Key Question Chapter Outline

What Is Therapy?

- Entering Therapy
- The Therapeutic Relationship and the Goals of Therapy
- Therapy in Historical and Cultural Context

How Do Psychologists Treat Psychological Disorders?

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- Cognitive–Behavioral Therapy: A Synthesis
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How Is the Biomedical Approach Used to Treat Psychological Disorders?

- Drug Therapy/Psychopharmacology
- Other Medical Therapies for Mental Disorder
- Hospitalization and the Alternatives

Therapies: The State of the Art

CORE CONCEPTS

▼

Therapy for psychological disorders takes a variety of forms, but all involve some relationship focused on improving a person's mental, behavioral, or social functioning.

▼

Psychologists employ two main forms of treatment: the insight therapies (focused on developing understanding of the problem) and the behavior therapies (focused on changing behavior through conditioning).

▼

Biomedical therapies seek to treat psychological disorders by changing the brain's chemistry with drugs, its circuitry with surgery, or its patterns of activity with pulses of electricity or powerful magnetic fields.

Psychology in Your Life

Paraprofessionals Do Therapy, Too.

Some studies show that the therapist's level of training is not the main factor in therapeutic effectiveness.

Where Do Most People Get Help?

A lot of therapy is done by friends, hairdressers, and bartenders.

What Sort of Therapy Would You Recommend?

There is a wide range of therapeutic possibilities to discuss with a friend who asks for your recommendation.

USING PSYCHOLOGY TO LEARN PSYCHOLOGY:
How Is Education Like Therapy?

Chapter

13

Therapies for Psychological Disorders

"You are a very sick rabbit."

LAURA, A PETITE WOMAN in her 40s with a contagious smile, speaks intently about her profession as a psychotherapist. "Yes," she says, "Once your therapeutic practice is established, you might enjoy greater flexibility, autonomy, and meaningfulness than in many other careers. But no, it's not easy work, and it demands both an intellectual and an emotional investment. Moreover," Laura protests, dispelling a common myth about therapy, "A therapist is not a 'paid friend'! A therapist is a trained professional who knows the art of establishing a helping relationship and knows how to apply the knowledge of psychology to an individual struggling with problems and choices."

Laura's orientation is in humanistic therapy, an approach aimed at helping clients see themselves clearly. Humanistic therapies are designed for individuals who seek to be more adaptive, healthy, and productive in their lives. "Early in the therapeutic relationship, my role might be somewhat parental," Laura explains. "Perhaps my client never had the opportunity to grow up with real support. As a child, this client may have created a way to function that worked for her. But now, she needs to be an adult—not a child—and she gets pushed back into those old ways of reacting. It becomes self-sabotaging. The client feels stuck." Laura sits quietly for a few moments, then goes on. "Since I've been there myself, I recognize it. When the client finally trusts me

enough, I point these issues out to her, and she can begin to take charge of her life in a healthier way."

Today, practicing psychotherapists may hold any of dozens of degrees and certifications, choosing from scores of therapeutic techniques. For all that training, however, Laura insists that working as a therapist is not purely a science. "Therapy is also an art," asserts Laura, "It's experiential. We may know the skills required to be an effective therapist, like listening well. And we know the central issues, like trust between therapist and client. But these aren't enough to make someone a good therapist. You also need personal experience and insight. You need to be able to sense what your client cannot communicate. And there's no science for that—it's intuitive."

But there's still more to having a psychotherapy practice, Laura points out: "It's not only challenging cases that are difficult! Sometimes it's the hassles of dealing with health insurance that get to you." Laura grins. "But when the therapeutic relationship is real, and our work together progresses, it's very satisfying—even, sometimes, fun! Once we finally 'get it,' my client and I can laugh together.

"I do love it. I love the intensity of it," Laura concludes. "As a therapist, I am there for my clients—*with* my clients. I see them clearly. They come to me with the gift of their trust. It's awe-inspiring. And they wouldn't come if they didn't have the strength and the love to keep going and keep growing."

■ **Therapy** A general term for any treatment process; in psychology and psychiatry, *therapy* refers to a variety of psychological and biomedical techniques aimed at dealing with mental disorders or coping with problems of living.

As Laura makes clear, therapists work at the interface between the science and art of helping. Her approach to therapy, as you will see in this chapter, is just one of many ways to be a therapist. Yet, despite the diversity of approaches that Laura and her colleagues bring to their work, the overwhelming majority of people who enter **therapy** receive significant help. Not everyone becomes a success case, of course. Some people wait too long, until their problems become intractable. Some do not end up with the right sort of therapy for their problems. And, unfortunately, many people who could benefit from therapy do not have access to it because of financial constraints. Still, the development of a wide range of effective therapies is one of the success stories in modern psychology.

● Many people could benefit from some form of therapy. Most people who enter therapy receive significant help.

In this next-to-last chapter of our journey together through psychology, we begin an overview of therapy by considering what therapy is, who seeks it, what sorts of problems they bring to it, and who administers it. Here we will also see how therapeutic practices have been influenced by history and culture. In the second section of the chapter, we will consider the major types of psychological treatments currently used and how well they work. Then, in the final section, we will look at medical treatments for mental disorders, including drug therapy, psychosurgery, and "shock treatment." There we will also compare hospital treatment for mental disorder with community-based treatment.

As you read through this chapter, we hope you will weigh the advantages and disadvantages of each therapy. Keep in mind, too, that you may sometime be asked by a friend or relative to use what you have learned here to recommend an appropriate therapy. It's even possible that you may sometime need to select a therapist for yourself.

WHAT IS THERAPY?

When you think of "therapy," chances are that a stereotype pops into mind, absorbed from countless cartoons and movies: a "neurotic" patient lying on the analyst's couch, with a bearded therapist sitting at the patient's head, scribbling notes and making interpretations. In fact, this is a scene from classic Freudian psychoanalysis, which is a rarity today, although it dominated the first half of the 20th century.

The reality of modern therapy differs from the old stereotype on several counts. First, most therapists don't have their patients (or *clients*) lie on a couch. Second, people now seek therapeutic help for a wide range of problems besides the serious *DSM-IV* disorders: People also go to counselors or therapists for help in making difficult choices, dealing with academic problems, and coping with losses or unhappy relationships. And here's a third way in which the stereotype of therapy is false: Some forms of therapy now involve as much action as they do talk and interpretation—as you will see shortly.

"You are a very sick rabbit."

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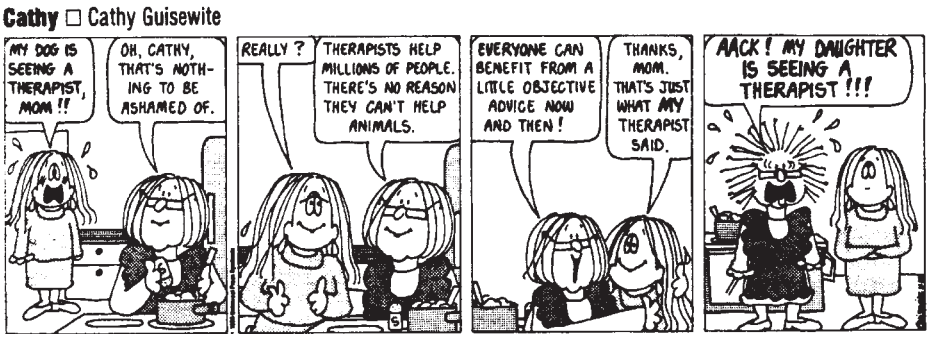
At first, the therapeutic menu may appear to offer a bewildering list of choices, involving talk and interpretation, behavior modification, drugs, and, in some cases, even "shock treatment" or brain surgery. No matter what form therapy takes, however, there is one constant, as our Core Concept suggests:

Therapy for psychological disorders takes a variety of forms, but all involve some relationship focused on improving a person's mental, behavioral, or social functioning.

In this chapter, as we examine a sample from the therapeutic universe, we will see that each form of therapy is based on different assumptions about mental disorder. Yet all involve relationships designed to change a person's functioning in some way. Let's begin our exploration of therapy by looking at the variety of people who enter treatment and the problems they bring with them to the therapeutic relationship.

Entering Therapy

Why would you go into therapy? Why would anyone? Most often, people enter therapy when they have a problem that they are unable to resolve by themselves. They may seek therapy on their own initiative, or they may be advised to do so by family, friends, a physician, or a coworker.



Cathy by Cathy Guisewite/Universal Press Syndicate

CONNECTION CHAPTER 12
The *medical model* assumes that mental disorders are similar to physical diseases.

Obviously, you don't have to be "crazy" to seek therapy. If you do enter therapy, however, you may be called either a patient or a client. Practitioners who take a biological or medical approach to treatment commonly use the term *patient.* On the other hand, *client* is often used by professionals who think of psychological disorders not as mental *illnesses* but as *problems in living* (Rogers, 1951; Szasz, 1961).

Access to therapy can be affected by a variety of factors. As we have noted, therapy is far easier to obtain if you have money or adequate health insurance. For the poor, especially poor ethnic minorities, economic obstacles block access to professional mental health care (Bower, 1998d; Nemecek, 1999). Another problem can be lack of qualified therapists. In many communities, it is still much easier to get help for physical health problems than for psychological problems. Even the nature of a person's psychological problems can interfere with getting help. An individual with agoraphobia, for example, finds it hard, even impossible, to leave home to seek therapy. Similarly, paranoid persons may not seek help because they don't trust mental health professionals. Obviously, many problems remain to be solved before all those who need therapy can get it.

The Therapeutic Relationship and the Goals of Therapy

Sometimes you only need to talk out a problem with a sympathetic friend or family member, perhaps to "hear yourself think" or to receive reassurance that you are still worthwhile or likeable. But friends and family have needs and agendas of their own that may interfere with helping you. In fact, they may sometimes be part of the problem. For whatever reason, when the people you are close to cannot offer the help and support you need, it may be appropriate to seek the help of a professionally trained therapist. You might also want professional help if you wish to keep your problems and concerns confidential. Moreover, professional therapists have expertise in identifying mental disorders and in using therapeutic techniques that a friend would probably not know about and certainly would not have the skills to employ. In all these ways, a professional relationship with a therapist differs from friendship or kinship.

What Are the Components of Therapy? In nearly all forms of therapy there is some sort of *relationship* between the therapist and the patient/client seeking

assistance—as our Core Concept indicates. (There are computer-therapy programs, where the idea of a "relationship" is stretching the point.) Trust is one of the essential ingredients of a good therapeutic relationship. You and your therapist must be able to work together as allies, on the same side and toward the same goals, joining forces to cope with and solve the problems that have brought you to therapy (Horvath & Luborsky, 1993). It also helps if you *believe* that therapy will be effective for your problem.

