

**Chapter 1 – Abnormal Psychology: An Overview**

- **Family aggregation:** whether a disorder runs in the family
- No universal agreement on what abnormality/disorder is
  - o A “prototype” is adopted to assess the degree of “abnormality”

*The Elements of Abnormality*

- 1) Suffering: suffer psychologically (e.g. depression)
  - 2) Maladaptiveness: interferes w/ wellbeing and ability to enjoy work/relationships
  - 3) Deviancy: away from the norm (determined thru value judgments)
  - 4) Violation of standards of society: when people fail to follow conventional social & moral rules (depending on magnitude and commonality of violation)
  - 5) Social discomfort: violating a social rule -> uneasiness/discomfort
  - 6) Irrationality and unpredictability
- Society is constantly evolving and changing -> definition of abnormality can change
  - **Stigma:** (disgrace) attached to receiving a psychiatric diagnosis
  - **Stereotyping:** automatic beliefs people have about others based on knowing one thing about them
  - **Symptom:** single indicator of a problem; can involve affect, behaviour and cognition
  - **Syndrome:** group/cluster of symptoms that all occur together
  - DSM (Diagnostic and Statistical Manual of Mental Disorders)
    - o Doesn't refer to causes of mental disorders
    - o Rules out behaviour that is culturally sanctioned
    - o **Mental disorder:** a clinically significant behavioural/psychological syndrome or pattern
  - **Culture-specific disorders:** forms of psychopathology found in only certain areas
    - o Taijin Kyofusho (found in Japan): anxiety disorder -> marked fear that body/parts/functions may offend or embarrass others
    - o Ataque de nervios (Latino-Caribbean/Mediterranean) triggered by a stressful event -> uncontrollable screaming/crying
      - Person returns to normal w/out memory
  - **Abnormal behaviour:** behaviour that deviates from norms of society enacted in
  - **Epidemiology:** study of distribution of diseases, disorders in a given population
  - **Prevalence:** number of active cases in a population during any given period of time
  - **Point prevalence:** estimated proportion of actual, active cases of disorder in population at given time
    - o One-year prevalence -> count people who suffered from disorder at any time during the year (higher than point prevalence b/c cover long time)
  - **Lifetime prevalence:** estimate of how many people had suffered from a particular disorder at any time in their lives (higher than other kinds of prevalence)
  - **Incidence:** number of new cases that occur w/in a time period (exclude existing ones)
  - **Comorbidity:** presence of 2+ disorders in the same person
    - o Higher in people w/ severe mental disorders
  - People don't like to seek help b/c of access to mental health services/attitudes about it

**Chapter 2 – Historical Views of Abnormal Behaviour**

- Chinese, Egyptians, Hebrews, and Greeks thought a demon or god had taken control of the person (good/bad spirits)
- Hippocrates -> believed brain was central to intellectivity and mental disorders were due to brain pathology
  - o 3 categories: mania, melancholia, phrenitis (brain fever)
  - o With Galen, thought the 4 elements of earth combined to form 4 humours (essential fluids) in the body -> blood, phlegm, bile, black bile
    - Combined in diff proportions w/ diff individuals (most dominant humour led to main temperament of the person)
- Plato -> thought psychological phenomena was responses of the whole organism, reflecting internal state and natural appetites (even partly divine)
- Aristotle -> held the view that “thinking” would eliminate pain and attain pleasure
- **Hysteria (conversion disorder):** wandering uterus in the human body
- **Melancholia (depression):** many different forms in men and women
- Galen -> made contributions to anatomy of the nervous system (animal dissection)
- **Mass madness:** groups of people were affected simultaneously by hysteria (psychogenic)
  - o Cases were related to the terrible events in this period (environmental trigger)
- **Tarantism:** uncontrollable impulse to dance that was attributed to the bite of a tarantula or wolf spider (Saint Vitus Dance in Germany)
- **Lycanthropy:** people believed themselves to be possessed by wolves and imitate behaviour
- **Exorcisms:** symbolic acts performed to drive out the devil from possessed people
- Paracelsus -> treatment by “body magnetism” (hypnosis)
  - o Convinced moon had supernatural influence over brain -> lunatic

