to psychological aspects of psychopathology.

- Pavlov and Classical Conditioning
- BF Skinner and operant conditioning,
- John B Watson- conditioned fear and experiment with little Albert.
- Edward Thorndike and the law of effect- behaviour is strengthened or weakened if it occurs frequently/less frequently.
- The first effective drug for severe psychotic disorders are developed. Humanistic psychology gets acceptance
- The first edition of the DSM

Neurosis- all nonpsychotic psychological disorders resulted from underlying unconscious conflicts, the anxiety that resulted from those conflicts, and the implementation of ego defence mechanisms.

…

Current thinking is that stressful life events activate stress hormones, which, in turn, have wide-ranging effects on neurotransmitter systems, particularly those involving serotonin, norepinephrine, and the corticotropin-releasing factor system. Booij and Van der Does (2007) have illustrated how neurotransmitter function and negative cognitive styles interact. They collaborated with 39 patients who had suffered an episode of major depression but had recovered. These patients participated in two biological test or "challenge" procedures called acute tryptophan depletion (ATD) that had the effect of temporarily lowering levels of serotonin. This is accomplished fairly easily by altering diet for 1 day by restricting intake of tryptophan (a precursor to serotonergic functioning) and increasing

a mixture of essential amino acids. Participants in the experiment, of course, were fully informed of these effects and collaborated willingly.

- factors such as interpersonal relationships or cognitive style may protect us from the effects of stress and therefore from developing mood disorders.

SUICIDE
-Regardless of age, in every country around the world except China males are 4 times more likely to commit suicide than females.

- Suicide, particularly among women, is often portrayed in classical Chinese literature as a reasonable solution to problems. A rural Chinese woman's family is her entire world, and suicide is an honorable solution if the family collapses

the prevalence of suicide ideation has been estimated at 9.2%; 3.1% reported a suicide plan and 2.7% attempted suicide during their lifetime

Sigmund Freud (1917/1957) believed that suicide (and depression, to some extent) indicated unconscious hostility directed inward to the self rather than outward to the person or situation causing the anger

- FAMILY HISTORY CONTRIBUTES TO PREVALENCE
- Reciprocal gene: impulsivity trait inherited.
- Neurobiology: low levels of serotonin
- many people with mood disorders do not attempt suicide, and, conversely, many people who attempt suicide do not have mood disorders.
- most important risk factor for suicide is a severe, stressful event experienced as shameful or humiliating, such as a failure or sexual abuse.
- Suicide is romanticised in the media: and not often shown the extent of damage such as brain damage, paralysis, family burden etc.

Emile Durkheim (1951) defi ned a number of suicide types, based on the social or cultural conditions in which they occurred.

- Altruistic suicide: when individuals brings dishonour to themselves and engage in suicde
- Egoistic suicide: loss of social support
- Anomic: feeling lost and confused
- Fatalistic : loss of control over ones destiny.

A disorder characterized more by impulsivity than depression is borderline personality disorder

TREATMENT
In summary, the clinician must assess for (1) suicidal desire (ideation, hopelessness, burdensomeness, feeling trapped); (2) suicidal capability (past attempts, high anxiety and/or rage, available means); and (3) suicidal intent (available plan, expressed intent to die, preparatory behavior

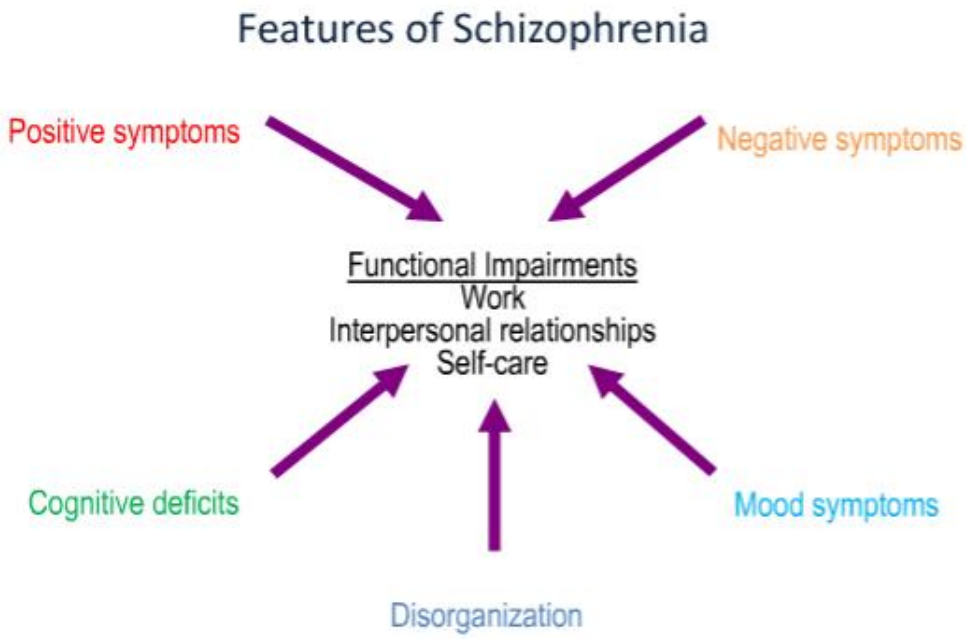
- Immediate hospitalisation
- Limiting access to lethal weapons

SCHIZOPHRENIA

People with schizophrenia are no more danger than others within the society.
Nature:
Heterogenous disorder presentation: number of different symptom clusters that occur within the disorder, more than usual (as lots of disorders are co-morbid, like OCD)

- Among top 10 disabling conditions worldwide for young adults, affecting approx 1%

Due to heterogeneity, there isn't a certain way that one with schizophrenia looks like.
Brain abnormalities which interfere with either or all of an individual's ability to think, feel and behave. Usually characterised by psychosis.