In addition to the relationship between therapist and client, depending on the specific approach used, the therapeutic process typically involves some or all of the following processes:

1. *Identifying the problem:* This may mean merely agreeing on a simple description of circumstances or feelings to be changed, or, in the case of a *DSM-IV* disorder, this step may call for a formal diagnosis about what is wrong.
2. *Identifying the cause of the problem or the conditions that maintain the problem:* In some forms of therapy, this involves searching for the source of the patient's or client's discomfort. Alternatively, other forms of therapy emphasize the present causes—that is, the conditions that are keeping the problem alive.
3. *Deciding on and carrying out some form of treatment:* This involves selecting a specific type of therapy designed to minimize or eliminate the troublesome symptoms.

Who Does Therapy? Although more people seek out therapy now than in the past, people usually turn to trained mental health professionals only when their psychological problems become severe or persist for extended periods. When they do, those seeking therapy usually choose one of seven main types of professional helpers: counseling psychologists, clinical psychologists, psychiatrists, psychoanalysts, psychiatric nurse practitioners, clinical (psychiatric) social workers, or pastoral counselors. The differences among these specialties are detailed in Table 13.1. As you examine that table, note that each specialty has its area of expertise. For example, the only therapists who are widely licensed to prescribe drugs are psychiatrists, psychoanalysts (with medical degrees), and psychiatric nurse practitioners.

Currently, through their professional organizations, clinical psychologists are seeking to obtain prescription privileges (Sternberg, 2003). Already, a few military psychologists have been trained, in a highly acclaimed program, to prescribe drugs (Dittmann, 2004; Newman et al., 2000; Rabasca, 1999). And in 2002, New Mexico became the first state to grant prescription privileges to psychologists who have completed a rigorous training program, including 850 hours of course work and supervised internship (Dittmann, 2003). Similar legislation has been introduced in a dozen other states. Nevertheless, prescription privileges for psychologists remains a highly political issue, hotly contested by the medical profession (Clay, 1998; Hayes & Heiby, 1996; Sleek, 1996).

Therapy in Historical and Cultural Context

How you deal with mental disorder depends on how you think about mental disorder. If you believe, for example, that mental problems are diseases, you will treat them differently than another person who believes they indicate a flaw in one's character or a sign of influence by evil spirits. Likewise, the way society treats people with mental disorders has always depended on its prevailing beliefs.

History of Therapy As we saw in the previous chapter, people in medieval Europe often interpreted mental disorder as the work of devils and demons.

TABLE 13.1 Types of Mental Health Care Professionals

Professional title	Specialty and common work settings	Credentials and qualifications
Counseling psychologist	Provides help in dealing with the common problems of normal living, such as relationship problems, child rearing, occupational choice, and school problems. Typically counselors work in schools, clinics, or other institutions.	Depends on the state: typically at least a master's in counseling, but more commonly a PhD (Doctor of Philosophy), EdD (Doctor of Education), or PsyD (Doctor of Psychology)
Clinical psychologist	Trained primarily to work with those who have more severe disorders, but may also work with clients having less severe problems. Usually in private practice or employed by mental health agencies or by hospitals. Not typically licensed to prescribe drugs.	Usually required to hold PhD or PsyD; often an internship and state certification required.
Psychiatrist	A specialty of medicine; deals with severe mental problems–most often by prescribing drugs. May be in private practice or employed by clinics or mental hospitals.	MD (Doctor of Medicine); may be required to be certified by medical specialty board.
Psychoanalyst	Practitioners of Freudian therapy. Usually in private practice.	MD (some practitioners have doctorates in psychology, but most are psychiatrists who have taken additional training in psychoanalysis).
Psychiatric nurse practitioner	A nursing specialty; licensed to prescribe drugs for mental disorders. May work in private practice or in clinics and hospitals.	Requires RN (Registered Nurse) credential, plus special training in treating mental disorders and prescribing drugs.
Clinical or psychiatric social worker	Social workers with a specialty in dealing with mental disorders, especially from the viewpoint of the social and environmental context of the problem.	MSW (Master of Social Work)
Pastoral counselor	A member of a religious order or ministry who specializes in treatment of psychological disorders. Combines spiritual guidance with practical counseling.	Varies

In that context, then, the job of the "therapist" was to perform an exorcism or to "beat the devil" out of the disordered person—to make the body an inhospitable place for a spirit or demon. In more recent times, however, reformers have urged that the mentally ill be placed in institutions called *asylums,* where they could be shielded from the stresses of the world—and from the brutal "therapies" that had been all too customary. Unfortunately, the ideal of the insane asylums was not often realized.

One of the most infamous of the asylums was also one of the first: Bethlehem Hospital in London, where for a few pence on the weekend sightseers could go to observe the inmates, who often put on a wild and noisy "show" for the curious audience. As a result, "Bedlam," the shortened term Londoners used for "Bethlehem," became a word used to describe any noisy, chaotic place.

In most asylums, inmates received, at best, only custodial care; at worst they were neglected or put in cruel restraints, such as cages and straightjackets. Some even continued to receive beatings, cold showers, and other forms of abuse. It's not hard to guess that such treatment rarely produced improvement in people suffering from psychological disorders.

Modern Approaches to Therapy Modern mental health professionals have abandoned the old demon model and frankly abusive treatments in favor of therapies based on psychological and biological theories of mind and behavior. Yet, as we will see, even modern professionals disagree on the exact causes and the most appropriate treatments—a state of the art that gives us a wide variety of therapies from which to choose. To help you get an overview of this cluttered therapeutic landscape, here is a preview of things to come.

The **psychological therapies** are often collectively called simply *psychotherapy*.[1] They focus on changing disordered thoughts, feelings, and behavior using psychological techniques (rather than biomedical interventions). And they come in two main forms. *Insight therapy* focuses on helping people understand their problems and change their thoughts, motives, or feelings. *Behavior therapy* focuses primarily on behavior change.

In contrast with psychotherapy, the **biomedical therapies** focus on treating mental problems by changing the underlying biology of the brain. To do so, a physician or nurse practitioner can employ a variety of drugs, including antidepressants, tranquilizers, and stimulants. Occasionally the brain may be treated directly with electromagnetic stimulation or even surgery.

■ **Psychological therapies** Therapies based on psychological principles (rather than on the biomedical approach); often called "psychotherapy."

■ **Biomedical therapies** Treatments that focus on altering the brain, especially with drugs, psychosurgery, or electroconvulsive therapy.

Disorder and Therapy in a Cultural Context Ways of thinking about and treating mental disorder vary widely across cultures (Matsumoto, 1996). Individualistic Western (European and North American) views and practices generally regard psychological disorders to be the result of disease processes, abnormal genetics, distorted thinking, unhealthy environments, or stressors. But collectivist cultures often have quite different perspectives (Triandis, 1990; Zaman, 1992). Asian societies may think of mental disorder as a disconnect between the person and the group. Likewise, many Africans believe that mental disorder results when an individual becomes estranged from nature and from the community, including the community of ancestral spirits (Nobles, 1976; Sow, 1977). In such cultures, treating mentally disturbed individuals by removing them from society is unthinkable. Instead, healing takes place in a social context, emphasizing a distressed person's beliefs, family, work, and life environment. An African use of group support in therapy has

● In this painting from the 1730s, we see the chaos of a cell in the London hospital St. Mary of Bethlehem. Here the upper classes have paid to see the horrors, the fiddler who entertains, and the mental patients chained, tortured, and dehumanized. The chaos of Bethlehem eventually became synonymous with the corruption of its name—Bedlam.

[1]No sharp distinction exists between *counseling* and *psychotherapy*. In general, however, counseling is a shorter process, more likely to be focused on a specific problem, while psychotherapy characteristically involves a longer-term and wider-ranging exploration of issues.

In many cultures, treatments for mental and physical disorders are closely allied with religious beliefs. Here, a Native American healer concentrates on spiritual forces that are presumed to have a role in the woman's discomfort.

developed into a procedure called "network therapy," where a patient's entire network of relatives, coworkers, and friends becomes involved in the treatment (Lambo, 1978).

In many places around the world, the treatments of both mental and physical problems is also bound up with religion and the supernatural—much as in medieval Europe, although their treatments are not usually so harsh. Certain persons—priests, ministers, shamans, sorcerers, and witches—are assumed to have special mystical powers to help distressed fellow beings. Their methods involve ceremonies and rituals that bring emotional intensity and meaning into the healing process. Combined with the use of symbols, they connect the individual sufferer, the shaman, and the society to supernatural forces to be won over in the battle against madness (Devereux, 1981; Wallace, 1959).

PSYCHOLOGY IN YOUR LIFE: PARAPROFESSIONALS DO THERAPY, TOO

Does the best therapy always require a highly trained (and expensive) professional? Or can *paraprofessionals*—who may have received on-the-job training in place of graduate training and certification—be effective therapists? If you are seeking treatment, these questions are important because hospitals, clinics, and agencies are increasingly turning to paraprofessionals as a cost-cutting measure: Those who lack full professional credentials can be hired at a fraction of the cost of those with professional degrees. They are often called "aides" or "counselors" (although many counselors do have professional credentials).

Surprisingly, a review of the literature has found no substantial differences in the effectiveness of the two groups across a wide spectrum of psychological problems (Christensen & Jacobson, 1994). This is good news in the sense that the need for mental health services is far greater than the number of professional therapists can possibly fill. And, because paraprofessional therapists can be effective, highly trained professionals may be freed for other roles, including prevention and community education programs, assessment of patients, training and supervision of paraprofessionals, and research. The reader should be cautioned about overinterpreting this finding, however. Professionals and paraprofessionals have been found to be equivalent only in the realm of the insight therapies, which we will discuss in a moment (Zilbergeld, 1986). Such differences have not yet been demonstrated in the areas of behavior therapies, which require extensive knowledge of operant and classical conditioning and of social-learning theory.

More and more therapy is being done by paraprofessionals.

CHECK YOUR UNDERSTANDING

1. **RECALL:** People in collectivist cultures are likely to view mental disorder as a symptom of something wrong in
   - **a.** the unconscious mind.
   - **b.** a person's behavior, rather than in the mind.
   - **c.** a person's relationship with family or community.
   - **d.** a person's character.
   - **e.** a person's attitude.

2. **RECALL:** A therapist, but not necessarily a friend, can be relied on to
   - **a.** maintain confidentiality.
   - **b.** give you good advice.
   - **c.** offer sympathy when you are feeling depressed.
   - **d.** be available when needed.
   - **e.** all of the above.