- Pinel -> experimented on prisoners -> treated mentally unstable w/ kindness
- **Moral management:** focused on social, individual & occupational need
- **Mental hygiene movement:** focused exclusively on physical well-being -> no change on mental health
- **Deinstitutionalization:** movement when many mental hospital closed down to integrate psychiatrically disturbed people
- The Eugenics Movement -> crimes, STDs, unwanted pregnancies, etc. result of mental retardation and other psychopathology (result of heredity) -> removal of reproductive systems
- General paresis -> paralysis and insanity (led to death after 2-5 years)
  - o Actually syphilis of the brain; many ppl thought other mental disorders could be solved
- **Catharsis:** discharge of emotional tension associated w/ something, such as by talking about past trauma
  - o When freely talking under hypnosis -> discovery of the unconscious (portion of mind containing experiences)
- **Free association;** talking freely to provide info about feelings and emotions, motives
- **Dream analysis:** record and describe their dreams -> insight to emotional problems

### Chapter 3 – Causal Factors and Viewpoints

- **Necessary cause:** condition that must exist for a disorder -> many psychological disorders don't have one
- **Sufficient cause:** condition that guarantees occurrence of disorder (may not be a necessary cause)
- **Contributory cause:** one that increases the probability of development of a disorder (may not be necessary not sufficient for disorder to occur)
- **Distal causal factors:** occur early in life; may not show effects for many years
- **Proximal causal factors:** operates shortly before occurrence of disorder (triggers onset)
  - o Might include biological changes
- **Reinforcing contributory cause:** maintain maladaptive behaviour that's already occurring
- **Diathesis:** predisposition/vulnerability toward developing a disorder
- **Protective factors:** high resilience to environmental stress

### The Biological Viewpoint and Biological Causal Factors

- Psychological disorders -> due to problems in CNS & ANS or endocrine system
  - o Neurological disease: disruption of brain by physical/biochemical -> psychological/behavioural aberrations
- Neurotransmitter imbalance -> excessive production, dysfunction of receptors in postsynaptic neuron
- Chemical circuits: neurons cluster together to form neural path
- Monoamines (norepinephrine, dopamine, serotonin) and gamma aminobutyric acid (GABA)
  - o Norepinephrine – emergency reactions when exposed to stressful situations
  - o Dopamine – implicated in schizophrenia and addictive disorders
  - o Serotonin – effects on thinking, and how we process information, behaviours, mood
  - o GABA – reducing anxiety and emotional states
- Hypothalamic – pituitary – adrenal – cortical axis
  - 1) Corticotropin – releasing hormone -> hypothalamus -> pituitary
  - 2) Pituitary -> adreno-corticotrophic hormone -> cortical of adrenal -> epinephrine and cortisol (stress)
  - 3) Negative feedback – hypothalamus > decrease release
- Personality traits and psychological disorders not affected by chromosomal abnormalities, but abnormalities in some of the genes of the chromosome -> polygenic (influenced by many genes)
- Gene expression is end product of intricate processes influenced by internal and external environment
- Genotype-environment correlations: genotype shapes environmental experiences
  - o Passive effect -> genetic similarity b/w parents and children
  - o Evocative effect -> genotype evoke particular kinds of reactions for social and physical environment
  - o Active effect -> child seeks out environment that is congenial
- Genotype-environment interaction: people w/ different genotypes may be differentially sensitive/susceptible to their environments
- Behaviour genetics: studying heritability of psychological disorders
  - o Family history/pedigree method: if incidence increase is proportional to degree of hereditary
    - Compare incidence of trait in population and relatives
    - Hard because closely related tend to have same environment (doesn't separate environment and genetics)
  - o Twin method: concordance rate (% of sharing) = 100% in monozygotic twins
    - No concordance rate that high; not all disorders entirely heritable
    - Not conclusive b/c treated more similarly than dizygotic twins
  - o Adoption method: if genetic influence, higher rates in biological relatives w/ disorder
- **Temperament:** child's reactivity and characteristic ways of self-regulation
  - o 5 identified in 2-3 months of age -> fearfulness, irritability, positive affect activity level and attentional persistence
    - Related to
      - Neuroticism/negative emotionality
      - Extroversion/ positive emotionality
      - Constraint/conscientiousness & agreeability

### The Psychological Viewpoints

- Id -> life instincts (sexual nature, libido) and death instincts (aggression)