Positive symptoms: distortion or excess of normal brain 'extra' than normal of thought functioning.

- Hallucinations-disturbances of perception i.e. experiencing sensory events without external input from the world. Internally generated, most common is auditory hallucination.
- Delusions- disturbances of thought content
- Positive symptoms typically occur within a psychotic episode.
- Between 50% and 70% of people with schizophrenia experience hallucinations

Auditory hallucination can take in the form of voices of a dead relation, god, devil, multiple different voices. Content can be malevolent (hurt yourself), benevolent (cleaning), ambivalent (watch tv), serious acts such as killing yourself etc.

During hallucinations Broca's area is activated, suggested that hallucinations are indeed internally generated as this is the area for receptive speech (speech production).

- group of researchers who also found that Broca's area was more active than Wernicke's area during auditory hallucinations (Cleghorn et al., 1992). These observations support the metacognition theory that people who are hallucinating are not hearing the voices of others but are listening to their own thoughts or their own voices and cannot recognize the difference

Delusions are thoughts of the world not based on reality.

- Paranoid delusion (most common)- thinking that people are trying to hurt you or that organised systems in the world are harming you.
- Delusions of reference: believing that messages are directed at you personally when they are not i.e. the tv is talking to me
- Delusions about thinking: thinking that people are reading your thoughts, inserting thoughts in your head or controlling your thinking or behaviour

- Grandiose and religious delusions: thinking that one has supernatural powers or control over others.

Negative symptoms: deficits in functioning; lacking in the brain. They involve disruptions to emotional experience and behaviour- lacking in behaviour/emotional capacity.

- Common negative symptoms are decreased expression of feelings, diminished emotional range, poverty of speech, decreased interests, diminished sense of purpose and social drive, schizophrenia believed to be a cause by low levels of dopamine.

- Also has an effect on social functioning i.e. employment, depression, daily living tasks.
- Avolition (apathy) lack of initiation and persistence i.e. getting out of bed, personal hygiene
- Alogia- relative absence of speech, replying with brief responses, lack of expression
- Anhedonia- lack of pleasure, in sexual relations, eating, social interactions
- Affective flattening- little expressed emotion, flat affect staring at you vacantly, monotone

Disorganisation Symptoms: may include disorganised expression i.e. speech or behaviours
Such as behaviours that are not typically expected.

- Disorganisation of speech: tangential, word salad, sentence spoken fluidly but nonsense
- Disorganisation of behaviour, odd mannerisms
- Lack of insight- not aware that they have a problem.
- This can also include inappropriate affect; laughing or crying at improper times.

Catatonic immobility: holding of unusual postures as if something were about to happen. Or wavy flexibility: keeping bodies and limbs in the position they are put in by someone else. Wtf lol

Differential impact of symptoms and onset:

POSITIVE VS. NEGATIVE

- Positive symptoms, good response to medications and there is no intellectual impairment
- Negative symptoms, have a poor response to medication, pessimistic to prognosis and have intellectual impairments

SUDDEN VS. CHRONIC

- Sudden onset schizophrenia is associated with a better outcome and prognosis- more of an influence of environment
- Chronic/slow onset schizophrenia is associated with a worse outcome and it presumed to be **biologically** developed.

What causes symptoms?

RISK AND ENVIROMENTAL FACTORS

- Low SES
- Pre-birth (in utero) complications i.e. viral infection
- In twins, competing for nutrition,and they may not be evenly shared
- Anoxia during child birth
- Significant stress, first age onset is typically adolescence
- Substance use i.e. cannabis, alcohol and other drugs

- Family communication problems i.e. in maintaining the disorder; evidence for association with relapse rate and highly expressed emotion
- Fetal exposure to viral infection, pregnancy complications, and delivery complications are among the environmental infl uences

GENETIC FACTORS

- Summary of studies: monozygotic 41-65% chance of developing the disorder as opposed to 1% of developing disorder in general population
- Monozygotic twin 45%
- Dizygotic twins 17% chance
- Hypofrontality in the frontal lobes.

BIOLOGICAL FACTORS

- The Dopamine Hypothesis: dopamine is a neurochemical influencing the communication of structures in the brain.
- Drugs that increase dopamine in the brain result in schizophrenic like behaviour i.e. psychosis. Therefore drugs that decrease dopamine within the brain can reduce psychotic symptoms i.e. Neuroleptics, L-Dopa as pharmacological treatments

Criticisms:

- Too simplistic?
- Does not account for large heterogeneity found in the nature of the disorder
- Possibly multiple neurotransmitters are involved in the disorder

>> Recent research by fMRI scans have revealed that grey and white matter at n=51, are significantly reduced in the brain of patients with schizophrenia.
>> unable to recognise emotions expressed by speech

TREATMENTS

- Antipsychotic medications i.e. Neuroleptic: first line drug and are effective in treating the positive symptoms

Side effects: Parkinson's side effects, lack of motor control of face and mouth