3. **APPLICATION:** Which of the following therapists would be most likely to treat an unwanted response, such as nail biting, as merely a bad habit, rather than as a symptom of an underlying disorder?
   a. a psychoanalyst
   b. a psychiatrist
   c. an insight therapist
   d. a group therapist.
   e. a behavioral therapist

4. **UNDERSTANDING THE CORE CONCEPT:** In what respect are all therapies alike?
   a. All may be legally administered only by licensed, trained professionals.
   b. All make use of insight into a patient's problems.
   c. All involve the aim of altering the mind, behavior, or social relationships.
   d. All focus on discovering the underlying cause of the patient's problem, which is often hidden in the unconscious mind.
   e. All involve a change in an individual's behavior.

ANSWERS: 1. c 2. a 3. e 4. c

HOW DO PSYCHOLOGISTS TREAT PSYCHOLOGICAL DISORDERS?

KEY QUESTION

Jim is depressed about his grades, his lack of direction in school, his relationship with Sheila . . . about everything. Sheila helps him make an appointment at the psychology department's depression clinic. The sort of therapy Jim will receive depends on whether the therapist prefers *insight therapy* or *behavior therapy.*

Insight therapy, as you will see, helps the individual gain an understanding of the problem. Various forms of insight therapy are based on the theories of personality we discussed in Chapter 10 and on the cognitive theories of perception, learning, and memory we discussed in Chapters 4, 6, and 7. The behavior therapies, on the other hand, put less emphasis on understanding and insight, while focusing more directly on changing behavior. They draw mainly on the work of Pavlov (classical conditioning) and Skinner (operant conditioning). Our Core Concept puts these ideas together in fewer words:

CORE CONCEPT

Psychologists employ two main forms of treatment: the insight therapies (focused on developing understanding of the problem) and the behavior therapies (focused on changing behavior through conditioning).

The insight therapies, we shall see, were the first truly psychological treatments developed, and for a long time they were the only psychological therapies available. In recent years they have been joined by the behavior therapies, which are now among the most effective tools we have. But it is with the insight therapies that we begin.

Insight Therapies

The **insight therapies** attempt to change people on the *inside*—changing the way they think and feel. Sometimes called **talk therapies,** these methods share the assumption that distressed persons need to develop an understanding of the disordered thoughts, emotions, and motives that underlie their mental difficulties.

The insight therapies come in dozens of different "brands," but all take a *clinical perspective,* using various techniques for revealing and changing a patient's disturbed mental processes through discussion and interpretation. Some, such as Freudian psychoanalysis, assume that problems lie hidden deep in the unconscious, so they employ elaborate and time-consuming techniques to draw them out. Others, such as Carl Rogers's nondirective therapy, minimize the importance of the unconscious and look for problems in the ways people think and interact with each other. Most modern insight therapies require much less time—usually weeks or months—than the years demanded by traditional

■ **Insight therapies** Psychotherapies in which the therapist helps patients/clients understand (gain insight into) their problems.
■ **Talk therapies** Psychotherapies that focus on communicating and verbalizing emotions and motives to understand their problems.

Insight Therapies
- Freudian psychoanalysis
- Neo-Freudian therapies
- Humanistic therapies
- Cognitive therapies
- Group therapies

Freudian psychoanalysis. We have space here to examine only a sampling of the most influential ones, beginning with the legendary methods developed by Sigmund Freud. (See the chart in the margin.)

Freudian Psychoanalysis In the classic Freudian view, psychological problems arise from tension created in the unconscious mind by forbidden impulses and threatening memories. Therefore, Freudian therapy, known as **psychoanalysis,** probes the unconscious in an attempt to bring these issues into the "light of day"—that is, into consciousness, where they can be rendered harmless. The major goal of psychoanalysis, then, is to reveal and interpret the contents of the unconscious mind.

To get at unconscious material, Freud needed ways to get around the defenses the ego has erected to protect itself. One ingenious method called for free association, by which the patient would relax and talk about whatever came to mind, while the therapist would listen, ever alert for veiled references to unconscious needs and conflicts. Another method involved *dream interpretation,* which you will recall from Chapter 3.

CONNECTION CHAPTER 12
The ego defense mechanisms include *repression, regression, projection, denial, rationalization, reaction formation, displacement,* and *sublimation.*

With these and other techniques, the psychoanalyst gradually developed a clinical picture of the problem and proceeded to help the patient understand the unconscious causes for symptoms. To give you the flavor of this process, we offer Freud's interpretation of a fascinating case involving a 19-year-old girl diagnosed with "obsessional neurosis" (now listed in the *DSM-IV* as *obsessive–compulsive disorder*). Please bear in mind that Freud's ideas no longer represent the mainstream of either psychology or psychiatry. But they remain important because many of Freud's techniques have carried over into newer forms of therapy. They are also important because many of Freud's concepts, such as *ego, repression, the unconscious, identification,* and *Oedipus complex,* have become part of our everyday vocabulary. The following case, then—in which you may find Freud's interpretations shocking—will give you a sense of the way psychotherapy began about a century ago.

With these cautions in mind, then, let's meet Freud's patient. When the girl entered treatment, she was causing her parents distress with a strange bedtime ritual that she performed each night. As part of this ritual, she first stopped the large clock in her room and removed other smaller clocks, including her wrist watch. Then she placed all vases and flower pots together on her writing table, so—in her "neurotic" way of thinking—they could not fall and break during the night. Next, she ensured that the door of her room would remain half open by placing various objects in the doorway. After these precautions, she turned her attention to the bed, where she made certain that the bolster did not touch the headboard and that a pillow lay diagonally in the center of the bolster. Then she shook the eiderdown in the quilt until all the feathers sank to the foot-end, after which she meticulously redistributed them evenly again. And finally, she would crawl in bed and attempt to sleep with her head precisely in the center of the diagonal pillow.

The ritual did not proceed smoothly, however. She would do and then redo first one and then another aspect of the ritual, anxious that she had not performed everything properly—although she acknowledged to Freud that all aspects of her nightly precautions were irrational. The result was that it took the girl about two hours to get everything ready for bed each night.

As we mentioned above, establishing a relationship with the patient is essential to psychoanalysis, and through this, Freud made some dramatic claims about her behavior. Not the least of which centered around unfulfilled sexual desires. These revelations came about through free-association, having the patient say the first that comes to mind, and by looking at resistances, which are topics and ideas that the patient avoids talking about in therapeutic sessions.

■ **Psychoanalysis** The form of psychodynamic therapy developed by Sigmund Freud. The goal of psychoanalysis is to release conflicts and memories from the unconscious.

● Sigmund Freud's study, including the famous couch (right), is housed in London's Freud Museum. The 82-year-old Freud fled to London in 1938 upon the Nazi occupation of Austria and died there the following year.

In the final stage of psychoanalysis, patients learn how the relationship they have established with the therapist reflects the unresolved problems they had with their parents. This projection of parental attributes onto the therapist is called transference, and the final phase of therapy is known as the **analysis of transference.** According to psychoanalytic theory, patients will recover when they are finally released from the repressive mental restraints established in the relationship with their parents during early childhood (Munroe, 1955).

Neo-Freudian Psychodynamic Therapies Please pardon us for doing a bit of analysis on Freud: He had a flair for the dramatic, and he also possessed a powerful, charismatic personality—or, as he himself might have said, a strong ego. Accordingly, Freud encouraged his disciples to debate the principles of psychoanalysis, but he would tolerate no fundamental changes in his doctrines. This inevitably led to conflicts with some of his equally strong-willed followers, such as Alfred Adler, Carl Jung, and Karen Horney, who eventually broke with Freud to establish their own schools of therapy.

In general the neo-Freudian renegades retained many of Freud's basic ideas and techniques, while adding some and modifying others. In the true psychodynamic tradition, the **neo-Freudian psychodynamic therapies** have retained Freud's emphasis on motivation. Most now have abandoned the psychoanalyst's couch and treat patients face-to-face. Most also see patients once a week for a few months, rather than several times a week for several years, as in classical psychoanalysis.

So how do the neo-Freudian therapists get the job done in a shorter time? Most have shifted the emphasis from the unconscious to conscious motivation—so they don't spend so much time probing for hidden conflicts and repressed memories. Most have also made a break with Freud on one or more of the following points:

- The significance of the self or ego (rather than the id)
- The influence of life experiences occurring after childhood (as opposed to Freud's emphasis on early-childhood experience)
- The role of social needs and interpersonal relationships (rather than sexual and aggressive desires)

■ **Analysis of transference** The Freudian technique of analyzing and interpreting the patient's relationship with the therapist, based on the assumption that this relationship mirrors unresolved conflicts in the patient's past.

■ **Neo-Freudian psychodynamic therapies** Therapies for mental disorder that were developed by psychodynamic theorists who embraced some of Freud's ideas but disagreed with others.

And, as we saw in Chapter 11, each constructed a theory of disorder and therapy that had different emphases. We do not have space here to go into these approaches in greater detail, but let's briefly consider how a neo-Freudian therapist might have approached the case of the obsessive girl that Freud described. Most likely a modern psychodynamic therapist would focus on the current relationship between the girl and her parents, perhaps on whether she has feelings of inadequacy for which she is compensating by becoming the center of her parents' attention for two hours each night. And, instead of working so intensively with the girl, the therapist might well work with the parents on changing the way they deal with the problem.

Humanistic Therapies The primary symptoms for which college students seek therapy include low self-esteem, feelings of alienation, failure to achieve all they feel they should, difficult relationships, and general dissatisfaction with their lives. These problems in everyday existence are commonly called *existential crises.* This term underscores the idea that many problems deal with questions about the meaning and purpose of one's existence. The humanistic psychologists have developed therapies aimed specifically at these problems—and this is the approach preferred by Laura, the therapist we met at the beginning of the chapter.

Humanistic therapist Carl Rogers (right center) facilitates a therapy group.

Humanistic therapists believe that people are generally motivated by healthy needs for growth and psychological well-being. Thus, they dispute Freud's assumption of a personality divided into conflicting parts, dominated by a selfish id, and driven by hedonistic instincts and repressed conflicts. Rather, the humanists emphasize the concept of a *whole* person engaged in a continual process of change. Humanistic therapists also assume that mental disorder occurs only when conditions interfere with normal development and produce low self-esteem. **Humanistic therapies,** therefore, attempt to help clients confront their problems by recognizing their own freedom, enhancing their self-esteem, and realizing their fullest potential (see Schneider & May, 1995). A humanistic therapist (if there had been one around a century ago) would probably have worked with Freud's patient to explore her self-concept and her feelings about her parents. There would have been no attempt at interpreting the girl's symptoms.