- Pleasure principle: id is completely selfish and pleasure-oriented
- Primary process thinking: generate mental images & fantasies (not real actions)
- Ego -> mediates id's demands and realities of external world
- Secondary process thinking: ensure well-being and survival while meeting id's demands
  - o Reality principle: use of reason and intellectual resources
- Superego (conscience) -> inner control/system deals w/ id's uninhibited desires
- **Displacement**: discharging pent-up feelings on objects less dangerous
- **Fixation**: attaching oneself in unreasonable way to person or arresting emotional development on a childhood/adolescent level
- **Projection**: attributing one's unacceptable motives/characteristics
- **Rationalization**: using "explanations" to disguise unworthy motives of behaviour
- **Reaction formation**: preventing awareness/expression of unacceptable desires by an exaggerated adoption of opposite behaviour
- **Regression**: preventing painful/dangerous thoughts from entering consciousness
- **Sublimation**: channelling frustrated sexual energy into substitute activities
- **Object-relations theory**: individual's interaction w/ real and imagined people and relationships b/w internal and external objects (symbol for another person)
  - o Introjection -> child symbolically incorporates important people into life
  - o Internalized objects can have conflicting properties -> split from central ego
    - e.g. borderline personality: unable to achieve full and stable personal identity b/c inability to integrate pathological internalized objects
- **Interpersonal perspective**: social and cultural forces instead of inner instincts as determinants of behaviour
  - o Adler -> people are inherently social beings motivated by desire to belong
- Fromm -> orientations/dispositions that people adopt in their interactions w/ others (maladaptive -> psychopathology)
- **Attachment theory**: early experience w/ attachment relationships as foundation for functioning in childhood, adolescence and adulthood
  - 1) Psychodynamic perspective fails to recognize scientific limits of personal reports of experience as primary method for obtaining information
  - 2) Lack of scientific evidence
  - 3) Freud -> overemphasis on sex drive, demeaning women, pessimism and role of unconscious

#### The Behavioural Perspective

- Study of subject experience not acceptable scientific data (no verification)
  - o Direct observable behaviours and stimuli -> basis for human behaviour
- **Learning**: modification of behaviour as a consequence of experience (central theme)
- **Classical conditioning**: specific stimulus -> specific response
  - o Conditioned stimulus -> UCR (conditioned response)
  - o Formally neutral stimulus elicits biologically adaptive responses
  - o Stimulus-stimulus expectancy -> only CS that provides reliable info will cause CR
- **Extinction**: if CS is repeatedly presented w/ UCS (not unlearning)
- **Instrumental/operant conditioning**: learn to achieve desired goal (obtain something rewarding or escape something unpleasant)
  - o Reinforcement -> delivery of reward or escape adverse stimulus
  - o Higher rate to establish instrumental response, lower rate to maintain it
  - o IR especially persistent when low/no reinforcement, but too much -> extinction
- **Generalization**: response can be evoked by other similar stimuli
- **Discrimination**: learns to distinguish b/w similar stimuli and respond differently
- **Observational learning**: learning thru observations alone w/ US/reinforcement
- Maladaptive behaviour caused by failure to learn necessary adaptive behaviour/learning of ineffective or maladaptive responses

#### The Cognitive-Behavioural Perspective

- Study of basic info-processing mechanisms (attention, memory, thinking, decision making)
- Internal reinforcement -> prepare for tasks by visualizing consequences if we didn't perform them
  - o Do not always require external reinforcement to alter behaviour patterns
    - Cognitive abilities allow us to solve problems internally
- **Self-efficacy**: belief that one can achieve desired goals (capacity for self-direction)
- Cognitive/CBP -> thoughts and info-processing can become distorted and lead to maladaptive thoughts and emotions
- **Schema**: underlying representation of knowledge that guides the current processing of information and often leads to distortions in attention, memory, and comprehension
  - o Guides through the complexities of living in the world as we understand it (e.g. social roles and events)
  - o Enable us to focus on relevant information
- **Self-schemas**: views on who we are, what we might become, and what is important to us
  - o Can be sources of psychological vulnerabilities b/c may be distorted or inaccurate
  - o May be resistant to change b/c not completely conscious of them and unaware of assumptions on which they are based on