Among the most influential of the humanistic therapists, Carl Rogers (1951, 1977) developed a method called **client-centered therapy,** which assumes that all people have the need to self-actualize—that is, to realize their potential. But healthy development can be hindered by a conflict between one's desire for a positive self-image and criticism by self and others. This conflict creates anxiety and unhappiness. The task of Rogerian therapy, then, is to create a nurturing environment in which clients can work through their conflicts to achieve self-enhancement and self-actualization.

Humanistic therapies Treatment techniques based on the assumption that people have a tendency for positive growth and self-actualization, which may be blocked by an unhealthy environment that can include negative self-evaluation and criticism from others.

Client-centered therapy A humanistic approach to treatment developed by Carl Rogers, emphasizing an individual's tendency for healthy psychological growth through self-actualization.

Reflection of feeling Carl Rogers's technique of paraphrasing the clients' words, attempting to capture the emotional tone expressed.

One of the main techniques used by Rogerian therapists involves **reflection of feeling** (also called *reflective listening*) to help clients understand their emotions. With this technique therapists paraphrase their clients' words, attempting to capture the emotional tone expressed and acting as a sort of psychological "mirror" in which clients can see themselves. Notice how the Rogerian therapist uses reflection of feeling in the following excerpt from a therapy session with a young woman (Rogers, 1951, p. 152):

CLIENT: It probably goes all the way back into my childhood. . . . My mother told me that I was the pet of my father. Although I never realized it—I mean, they never treated me as a pet at all.

And other people always seemed to think I was sort of a privileged one in the family. . . . And as far as I can see looking back on it now, it's just that the family let the other kids get away with more than they usually did me. And it seems for some reason to have held me to a more rigid standard than they did the other children.

THERAPIST: You're not so sure you were a pet in any sense, but more that the family situation seemed to hold you to pretty high standards.

CLIENT: M-hm. That's just what has occurred to me; and that the other people could sorta make mistakes, or do things as children that were naughty . . . but Alice wasn't supposed to do those things.

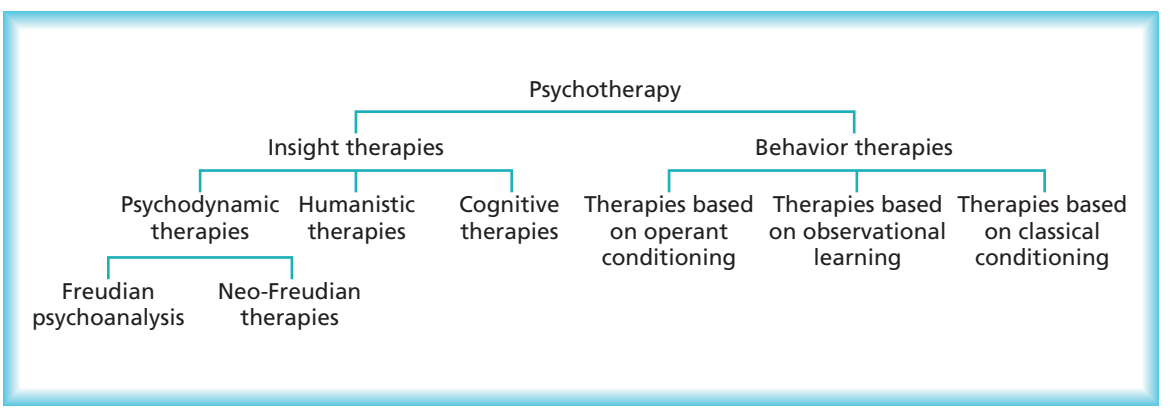
THERAPIST: M-hm. With somebody else it would be just—oh, be a little naughtiness; but as far as you were concerned, it shouldn't be done.

CLIENT: That's really the idea I've had. I think the whole business of my standards . . . is one that I need to think about rather carefully, since I've been doubting for a long time whether I even have any sincere ones.

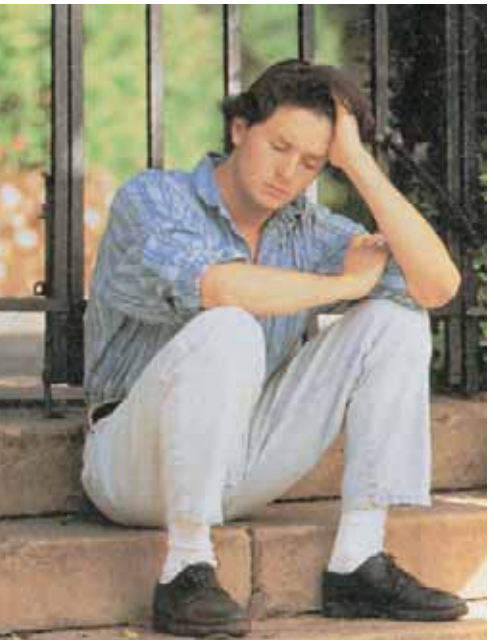
THERAPIST: M-hm. Not sure whether you really have any deep values which you are sure of.

CLIENT: M-hm. M-hm.

In stark contrast with psychoanalysis, the Rogerian therapist assumes that people have basically healthy motives. These motives, however, can be stifled or distorted by social pressures and low self-esteem. The therapist's task is mainly to remove barriers that limit the expression of this natural positive tendency and help the client clarify and accept his or her own feelings. This is accomplished within an atmosphere of *genuineness, empathy,* and *unconditional positive regard*—nonjudgmental acceptance and respect for the client. And although such concepts may seem to some as mere "feel-good" theorizing, they have solid scientific support. A recent American Psychological Association task force, charged with finding research-based practices that contribute to the effectiveness of therapy, combed the research literature and found evidence that therapy is most likely to be successful when the therapist provides the Rogerian qualities of empathy, positive regard, genuineness, and feedback (Ackerman et al., 2001). (See Figure 13.1.)



● **FIGURE 13.1** Types of Psychotherapy
Each of the two major branches of psychotherapy has many variations.



● A cognitive therapist would say that this student, depressed about a poor grade, may well stay depressed if he berates his own intelligence rather than reattributing the blame to the situation–a tough test.

Cognitive Therapies The insight therapies we have discussed so far focus primarily on people's emotions or motives. **Cognitive therapy,** on the other hand, sees rational *thinking* as the key to therapeutic change. The assumption is that psychological problems arise from erroneous thinking. Cognitive therapy takes several forms, but we will give you some of its flavor with one example: Aaron Beck's cognitive therapy for depression.

Beck, who was originally trained in classical psychoanalysis, broke with the Freudian tradition when he began noticing that the dreams and free associations of his depressed patients were filled with negative thoughts. Commonly they would make such self-deprecating statements as "Nobody would like me if they really knew me" and "I'm not smart enough to make it in this competitive school." Gradually Beck came to believe that depression occurs because of this negative self-talk. So, says Beck, "The therapist helps the patient to identify his warped thinking and to learn more realistic ways to formulate his experiences" (Beck, 1976, p. 20).

Here's a sample of Beck's approach, taken from a therapy session with a college student (Beck et al., 1979, pp. 145–146):

CLIENT: I get depressed when things go wrong. Like when I fail a test.

THERAPIST: How can failing a test make you depressed?

CLIENT: Well, if I fail, I'll never get into law school.

THERAPIST: Do you agree that the way you interpret the results of the test will affect you? You might feel depressed, you might have trouble sleeping, not feel like eating, and you might even wonder if you should drop out of the course.

CLIENT: I have been thinking that I wasn't going to make it. Yes, I agree.

THERAPIST: Now what did failing mean?

CLIENT: (tearful) That I couldn't get into law school.

THERAPIST: And what does that mean to you?

CLIENT: That I'm just not smart enough.

THERAPIST: Anything else?

CLIENT: That I can never be happy.

THERAPIST: And how do these thoughts make you feel?

CLIENT: Very unhappy.

THERAPIST: So it is the meaning of failing a test that makes you very unhappy. In fact, believing that you can never be happy is a powerful factor in producing unhappiness. So, you get yourself into a trap—by definition, failure to get into law school equals "I can never be happy."

As you can see from this exchange, the cognitive therapist helps the individual confront the destructive thoughts that support depression. Studies have shown that Beck's approach can be at least as effective as medication in the treatment of depression (Antonuccio, 1995).

How might a cognitive therapist approach a 19-year-old obsessive patient? Most likely the focus would be on the irrational beliefs she held, such as the idea that flower pots and vases could, by themselves, fall down in the night and break. A cognitive therapist would also challenge the assumption that something catastrophic might happen (such as not being able to sleep!) if she didn't perform a nightly ritual.

■ **Cognitive therapy** Emphasizes rational thinking (as opposed to subjective emotion, motivation, or repressed conflicts) as the key to treating mental disorder.

■ **Group therapy** Any form of psychotherapy done with more than one client/patient at a time. Group therapy is often done from a humanistic perspective.

Group Therapies All the treatments we have discussed to this point involve one-to-one relationships between a patient or client and therapist. However, **group therapy** can have value in treating a variety of concerns, particularly

problems with social behavior and relationships. This can be done in many ways—with couples, families, or groups of people who have similar problems, such as drug addictions. Usually they meet together once a week, but some innovative therapy groups are even available on the Internet (Davison et al., 2000). Most commonly, group approaches employ a humanistic perspective, although psychodynamic groups are common, too. Among the benefits of group therapy, clients have opportunities to observe and imitate new social behaviors in a forgiving, supportive atmosphere. We will touch on only a small sample of group therapies below: *self-help groups* and *marital and family therapy.*

Self-Help Support Groups Perhaps the most noteworthy development in group therapy has been the surge of interest in **self-help support groups.** It is estimated that there are more than 500,000 such groups, which are attended by some 15 million Americans every week (Leerhsen, 1990). Many are free, especially those that are not directed by a health care professional. Such groups give people a chance to meet under nonthreatening conditions to exchange ideas with others who are having similar problems and are surviving and sometimes even thriving (Christensen & Jacobson, 1994; Jacobs & Goodman, 1989; Schiff & Bargal, 2000).

One of the oldest, Alcoholics Anonymous (AA), pioneered the self-help concept, beginning in the mid-1930s. Central to the original AA process is the concept of "12 steps" to recovery from alcohol addiction, based not on psychological theory but on the trial-and-error experience of early AA members. The first step begins with recognizing that one has become powerless over alcohol; the second affirms that faith in a "greater power" is necessary for recovery. In the remaining steps the individual seeks help from God and sets goals for making amends to those who have been hurt by his or her actions. Members are urged and helped by the group to accept as many of the steps as possible in order to maintain recovery.