- **Assimilation:** work new exps into our existing cognitive frameworks, even if new info has to be reinterpreted or distorted to make it fit (cling to existing assumptions and reject new info that contradicts them)
- **Accommodation:** changing our existing frameworks to make it possible to incorporate new info that doesn't fit
- Beck -> different forms of psychopathology form from diff maladaptive schemas developed from adverse early learning exps -> distortions in thinking
- **Nonconscious mental activity:** mental processes that are occurring w/out our being aware of them; how most information is processed
  - o E.g. anxious ppl seem to have attention drawn to threatening info subliminally
  - o **Implicit memory:** person's behaviour reveals that she/he remembers a previously learned word/activity even tho she/he cannot consciously remember it
- **Attribution:** process of assigning causes to things that happen
  - o Attribute behaviour to external events (rewards/punishments) or internally and derive from traits w/in others or ourselves

### Psychological Causal Factors

- Children's lives may be different depending on whether the events are predictable/controllable
  - o Exposure to lots of uncontrollable/unpredictable events -> vulnerable to anxiety, stress & depression
  - o Exposure to same frequency and intensity of negative outcomes but controllable and predictable -> less stress

### Early Deprivation or Trauma

- Deprivation of needed resources (food, shelter, love, attention) can cause psychological scars
- Many children institutionalized during infancy and early childhood (less warmth and attention) show severe emotional, behavioural and learning problems -> risk for disturbed attachment relationships and psychopathology
  - o Children institutionalized early may show resilience; due to influential protective factors (good exps at school, etc.)
- Most infants suffer from maltreatment at home -> physical neglect, denial of love, failure to spend time, lack of interest, sexual/emotional/physical abuse (partial/complete, passive/active, subtly/overtly cruel)
  - o Grow up to be overly aggressive (verbally & physically)
  - o Difficulties in linguistic development and sig problems in behavioural, emotional, and social functioning
- Prolonged separation -> significant despair and detachment upon reunion
  - o Can lead to insecure attachment -> increased to stressors in adulthood

### Inadequate Parenting Styles

- Parents w/ various forms of psychopathology tend to have children who are at heightened risk for a wide range of developmental difficulties
  - o Not entirely genetic; could be due to the fact that parents treat kids with hostility, etc.
- Discipline -> structure and guidance for promoting a child's healthy growth; important to be clear on what behaviour is inappropriate
- Four types of parenting styles leads to diff developmental outcomes for children
  - o Authoritative: very warm, careful to set clear limits w/ considerable freedom
    - Most positive early social development (energetic, friendly)
  - o Authoritarian: low warmth, very controlling and often cold, and demanding
    - Conflicted, irritable, moody children; boys have poor social & cognitive skills
    - Severe physical punishment -> extremely aggressive behaviour
  - o Permissive/Indulgent: very warm, low on control
    - Impulsive and aggressive; overly indulged -> selfish, spoiled, inconsiderate
    - Adolescence -> anti-social behaviours, poor academics
  - o Neglectful/Uninvolved: low warmth, low control
    - Disruptions in attachment during childhood -> moodiness, low self-esteem
    - Problems w/ peer relations and academic performance

### Marital Discord and Divorce

- Children of parents w/ high levels of overt conflicts -> greater disposition to behave aggressively toward peers and parents
  - o Can be buffered if parents are warm, give praise and approval, and inhibit rejecting behaviour towards children
- Divorce on adults is a major source of psychopathology, physical illness, death, suicide and homicide
- Temperamentally difficult children are more likely to have a harder time adjusting to divorces; may be the ones whose parents are more likely to divorce b/c -> marital problems
- Effects of divorce on children are more favourable than staying in a home w/ marital conflict and dissension

### Maladaptive Peer Relationships

- Bullies show high levels of proactive regression and reactive aggression (overreact when confronted)
  - o B/c of social deficit skills or sophisticated understanding of social behaviour -> manipulate and organize peers to avoid being caught while making others suffer
- Experience of intimacy w/ a friend -> social competence (considerable repertoire of social knowledge and skills)
  - o Protective factor against mental disorder, frustration, despair
- Two types of popular children
  - o Prosocial -> friendly, assertive, cooperative
  - o Antisocial -> "tough boys"; athletically skilled but poor academics, highly aggressive, defiant of authority
- Two types of rejected children
  - o Aggressive -> demanding approach when interacting w/ peers