The feminist consciousness-raising movement of the 1960s brought the self-help concept to a wider audience. As a result, self-help support groups now exist for an enormous range of problems, including

- Managing life transition or other crises, such as divorce or death of a child
- Coping with physical and mental disorders, such as depression or heart attack
- Dealing with addictions and other uncontrolled behaviors, such as alcoholism, gambling, overeating, sexual excess, and drug dependency
- Handling the stress felt by relatives or friends of those who are dealing with addictions

Group therapy also makes valuable contributions to the treatment of terminally ill patients. The goals of such therapy are to help patients and their families live their lives as fully as possible, to cope realistically with impending death, and to adjust to the terminal illness (Adams, 1979; Yalom & Greaves, 1977). One general focus of such support groups for the terminally ill is to help them learn "how to live fully until you say goodbye" (Nungesser, 1990).

Couples and Family Therapy Sometimes the best setting in which to learn about relationships is in a group of people struggling with relationships. *Couples counseling* (or therapy), for example, may involve one or more couples who are learning to clarify their communication patterns and improve the quality of their interaction (Napier, 2000). By seeing couples together, a therapist can help the partners identify the verbal and nonverbal styles they use to dominate, control, or confuse each other. Each party is taught how to reinforce desired responses in the other and withdraw reinforcement for undesirable reactions. Couples are also taught nondirective listening skills to help

Self-help support groups Groups, such as Alcoholics Anonymous, that provide social support and an opportunity for sharing ideas about dealing with common problems. Such groups are typically organized and run by laypersons, rather than professional therapists.

the other person clarify and express feelings and ideas (Dattilio & Padesky, 1990; O'Leary, 1987).

Couples therapy typically focuses not on the personalities involved but on the *processes* of their relationship, particularly their patterns of conflict and communication (Gottman, 1994; Greenberg & Johnson, 1988; Notarius & Markman, 1993). Difficult as this may be, changing a couple's interaction patterns can be more effective than individual therapy with one person at a time (Gottman, 1994).

In *family therapy*, the "client" is an entire nuclear family, and each family member is treated as a member of a system of relationships (Fishman, 1993). A family therapist helps troubled family members perceive the issues or patterns that are creating problems for them. The focus is on altering the psychological "spaces" between people and the interpersonal dynamics among people (Foley, 1979; Schwebel & Fine, 1994).

Family therapy can not only reduce tensions within a family, but it can also improve the functioning of individual members by helping them recognize their roles in the group. Virginia Satir, a pioneer of family therapy, noted that the therapist, too, has roles to play during therapy. Among them, the therapist acts as an interpreter and clarifier of the interactions that take place in the therapy session, as well as an advisor, mediator, and referee (Satir, 1983; Satir et al., 1991). As in couples therapy, family therapy focuses on the *situational* rather than the *dispositional* aspects of a problem. That is, the therapist helps family members look at how they interact, rather than at individual's motives and intentions. For example, the therapist might point out how one family member's unemployment affects everyone's feelings and relationships—rather than seeking to assign blame or label anyone as lazy or selfish. The goal of a family therapy meeting, then, is not to have a "gripe session," but to develop the family's ability to come together for constructive problem solving.

Behavior Therapies

Behavior Therapies
- Systematic desensitization
- Aversion therapy
- Contingency management
- Token economies
- Participant modeling

If the problem is overeating, bed-wetting, shyness, antisocial behavior, or anything else that can be described in purely behavioral terms, the chances are good that it can be modified by one of the behavior therapies (also known as **behavior modification**). Based on the assumption that these undesirable behaviors have been *learned* and therefore can be *un*learned, **behavior therapy** relies on the principles of operant and classical conditioning. In addition to those difficulties listed above, behavior therapists report success in dealing with fears, compulsions, depression, addictions, aggression, and delinquent behaviors.

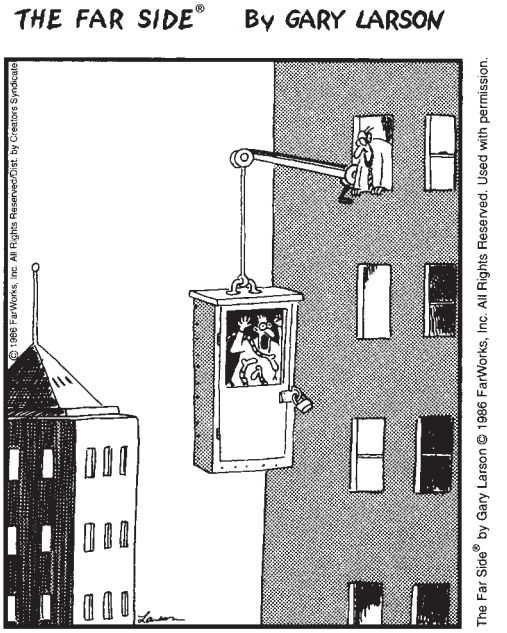
Behavior therapists focus on problem behaviors (rather than inner thoughts, motives, or emotions). They determine how these behaviors might have been learned and, more important, how they can be eliminated and replaced by more effective patterns. To see how this is done, we will look first at the therapy techniques borrowed from classical conditioning. (See the chart in the margin.)

Classical Conditioning Therapies The first example of behavior therapy came from psychologist Mary Cover Jones (1924). Working with a fearful small boy named Peter, she was able to desensitize the boy's intense fear of a rabbit, over a period of weeks, by gradually bringing the rabbit closer and closer while the boy was eating. Eventually, Peter was able to allow the rabbit to sit on his lap while he petted it. (You may notice the similarity to John Watson's experiments on Little Albert. Indeed, Jones was an associate of Watson and knew of the Little Albert study. Unlike Albert, however, Peter came to treatment already possessing an intense fear of rabbits and other furry objects.)

Behavior modification Another term for behavior therapy.

Behavior therapy Any form of psychotherapy based on the principles of behavioral learning, especially operant conditioning and classical conditioning.

Surprisingly, it was another 14 years before behavior therapy reappeared, this time as a treatment for bed-wetting (Mowrer & Mowrer, 1938). The method involved a fluid-sensitive pad placed under the patient. When moisture set off an alarm, the patient would awaken. The treatment was effective in 75% of cases—an amazing success rate, in view of the dismal failure of psychodynamic therapy to prevent bed-wetting by talking about the meaning of the symptom. Yet it took another 20 years before behavior therapy entered the mainstream of psychological treatment. Why the delay? The old Freudian idea—that every symptom has an underlying, unconscious cause that must be discovered and eradicated—was extremely well rooted in clinical lore. Therapists dared not attack symptoms (behaviors) directly for fear of *symptom substitution:* the idea that when one symptom was eliminated, another, which might be much worse, could take its place. It took the psychiatrist Joseph Wolpe to challenge that entrenched notion.



Professor Gallagher and his controversial technique of simultaneously confronting the fear of heights, snakes, and the dark.

Systematic Desensitization Wolpe reasoned that the development of irrational fear responses and other undesirable emotionally based behaviors seems to follow the classical conditioning model. As you will recall, classical conditioning involves the association of a new stimulus with an unconditioned stimulus, so that the person responds the same way to both. Wolpe also realized another simple truth: The nervous system cannot be relaxed and agitated at the same time, because these two incompatible processes cannot be activated simultaneously. These two ideas, then, became the basis for **systematic desensitization** (Wolpe, 1958, 1973).

CONNECTION CHAPTER 6

In *classical conditioning,* a CS comes to produce essentially the same response as the UCS.

His method begins with a training program that teaches his patients to relax their muscles and their minds (Rachman, 2000). While patients are in this deeply relaxed state, he helps them extinguish their fears by having them imagine fearful situations. They do so in gradual steps that move from remote associations of the feared situation to direct images of it.

In the process of systematic desensitization, the therapist and client first identify the stimuli that provoke anxiety and arrange them in a *hierarchy* ranked from weakest to strongest (Shapiro, 1995). For example, a patient suffering from severe fear of public speaking constructed the hierarchy of unconditioned stimuli shown in Table 13.2. During desensitization, the relaxed client vividly imagines the *weakest* anxiety stimulus on the list. If the stimulus can be

Systematic desensitization
A behavioral therapy technique in which anxiety is extinguished by exposing the patient to an anxiety-provoking stimulus.

TABLE 13.2 A Sample Anxiety Hierarchy

The following is typical of anxiety hierarchies that a therapist and a patient might develop to desensitize a fear of public speaking. The therapist guides the deeply relaxed patient in imagining the following situations:

1. Seeing a picture of another person giving a speech
2. Watching another person give a speech
3. Preparing a speech that I will give
4. Having to introduce myself to a large group
5. Waiting to be called upon to speak in a meeting
6. Being introduced as a speaker to a group
7. Walking to the podium to make a speech
8. Making a speech to a large group

In "virtual reality," phobic patients can confront their fears safely and conveniently in the behavior therapist's office. On a screen inside the headset, the patient sees computer-generated images of feared situations, such as seeing a snake, flying in an airplane, or looking down from the top of a tall building.

visualized without discomfort, the client goes on to the next stronger one. After a number of sessions, the client can imagine the most distressing situations on the list without anxiety (Lang & Lazovik, 1963)—hence the term *systematic* desensitization. In some forms of systematic desensitization, called **exposure therapy,** the therapist may actually have the patient confront the feared object or situation, such as a spider or a snake, rather than just imagining it. You will recall that Sabra, whom you met in the story opening Chapter 6, went through a form of desensitization to deal with her fear of flying.

A number of studies have shown that desensitization works remarkably well with phobic patients (Smith & Glass, 1977). Desensitization has also been successfully applied to a variety of fears, including stage fright and anxiety about sexual performance (Kazdin, 1994; Kazdin & Wilcoxin, 1976). Recently, psychologists have added a high-tech twist by using computer-generated images that expose phobic patients to fearful situations in a safe virtual-reality environment (Hoffman, 2004; Rothbaum & Hodges, 1999; Rothbaum et al., 2000a).

Aversion Therapy Clearly, desensitization therapy helps clients deal with stimuli that they want to *avoid*. But what about the reverse? What can be done to help those who are attracted to stimuli that are harmful or illegal? Examples include drug addiction, certain sexual attractions, and tendencies to violence—all problems in which deviant behavior is elicited by some specific stimulus. **Aversion therapy** tackles these problems with a conditioning procedure designed to make tempting stimuli less provocative by pairing them with unpleasant (aversive) stimuli. For example, the aversive stimuli could be electric shocks or nausea-producing drugs, whose effects are highly unpleasant but not in themselves dangerous to the client. In time, the negative reactions (unconditioned responses) associated with the aversive stimuli come to be associated with the conditioned stimuli (such as an addictive drug), and the person develops an aversion that replaces the desire.