- Take offence too readily, attribute hostile intent to teasing of peers
- Likely in children who have been maltreated by parents
- Withdrawn (highly unassertive and submissive) -> social anxiety and fear of being scorned
  - Deprives a child of opportunities to learn rules of social behaviour
  - Damaging effects on self-confidence and self-esteem -> depression and anxiety
- Children who fail to establish satisfactory relationships w/ peers during the developmental years are deprived of a crucial set of bg exps and is at higher than average risk for a variety of negative outcomes (depression, school dropout, delinquency)
  - Peer social problems may be early markers of disorders w/ a heritable component (may be stressors)

### The Sociocultural Viewpoint

- Concerned w/ the impact of culture and other features of social environment or psychological disorders
  - Patterns of psychological disorders w/in a society can change over time as sociocultural conditions change
- Sociocultural factors influence which disorders develop, the forms that they take, how prevalent they are, and their courses
- Undercontrolled behaviour: aggression, disobedience, disrespectful acts
- Overcontrolled behaviour: shyness, anxiety, depression
  - E.g. Thailand parents are intolerant of undercontrolled behaviour -> greater prevalence of overcontrolled problems than North American children
- Cultural differences in psychopathology may result from differences in what cultures consider to be the ideal kinds of parent-child attachment relationships

### Sociocultural Causal Factors

- Sociocultural group fosters own cultural patterns by teaching offspring -> everyone seems alike
- Subgroups of sociocultural environment (age, sex, ethnicity) foster beliefs and norms of their own that members learn to adopt
  - When conflicting, personality development may be impaired

### Low Socioeconomic Status and Unemployment

- Lower the SES, the higher the incidence of mental disorders
  - Ppl w/ psychological disorders slide down economic ladder and stay there b/c no economical/personal resources to get back up and sometimes b/c of prejudice and mental stigma
  - Ppl who live in poverty have more severe stressors and less resources for getting back up
- Prejudice against minority groups may explain why they show increased prevalence of certain psychological disorders
  - More women than men suffer from depression and anxiety disorders
    - Consequence of the vulnerabilities intrinsic to the traditional roles assigned to women
    - Access discrimination -> women are not hired b/c they are women
    - Treatment discrimination -> women who have a job are paid less treated more poorly and receive fewer opportunities for promotion
    - Special stressors: when women must cope with rapidly changing traditional roles (mother, employee, etc.)
      - Working outside home also protective factor against depression and marital dissatisfaction
- One third of homeless people suffer from severe mental illness
  - Increases risk of mental disorder, but mental disorder also leads to homelessness

## Chapter 16 – Disorders of Childhood and Adolescence

### Maladaptive Behaviour in Different Life Persons

- **Developmental psychopathology:** studying the origins and course of individual maladaptation in the context of normal growth processes
- Harder to understand mental disorders in children than adults because
  - Do not have as complex and realistic view of themselves and their world (less self-understanding and unstable sense of identity)
  - Immediately perceived threats are tempered less by considerations of the past or future -> more difficulty coping w/ stress
  - Limited perspectives lead them to use unrealistic concepts to explain events
  - More dependent on other people -> highly vulnerable to experiences of rejection, disappointment and failure if adults ignore child
  - Lack of experience in dealing w/ hardship make overcoming problems seem impossible, but recover more rapidly than parents

### Common Disorders of Childhood

#### Attention-Deficit/Hyperactivity Disorder

- **ADHD:** difficulties that interfere w/ effective task-oriented behaviour in children – particularly impulsivity, excessive motor activity (aimless running/fidgeting) and difficulties in sustaining attention
  - Children are often lower intelligence (7-15 IQ points)
  - Great difficulty in getting along w/ their parents b/c they don't obey rules
- Family pathology (parental personality problems/hysteria) -> hyperactivity in children
- Most children diagnosed were prescribed mostly Ritalin (amphetamine) – (short-term)
  - Quieting effect on children -> decreases overactivity, distractibility and aggressiveness, and increases alertness

- Side effects: decreased blood flow to brain -> impaired thinking and memory loss; disruption of growth hormone -> suppression of growth in body and brain; insomnia
- Strattera: nonstimulant medication; norepinephrine reuptake inhibitor -> reduce symptoms (short-term)
  - Side effects: decreased appetite, nausea, vomiting, fatigue, jaundice
- Gold standard is combination of psychological interventions and medications
  - Selective reinforcement in classroom and family therapy -> successful for short-term gains
- May go on to have other psychological problems (overly aggressive behaviour or substance abuse)