To give another example, if you were to elect aversion therapy to help you quit smoking, you might be required to chain-smoke cigarettes while having a foul odor blown in your face—until you develop a strong association between smoking and nausea. (see Figure 13.2). A similar conditioning effect occurs in alcoholics who drink while taking Antabuse, a drug often prescribed to encourage sobriety.

In some ways, aversion therapy resembles nothing so much as torture. So why would anyone submit voluntarily to it? Usually people do so only because they have unsuccessfully tried other treatments. In some cases, people may be required to enter aversion therapy by the courts or as part of a treatment program while in prison.

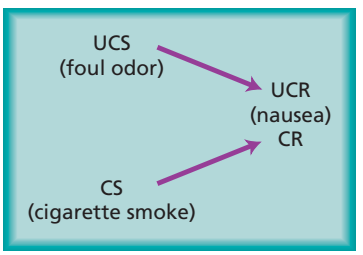


FIGURE 13.2 Conditioning an Aversion for Cigarette Smoke

Aversion therapy for smoking might simultaneously pair a foul odor with cigarette smoke blown in the smoker's face. The foul odor (such as rotten eggs) produces nausea. This response then becomes the conditioned response associated with cigarette smoke. (*Source:* From THE PRACTICE OF BEHAVIOR THERAPY 4th ed. by Joseph Wolpe. Copyright © 1990 by Allyn & Bacon. Reprinted by Allyn & Bacon, Boston, MA)

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In *operant conditioning,* behavior changes because of consequences, such as rewards and punishments.

Exposure therapy A form of desensitization therapy in which the patient directly confronts the anxiety-provoking stimulus (as opposed to imagining the stimulus).

Aversion therapy As a classical conditioning procedure, aversive counterconditioning involves presenting individuals with an attractive stimulus paired with unpleasant (aversive) stimulation in order to condition revulsion.

Operant Conditioning Therapies Johnny has a screaming fit when he goes to the grocery store with his parents and they refuse to buy him candy. His behavior is an example of a problem that has been acquired by operant conditioning—he has been rewarded when his parents have given in to his demands. In fact, many behavior problems found in both children and adults have been shaped by rewards and punishments. Consider, for example, the similarities between Johnny's case and the employee who chronically arrives late for work or the student who waits until the last minute to study for a test. Behavior therapists argue that changing such behaviors requires operant conditioning techniques. Let's look at two variations on this theme.

Contingency Management Johnny's parents may learn to extinguish his fits at the grocery store by simply withdrawing their attention—no easy task, by the way. In addition, the therapist may coach them to "catch Johnny being good"

DO IT YOURSELF! Behavior Self-Modification

Is there a behavior you would like to engage in more often than you do—studying, initiating conversations with others, exercising to keep fit? Write this in behavioral terms on the line below. (No fair using mentalistic words, such as "feeling" or "wanting." Behaviorists require that you keep things objective by specifying only an observable behavior.)

The desired new behavior: _____

_____

When or under what conditions would you like to engage in this new behavior? On the line below, write in the time or stimulus conditions when you want to initiate the behavior (for example: in class, when relaxing with friends, or at a certain time every morning).

The time or conditions for the new behavior: _____

_____

To increase your likelihood of producing the desired response, apply some positive reinforcement therapy to yourself. Choose an appropriate reward that you will give yourself when you have produced the desired behavior at the appropriate time. Write the reward that you will give yourself on the line below.

Your reward: _____

_____

Give yourself feedback on your progress by keeping a daily record of the occurrence of your new behavior. This could be done, for example, on a calendar or a graph. In time, you will discover that the desired behavior has increased in frequency. You will also find that your new habit carries its own rewards, such as better grades or more satisfying social interactions (Kazdin, 1994).

and give him the attention he needs then. Over time, the changing contingencies will work to extinguish the old, undesirable behaviors and help to keep the new ones in place. This approach is an example of **contingency management:** changing behavior by modifying its consequences. It has proved effective in managing behavior problems found in many settings, including families, schools, prisons, the military, and mental hospitals. To give another example, the careful application of reward and punishment can dramatically reduce the self-destructive behaviors in autistic children (Frith, 1997). You can also apply contingency management techniques to yourself, if you would like to change some undesirable habit: See the accompanying box, "Do It Yourself! Behavior Self-Modification."

● A patient undergoes a simplified form of aversion therapy in which overexposure to smoke makes her nauseous. The smell of smoke and smoking behavior then take on unpleasant associations.

One caution is in order: Although some people misbehave merely because they want attention, simply giving more attention can be counterproductive. For example, overzealous parents and teachers may be tempted to praise children lavishly, even when their performance has been mediocre—under the mistaken impression that the extra praise will increase low self-esteem and boost performance. In such cases, parents and teachers can aggravate behavior problems by increasing rewards (Viken & McFall, 1994). How could this be? What the child actually learns is that more rewards can be "earned" by producing fewer and fewer desirable behaviors. One must, therefore, take care in simply piling on more rewards. The key to success lies in tying rewards more closely to (making them *contingent on*) desirable behaviors.

Token Economies The special form of therapy called a **token economy** is the behavioral version of group therapy. It commonly finds application in classrooms and institutions (Ayllon & Azrin, 1968; Martin & Pear, 1999). The method takes its name from the plastic tokens sometimes awarded by therapists or teachers as immediate reinforcers for desirable behaviors. In a classroom, earning a token might mean sitting quietly for several minutes, participating in a class discussion, or turning in an assignment. Later, recipients may redeem the tokens for food, merchandise, or privileges. Often, "points" or play money are used in place of tokens. The important thing is that the individual receive something as a reinforcer immediately after giving desired responses.

■ **Contingency management** An operant conditioning approach to changing behavior by altering the consequences, especially rewards and punishments, of behavior.

■ **Token economy** An operant technique applied to groups, such as classrooms or mental hospital wards, involving the distribution of "tokens" or other indicators of reinforcement contingent on desired behaviors. The tokens can later be exchanged for privileges, food, or other reinforcers.

■ **Participant modeling** A social-learning technique in which a therapist demonstrates and encourages a client to imitate a desired behavior.

■ **Cognitive–behavioral therapy** A newer form of psychotherapy that combines the techniques of cognitive therapy with those of behavior therapy.

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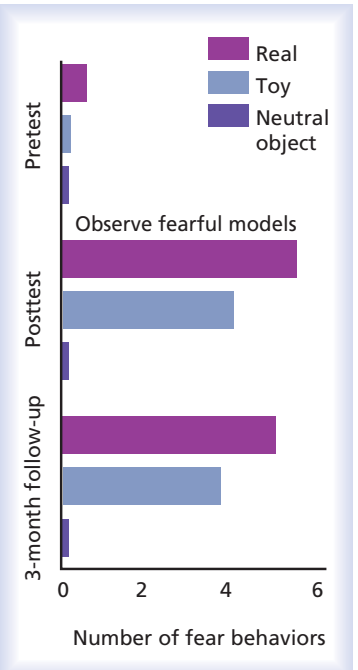
Participant modeling is based on Bandura's theory of *observational learning.*



● **FIGURE 13.3** Fear Reactions in Monkeys

After young monkeys raised in laboratories observe unrelated adult monkeys showing a strong fear of snakes, they are vicariously conditioned to fear real snakes and toy snakes with an intensity that persists over time. (*Source:* From "Observational Conditioning of Snake Fear in Unrelated Rhesus Monkeys" by M. Cook, S. Mineka, B. Wokenstein, and K. Laitsch, *Journal of Abnormal Psychology, 94,* pp. 591–610. Copyright © 1985 by American Psychological Association. Reprinted by permission of American Psychological Association.)

The token economy approach has also been found to work well in encouraging prosocial behaviors among mental patients and prisoners (Schaefer & Martin, 1966). In these settings, the token reinforcers might be exchanged for cigarettes, reading material, or better living conditions. A PsychInfo search reveals that in the last 10 years alone, over 100 published studies attest to the effectiveness of the token economy in shaping desirable behavior.

Participant Modeling: An Observational-Learning Therapy "Monkey see—monkey do," we say. And sure enough, monkeys learn fears by observation and imitation. One study showed that laboratory monkeys with no previous aversion to snakes could acquire a simian version of *ophidiophobia* by observing their parents reacting fearfully to real snakes and toy snakes. (You don't remember that one? Look back at Table 12.3 on page 494.) The more disturbed the parents were at the sight of the snakes, the greater the resulting fear in their offspring (Mineka et al., 1984). A follow-up study showed that such fears were not just a family matter. When other monkeys that had previously shown no fear of snakes were given the opportunity to observe unrelated adults responding to snakes fearfully, they quickly acquired the same response, as you can see in Figure 13.3 (Cook et al., 1985).

Like monkeys, people also learn fears by observing the behavior of others. **Participant modeling** takes advantage of this propensity for observational learning by having the client, or *participant,* observe and imitate another person who is *modeling* desirable behaviors. Coaches, of course, often use participant modeling to teach their athletes new skills. Likewise, participant modeling has proved of value in therapy, where the therapist may model the behavior and encourage the client to imitate it. For example, in treating a phobia for snakes, a therapist might first approach a caged snake, then touch the snake, and so on. (Because snake phobias are so common, they are often the subject of behavior therapy demonstrations.) The client then imitates the modeled behavior but at no time is forced to perform. If the therapist senses resistance, the client may return to a previously successful, less-threatening behavior. As you can see, the procedure is similar to systematic desensitization, with the important addition of observational learning. In fact, participant modeling draws on concepts from both operant and classical conditioning.

The power of participant modeling in eliminating snake phobias can be seen in a study that compared the participant modeling technique with several other approaches: (1) *symbolic modeling,* a technique in which subjects receive indirect exposure by watching a film or video in which models deal with a feared situation; (2) desensitization therapy, which, as you will remember, involves exposure to an imagined fearful stimulus; and (3) no therapeutic intervention (the control condition). As you can see in Figure 13.4, participant modeling was the most successful. The snake phobia was eliminated in 11 of the 12 subjects in the participant modeling group (Bandura, 1970).

Cognitive–Behavioral Therapy: A Synthesis

Suppose you are having difficulty controlling feelings of jealousy every time your mate is friendly with someone else. Chances are that the problem originates in your cognitions about yourself and the others involved ("Marty is stealing Terry away from me!") These thoughts may also affect your behavior, making you act in ways that could drive Terry away from you. A dose of therapy aimed at *both* your cognitions and your behaviors may be a better bet than either one alone.

In brief, **cognitive–behavioral therapy** combines a cognitive emphasis on thoughts and attitudes with the behavioral strategies that we discussed earlier. This dual approach assumes that an irrational self-statement often underlies

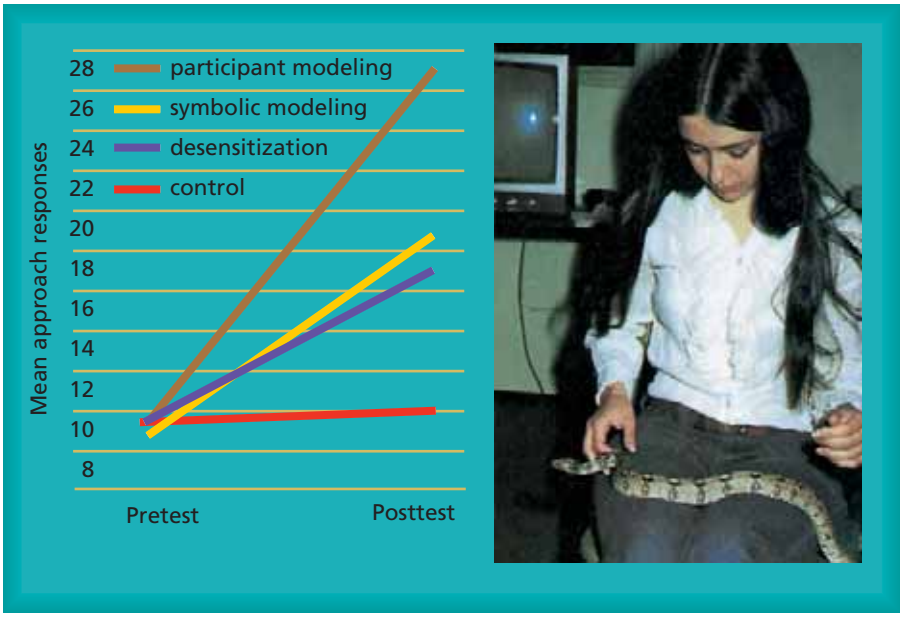


FIGURE 13.4 Participant Modeling Therapy

The subject shown in the photo first watches a model make a graduated series of snake-approach responses and then repeats them herself. Eventually, she can pick up the snake and let it move about on her. The graph compares the number of approach responses subjects made before and after receiving participant modeling therapy (most effective) with the behavior of those exposed to two other therapeutic techniques and a control group. (*Source:* From "Modeling Therapy" by D. Albert Bandura. Reprinted by permission of the author.)

maladaptive behavior. For example, an addicted smoker might automatically tell himself, "One more cigarette won't hurt me" or "I'll go crazy if I don't have a smoke now." These irrational self-statements must be changed or replaced with rational, constructive coping statements before the unacceptable behavior pattern can be modified. Here is an example of healthier thinking: "I can get through this craving if I distract myself with something else I like to do, like going to a movie."

In cognitive–behavioral treatment, the therapist and client work together to modify irrational self-talk, set attainable behavioral goals, develop realistic strategies for attaining them, and evaluate the results. In this way, people change the way they approach problems and gradually develop new skills and a sense of self-efficacy (Bandura, 1986, 1992; Schwarzer, 1992).

Rational–Emotive Behavior Therapy: Challenging the "Shoulds" and "Oughts"

One of the most famous (some would say "notorious") forms of cognitive–behavioral therapy was developed by the colorful Albert Ellis (1987, 1990, 1996) to help people eliminate self-defeating thought patterns. Ellis has dubbed his treatment **rational–emotive behavior therapy (REBT),** a name derived from its method of challenging certain "irrational" beliefs and behaviors.

What are the irrational beliefs challenged in REBT, and how do they lead to maladaptive feelings and actions? According to Ellis, maladjusted individuals base their lives on a set of unrealistic values and unachievable goals. These "neurotic" goals and values lead people to hold unrealistic expectations that they should *always* succeed, that they should *always* receive approval, that they should *always* be treated fairly, and that their experiences should *always* be pleasant. (You can see the most common irrational beliefs in the accompanying box, "Do It Yourself! Examining Your Own Beliefs.") For example, in your own daily life, you may frequently tell yourself that you "should" get an A in math or that you "ought to" spend an hour exercising every day. Further, he says, if you are unable to meet your goals and seldom question this neurotic self-talk, it may come to control your actions or even prevent you from choosing the life you want. If you were to enter REBT, your therapist would teach you to recognize such assumptions, question how rational they are, and replace faulty ideas with more valid ones. Don't "should" on yourself, warns Ellis.

CONNECTION: CHAPTER 10

Compare with Karen Horney's *neurotic trends*.

Rational–emotive behavior therapy (REBT) Albert Ellis's brand of cognitive therapy, based on the idea that irrational thoughts and behaviors are the cause of mental disorders.

DO IT YOURSELF! Examining Your Own Beliefs

It may be obvious that the following are not healthy beliefs, but Albert Ellis finds that many people hold them. Do you? Be honest: Put a check mark beside each of the following statements that accurately describes how you feel about yourself.

_____ 1. I must be loved and approved by everyone.
_____ 2. I must be thoroughly competent, adequate, and achieving.
_____ 3. It is catastrophic when things do not go the way I want them to go.
_____ 4. Unhappiness results from forces over which I have no control.
_____ 5. People must always treat each other fairly and justly; those who don't are nasty and terrible people.
_____ 6. I must constantly be on my guard against dangers and things that could go wrong.
_____ 7. Life is full of problems, and I must always find quick solutions to them.
_____ 8. It is easier to evade my problems and responsibilities than to face them.
_____ 9. Unpleasant experiences in my past have had a profound influence on me. Therefore, they must continue to influence my current feelings and actions.
_____ 10. I can achieve happiness by just enjoying myself each day. The future will take care of itself.

In Ellis's view, all these statements are irrational beliefs that can cause mental problems. The more items you have checked, the more "irrational" your beliefs. His cognitive approach to therapy, known as rational–emotive behavior therapy, concentrates on helping people see that they can "drive themselves crazy" with such irrational beliefs. For example, a student who parties rather than studying for a test holds irrational belief #8. A person who is depressed about not landing a certain job holds irrational belief #3. You can obtain more information on Ellis's system from his books.

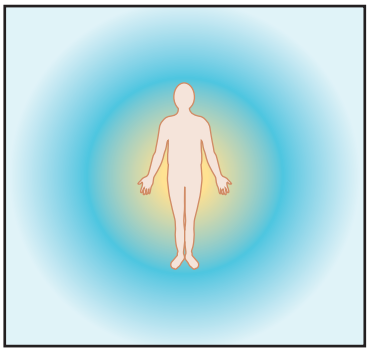
How might a cognitive–behavioral therapist have dealt with Freud's obsessive patient? First, donning a cognitive "thinking cap," the therapist would challenge the girl's irrational beliefs, as we suggested earlier. Then, switching to a behaviorist's hat, the therapist might teach the girl relaxation techniques to use when she began to get ready for bed each evening. These techniques then would substitute for the obsessive ritual. It is also likely that the therapist would work with the parents (as might the psychodynamic therapist), focusing on helping them learn not to reward the girl with attention for her ritual behavior.

Changing the Brain by Changing the Mind Research now shows that cognitive–behavioral therapy may not only help people change their minds but also change the brain itself. In one study, patients who suffered from obsessions about whether they had turned off their stoves or locked their doors, for example, were given cognitive behavior modification (Schwartz et al., 1996). When they felt an urge to run home and check on themselves, they were trained to relabel their experience as an obsession or compulsion—not a rational concern. They then focused on waiting out this "urge" rather than giving in to it, by distracting themselves with other activities for about 15 minutes. Positron emission tomography (PET) scans of the brains of subjects who were trained in this technique indicated that, over time, the part of the brain responsible for that nagging fear or urge gradually became less active. As this study shows, the mind can fix the brain!

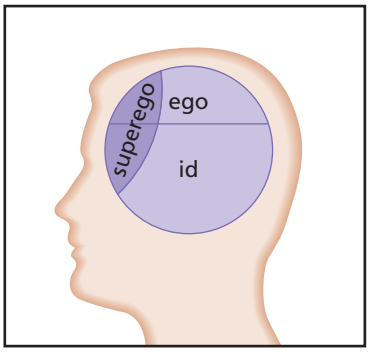
Evaluating the Psychological Therapies

Now that we have looked at a variety of psychological therapies (see Figure 13.5), let us step back and ask how well therapy works. Does it really make a difference? The answer to this question hasn't always been clear (Kopta et al., 1999; Shadish et al., 2000).

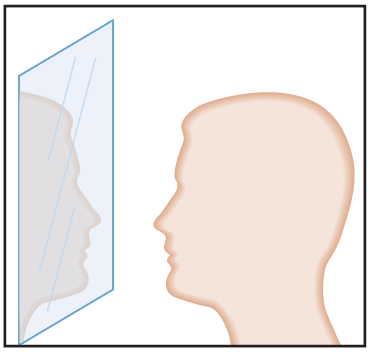
Think about it: How could you tell whether therapy works? Lots of evidence says that people who have undergone therapy *like* it. This was shown in a survey involving thousands of subscribers to *Consumer Reports* (1995). Respondents indicated how much their treatment helped, how satisfied they



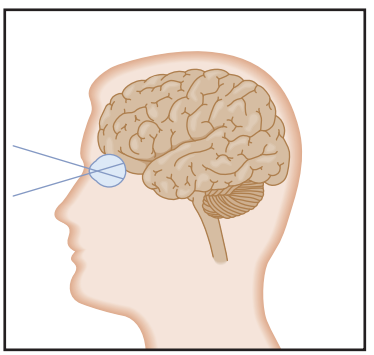
Behavior therapies
aim to change things *outside the individual*—rewards, punishments, and cues in the environment—in order to change the person's external behaviors



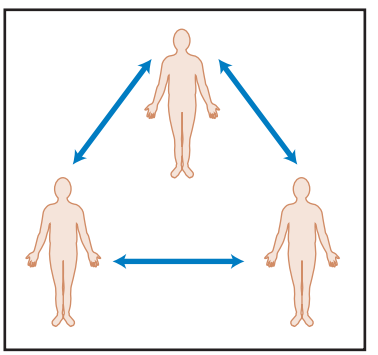
Psychodynamic therapies
aim to make changes *inside the person's mind*, especially the unconscious.



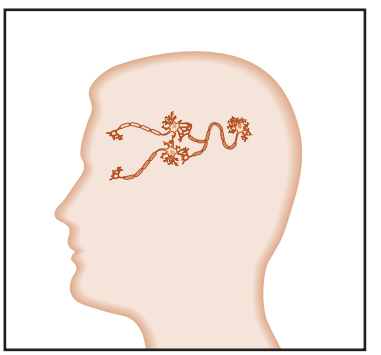
Humanistic therapies
aim to change the way people *see themselves*.