#### *Oppositional Defiant Disorder and Conduct Disorder*

- **ODD**: recurrent pattern of negativistic, defiant, disobedient, and hostile behaviour toward authority figures
  - Precursor for conduct disorder (occurs in middle childhood and adolescence)
- Risk factors – family discord, socioeconomic disadvantage, and antisocial behaviour in the parents
- **Conduct disorder**: persistent, repetitive violation of rules and a disregard for the rights of others
  - Deficit in social behaviour -> overt/covert hostility, disobedience, physical and verbal aggressiveness, etc.
  - Comorbid w/ substance-abuse disorder or depressive symptoms

#### *Pervasive Developmental Disorders*

- **PDD**: result of some structural differences in the brain that are usually evident at birth or become apparent as the child begins to develop
- **Asperger's disorder**: severe and persistent impairment in social interaction that involves marked stereotypic (repetitive) behaviour and inflexible adherence to routines -> long term psychological disability

#### *Autism*

- **Autism**: developmental disorder that involves a wide range of problematic behaviours including deficits in language, perceptual and motor development, defective reality testing, and inability to function in social situations
  - Do not show any need for affection or contact w/ anyone
    - Don't seem to know or care who their parents are
    - Sigman -> inability of autistic children to respond to others is a lack of social understanding (social cues)
      - "mind blindness": inability to take the attitude of others or to "see" things as others do
  - Have an imitative deficit and do not effectively learn by imitation
    - Echolalia: parrot-like repetition of a few words -> used in speech
  - Self-stimulation -> repetitive movements such as head banging, spinning, rocking
  - Show marked impairment on cognitive or intellectual tasks
    - Deficit in representing mental states -> deficits in social reasoning but can manipulate objects
  - Become preoccupied w/ and form strong attachments to unusual objects
    - When disturbed, may have a violent temper tantrum (maintenance of sameness)
- Believe autism beings w/ some type of inborn defect that impairs an infant's perceptual cognitive functioning
  - Primary impairment in the domains of social attachment and communication failures
  - Deficits in functioning of the amygdala (coordinate actions of ANS and endocrine system)
  - 80-90% of variance in risk for autism is based on genetic factors -> most heritable form of psychopathology
  - Fragile X -> constriction or breaking off of the end portion of the long arm of X sex chromosome (2% of males)
- Greater research on medications that target specific symptom clusters
  - Ritalin (used for ADHD) can treat the inattentiveness and hyperactivity
  - Antipsychotics are used for reducing aggressive behaviour
  - Antidepressants are used for repetitive and stereotypic behaviours to target serotonin

## **Chapter 17 – Therapy**

### *An Overview of Treatment*

- **Psychotherapy**: belief that people w/psychological problems can change – learn more adaptive ways of perceiving, evaluating, and behaving
- Men are much more likely to resist seeking treatment/therapy
  - Less able than women to recognize and label feelings of distress and identify them as emotional problems
  - Masculine stereotypes emphasize self-reliance and lack of emotionality (and giving up control)
- Most often to administer psychological treatments are clinical psychologists, psychiatrists, and clinical social workers
  - Psychiatrists differ from psychologists by using a biological approach whereas psychologists treat patients by changing behaviours and thought patterns
- How well clients do in treatment is related to the strength of the alliance they have w/ their therapists
  - Most people who have a lot of problems have troubled interpersonal relationships – first step is to foster good relationship w/ client
- Main objective is to gain different perspective through different methods and situations
  - Must help client give up dysfunctional behaviour patterns and replace them with new ones

### *Measuring Success in Psychotherapy*

- Estimating client's gains in therapy is dependent on
  - Therapist's impression of changes that have occurred – may be biased in favour or seeing themselves as competent and successful and limited observational sample to make judgments
  - A client's reports of change – may lie to please their therapists

- Reports from the client's family or friends – may be inclined to “see” the improvement they had hoped for
- Comparison of pretreatment and posttreatment scores on personality tests or other instruments
  - **Regression to the mean:** statistical tendency for extreme scores on a given measure to look less extreme at a second assessment -> false impression that a real change was documented
- Measures of change in selected overt behaviours

#### What Therapeutic Approaches Should be Used?

- **Manualized therapies:** standardization of psychosocial treatments to fit the randomized controlled trial paradigm
  - Compare using “active” therapies and no-treatment control (waitlists)
  - Therapists usually differ when delivering therapy so manual created to specify therapy sessions
  - Usually involve patients w/ single DSM-V diagnosis and 2/more control (one psychosocial, one biological)
- **Psychopharmacology:** determining which drugs alleviate which disorders and why they do so
  - Drugs only alleviate symptoms and don't change maladaptive behaviour or change the situation
- Medication can help patients benefit more from psychotherapy and also reduce noncompliant behaviour
  - May also be directed at family of patient to reduce relapse rates
  - Combined treatment may target if symptoms and work at different rates

#### Pharmacological Approaches to Treatment

- People differ in how rapidly they metabolize drugs – correct dosage is critical
- **Antipsychotic drugs:** treat psychotic disorders such as schizophrenia and psychotic mood disorders
- **Tardive dyskinesia:** movement that is a delayed result of taking antipsychotic medications
- **SSRIs:** selective serotonin reuptake inhibitors -> preferred because are considered “safe”
  - Increased suicidal ideation for children and adolescents (actual cases are rare)
  - Also used in treatment of panic disorder, social phobia, generalized anxiety disorder, OCD, bulimia
- **MAO:** monoamine oxidase inhibitors -> inhibit monoamine oxidase to increase monoamine
- **Tricyclic antidepressants:** inhibit reuptake of norepinephrine and serotonin
  - Alter a number of other aspects of cellular functioning (how receptors function, how cells respond to activation or receptors, synthesis of neurotransmitters)
- **Benzodiazepines:** most important drug used for anxiety
  - People can become psychologically and physiologically dependent on them
  - Enhance the activity of GABA receptors in the limbic system (inhibitory neurotransmitter that plays a role in the way our brain inhibits anxiety in stressful situations)
- Buspar -> used for anti-anxiety medication; act in complex ways on serotonergic functioning rather than on GABA
  - Patients who have previously taken benzodiazepines don't respond as well as patients who have never taken it
- Lithium salts were effective in treating manic disorders
  - Naturally occurring compound -> unpatentable
  - May affect electrolyte balances that may alter the activities of many neurotransmitter systems in the brain
  - Sometimes relieves bipolar depression
  - Relapse is 28x higher after withdrawal than when the patient continues to take lithium
  - Side effects - thirst, gastrointestinal difficulties, weight gain, tremor, fatigue
    - Can be toxic if exceed dosage or if kidneys fail to excrete it
- **Electroconvulsive therapy:** passing an electric current through a patient's head
  - Only way of dealing w/ severely depressed and suicidal patients – failed to respond to other forms of treatment
    - Treatment of choice for severely depressed pregnant women and the elderly
  - Every neurotransmitter is affected by ECT -> downregulates the receptors for norepinephrine -> ^ availability
  - Can be administered by:
    - Bilateral ECT -> electrodes placed on either side of head; high/low intensity pulses passed between them for up to about 1.5 seconds
    - Unilateral ECT -> limiting current flow to one side of the brain; typically nondominant side
  - Bilateral ECT more effective than unilateral, but causes more severe cognitive side effects and memory problems
- **Neurosurgery:** treat mental disorders by relieving pressure in the brain
  - Prefrontal lobotomy: frontal lobes of brain were severed from the deeper centres underlying them
  - Undesirable side effects – permanent inability to inhibit impulses, unnatural “tranquility”
  - Rare after introduction of major antipsychotics
  - Deep brain stimulation (new approach) -> no permanent lesion -> relief from unrelenting symptoms of depression

#### Psychological Approaches to Treatment

- **Behaviour therapy:** recognizes the primacy of behaviour, acknowledges the role of learning and includes thorough assessment and evaluation
  - Assume abnormal behaviour is acquired in the same way as normal behaviour -> can “unlearn” them
  - **Exposure therapy:** guided exposure to anxiety-provoking stimuli (controlled, slow or flooding, and real/imaginative)
    - **Systematic desensitization:** find behaviour that's incompatible w/ being anxious & pair w/ anxiety-prod stimulus
      - Taught to enter state of relaxation -> anxiety hierarchy w/ imagined scenes graded to capacity
  - **Aversion therapy:** modifying undesirable behaviour through punishment
  - **Modelling:** learns new skills by imitating another person

- Contingency management/systematic use of reinforcement -> suppress unwanted behaviour/to elicit effective behaviour
  - Eliminate reinforcers/response shaping -> positive reinforcement used to establish appropriate behaviour
- **Token economies:** earn tokens that could be used later for rewards and privileges
- **Cognitive and cognitive-behavioural therapy:** stem from cognitive psychology and behaviourism
  - Conviction that cognitive processes influence emotion, motivation and behaviour
  - Use of cognitive and behaviour-change techniques in a pragmatic manner
- **REBT:** rational emotive behaviour therapy -> change a client's maladaptive thought processes, on which maladaptive emotional responses are presumed to depend
  - Restructure an individual's belief system and self-evaluation (personal worth and human values)
- Beck's cognitive therapies -> assume problems result from biased processing of external events or internal stimuli -> distort the way that a person makes sense of the experiences in the world
  - Underlying biases is a relatively stable set of cognitive structures/schemas w/ dysfunctional beliefs
  - First, made aware of connection b/w patterns of thinking and emotional responses
  - Then, identify logical errors in thinking and learn to challenge validity of automatic thoughts
  - Do not change beliefs by debate and persuasion, but gather info about themselves -> discover faulty assumptions/dysfunctional schemas
- Humanistic-experiential therapies: psychopathology stems from problems of alienation, depersonalization, loneliness and failure to find meaning and genuine fulfillment
  - Assume that we have both the freedom and responsibility to control our own behaviour
  - **Client-centred therapy:** removing constraints & restrictions that grow out of unrealistic demands
    - Establishes psychological climate where they can feel unconditionally accepted and valued as people
    - Counsellor just restates or listens acceptingly to patient -> clarify feelings/ideas
  - Gestalt therapy -> emphasizes unity of mind and body (need to integrate thought, feeling and action)
    - Teach clients to recognize the bodily processes and emotions they blocked off from awareness
  - Emotion-focused therapy (EFT) -> emphasizes the experiencing of emotions during therapy
- **Psychodynamic therapies:** focuses on individual personality dynamics, from a psychoanalytic perspective
  - Freudian psychoanalysis -> long-term procedure for uncovering repressed memories, thoughts, fears, conflicts stemming from problems in early psychosexual development
    - **Free association:** individual must say whatever comes into mind (explore thoroughly the contents of preconscious)
    - Analysis of dreams -> manifest content (dream as it appears to dreamer) and latent content (actual motives that are seeking expression but are disguised b/c unacceptable)
    - Analysis of resistance -> resistance (unwillingness to talk about certain thoughts) -> seek out sources and face problem to deal with in a realistic manner
    - Analysis of transference -> transference (people carry over attitudes and feelings from relations w/ people close to them in the past) -> client may react to analyst w/ same emotions -> therapist provides insight and introduce corrective emotional experience (rejection of unwarranted assumption/react positively) -> rethink view of situation and recognize assumptions
      - Transference neurosis -> reliving of a pathogenic past relationship recreates neurosis in real life w/ therapist
      - Countertransference: therapists reacts in accord w/ client's transferred attributions instead of objectively
  - Interpersonal therapy -> emphasize all of a disturbed patient's relationships
    - All of us involuntarily invoke schemas acquired from our earliest interactions w/ others in interpreting what is going on in our current relationships
    - May distort the individual's ability to process accurately and objectively the info contained in current interpersonal transactions
  - Object-relations, self-psychology -> focus on interpersonal relationship issues
    - Understanding present in terms of past by bringing awareness and modifying effects of remote developmental sources of the difficulties being experienced
- **Marital and family therapy:** assumes that the within-family behaviour of any particular family member is subject to the influence of the behaviours and communication patterns of other family members
  - Product of a system that is amenable to both understanding and change
  - **Traditional behavioural couple therapy:** gold standard of marital therapy
    - Short-term and increases caring behaviours in the relationship and teach partners to resolve conflict in a more constructive way thru training in communication and problem solving
  - **Integrative behavioural couple therapy:** focuses on acceptance and includes strategies that help each member come to terms w/ limitations of partner
    - Acceptance strategies integrated w/ change strategies
  - **Family therapy:** includes every family member to prevent relapse of a patient
  - **Structural family therapy:** holds that if the family context can be changed, then the individual members will have altered experiences and behave differently in accordance w/ changed requirements
    - Goal -> changing organization of family so more supportive and less pathogenic towards each other