Cognitive therapies
aim to change the way people *think and perceive*.



Group therapies
aim to change the way people *interact*.



Biomedical therapies
aim to change the structure or function of the brain.

● **FIGURE 13.5** A Comparison of Different Types of Therapy

were with the therapist's treatment of their problems, how much their "overall emotional state" changed following therapy, as well as what kind of therapy they had undergone. For about 3000 of the 7000 respondents, therapy consisted of talking to friends, to relatives, or to clergy (as might be expected from our discussion earlier in this chapter). Another 2900 saw a mental health professional; the rest saw family doctors or support groups. Among the results: (a) Therapy works—that is, it was perceived to have helped clients diminish or eliminate their psychological problems; (b) long-term therapy is better than short-term therapy; and (c) all forms of therapy are about equally effective for improving clients' problems (see Jacobson & Christensen, 1996; Kazdin, 1986; Seligman, 1995).

We can't give a thumbs-up to therapy, however, merely because people say they like it or that it helped them (Hollon, 1996). Testimonials don't make for good science—which is why psychologists now demand that therapy be judged by studies having a *comparison group* or *control group.* Let's turn, therefore, to the controlled studies of therapy's effectiveness.

CONNECTION CHAPTER 2
A *control group* is treated exactly as the *experimental group,* except for the crucial *independent variable.*

Eysenck's Controversial Proclamation The issue of therapy's effectiveness came to a head in 1952. After reviewing the existing evidence, British psychologist Hans Eysenck shook the therapeutic world with the claim that

roughly two-thirds of all people with nonpsychotic problems recover within two years of the onset of the problem, *whether they get therapy or not.* The evidence came from a review of several outcome studies of various kinds of insight therapy, all of which compared patients who received therapy to those who were on waiting lists, awaiting their turn in therapy. What Eysenck noted, then, is that people on the waiting lists got better at the same rate as those in therapy. This meant that psychotherapy is essentially worthless—no better than having no treatment at all. To say the least, this wasn't a happy prospect for therapists. Eysenck's challenge had a most important result: It stimulated therapists to do a great deal of research on the effectiveness of therapy. And, as we will see, the discoveries that were made underscore the value of *replication* of research as a crucial part of the scientific method.

In Response to Eysenck Major reviews of the accumulating evidence on therapy began to be reported in 1970 (by Meltzoff & Kornreich), in 1975 (by Luborsky et al.), and in 1977 (by Smith and Glass). Overall, this literature—numbering some 375 studies—supported two major conclusions. First, therapy is, after all, more effective than no therapy. And second, Eysenck had overestimated the improvement rate in no-therapy control groups.

Gradually, then, a consensus supporting the value of psychotherapy emerged (Meredith, 1986; VandenBos, 1986). Moreover, the newest research began to show that therapy was effective not only in Western industrialized countries (in the United States, Canada, and Europe) but also in a variety of cultural settings throughout the world (Beutler & Machado, 1992; Lipsey & Wilson, 1993). A number of writers have cautioned, however, that therapists must be sensitive to cultural differences and adapt their techniques appropriately (Matsumoto, 1996; Shiraev & Levy, 2001).

New Questions The new studies have, however, raised new questions. Are some therapies better than others? Can we identify therapies that are best suited for treating specific disorders? The Smith and Glass survey (1977) hinted that the answers to those questions were "Yes" and "Yes." Smith and Glass found that the behavior therapies seemed to have an advantage over insight therapies for the treatment of many anxiety disorders. More recent evaluations have found that insight therapies can also be used effectively to treat certain problems, such as marital discord and depression. Indeed, there is a clear trend toward matching specific therapies to specific conditions. It is important to realize, however, that these therapeutic techniques do not necessarily "cure" psychological disorders. In the treatment of schizophrenia, mental retardation, or autism, for example, psychological therapies may be deemed effective when people suffering from these afflictions learn more adaptive behaviors (Hogarty et al., 1997; Lovaas, 1993; Wolpe, 1985).

Consensus and Controversy on Effective Therapies The American Psychological Association has sponsored a special task force charged with evaluating psychological therapies (Chambless et al., 1996; Nathan, 1998; "Task Force," 1993). The thrust of their findings is that more and more specific disorders—literally dozens of them—can be treated successfully by specific therapies that have been validated in well-designed experiments (Barlow, 1996). Here are some examples of therapies pronounced effective by this group:

- Behavior therapy for specific phobias, enuresis (bedwetting), autism, and alcoholism
- Cognitive–behavioral therapy for chronic pain, anorexia, bulimia, agoraphobia, and depression
- Insight therapy for couples' relationship problems

More recently, a report by the American Psychological Association focused specifically on evidence-based treatments for depression (Hollon et al., 2003). That document asserts that several varieties of psychotherapy can be effective. These include cognitive, behavior, and family therapy. The APA report also acknowledged that there is a legitimate role for both drug and electroconvulsive therapies in the treatment of depression. In fact, some studies suggest that for depression, a combination of cognitive–behavioral therapy and drug therapy can have a greater effect than either treatment alone (Keller et al., 2000).

Surprisingly, perhaps, the movement to identify therapies that work has generated spirited discussion among therapists (Glenn, 2003). Researchers find that a common element in successful therapy is a caring, hopeful relationship and a new way of looking at oneself and the world (Barker et al., 1988; Jones et al., 1988). This conclusion has been supported by a more recent study that found the effectiveness of therapy to depend less on the *type* of therapy used and more on the *quality of the relationship* between therapist and client (Blatt, Sanislow, & Pilkonis, 1996). Some practitioners fear that they will become locked into a therapeutic straitjacket by insurance companies, which will be unwilling to pay for any treatments not on the official list or for any deviations from "approved" treatments, no matter what the needs of the individual patient. On the other side of the issue are those who fear that nonmedical therapists will be squeezed out of the picture by drug-prescribing physicians.

To end this discussion on a more encouraging note: A recent study of 200 practitioners found that psychologists tend to modify their approach to treatment to fit the needs of their clients, as the situation unfolds during counseling or psychotherapy (Holloway, 2003b). That is, despite our emphasis in this chapter on conflicting opinions about treatment of psychological disorders, most practitioners are quite willing to adapt their methods to the individual client, rather than holding rigidly to a particular theoretical orientation. And that is good news, indeed, coming from a field that has traditionally had strongly divided allegiances. It appears that the emphasis on science-based practice is finally breaking down the old therapeutic boundaries.

PSYCHOLOGY IN YOUR LIFE: WHERE DO MOST PEOPLE GET HELP?

The effectiveness of psychotherapy for a variety of problems seems to be established beyond doubt. Having said that, we should again acknowledge that *most people experiencing mental distress do not turn to professional therapists for help.* Rather they turn to "just people" in the community (Wills & DePaulo, 1991). Those suffering from mental problems often look to friends, clergy, hairdressers, bartenders, and others with whom they have a trusting relationship. In fact, for some types of problems—perhaps the commonest problems of everyday living—a sympathetic friend may be just as effective as a trained professional therapist (Berman & Norton, 1985; Christensen & Jacobson, 1994).

To put the matter in a different way: Most mental problems are not the crippling disorders described in the previous chapter. Rather, the psychological difficulties most of us face result from lost jobs, difficult marriages, misbehaving children, friendships gone sour, loved ones dying . . . In brief, the most familiar problems involve chaos, confusion, choice, frustration, stress, and loss. People who find themselves in the throes of these adjustment difficulties may not need extensive psychotherapy, medication, or some other

special treatment. They need someone to help them sort through the pieces of their problems. Usually this means that they turn to someone like you.

What can you do when someone asks you for help? First, you should realize that some problems do indeed require immediate professional treatment. These include a suicide threat or an indication of intent to harm others. You should not delay finding competent help for someone with such tendencies. Second, you should remember that most therapy methods require special training, especially those calling for cognitive–behavioral therapy techniques or psychodynamic interpretations. We urge you to learn as much as you can about these methods—but we strongly recommend that you leave them to the professionals. Some other techniques, however, are simply extensions of good human relationships, and they fall well within the layperson's ability to administer mental "first aid." Briefly, we will consider three of these:

- *Listening:* You will rarely go wrong if you just listen. Sometimes listening is all the therapy a person in distress needs. It works by encouraging the speaker to organize a problem well enough to communicate it. As a result, those who talk out their problems frequently arrive at their own solutions. As an **active listener,** you take the role a step further by giving the speaker feedback: nodding, maintaining an expression that shows interest, paraphrasing, and asking for clarification when you don't understand. As we saw in the client-centered therapy excerpt on pages 534–535, active listening lets the speaker know that the listener is interested and *empathetic* (in tune with the other person's feelings). At the same time, you will do well to avoid the temptation to give advice. Advice robs the recipient of the opportunity to work out his or her own solutions.
- *Acceptance:* Nondirective therapists call this a *nonjudgmental attitude.* It means accepting the person and the problem as they are. It also means suppressing shock, disgust, or condemnation that would create a hostile climate for problem solving.
- *Exploration of alternatives:* People under stress may see only one course of action, so you can help by identifying other potential choices and exploring the consequences of each. (You can point out that *doing nothing* is also a choice.) Remember that, in the end, the choice of action is not up to you but to the individual who owns the problem.

Active listener A person who gives the speaker feedback in such forms as nodding, paraphrasing, maintaining an expression that shows interest, and asking questions for clarification.

Beyond these basic helping techniques lies the territory of the trained therapist. Again, we strongly advise you against trying out the therapy techniques discussed in this chapter for any of the serious psychological disorders discussed in the previous chapter or listed in the *DSM-IV*.

CHECK YOUR UNDERSTANDING

1. **RECALL:** Counterconditioning is based on the principles of
   a. operant conditioning.
   b. classical conditioning.
   c. social learning.
   d. cognitive learning.
   e. observational learning.

2. **APPLICATION:** You could use contingency management to change the behavior of a child who comes home late for dinner by
   a. pairing food with punishment.
   b. having the child observe someone else coming home on time and being rewarded.
   c. pairing food with rewards.
   d. having the child relax and imagine being home on time for dinner.
   e. refusing to let the child have dinner.

3. **RECALL:** A primary goal of psychoanalysis is to
   - **a.** change behavior.
   - **b.** reveal problems in the unconscious.
   - **c.** overcome low self-esteem.
   - **d.** help the client learn how to get along with others.
   - **e.** alter interior thought processes.

4. **RECALL:** Carl Rogers invented a technique to help people see their own thinking more clearly. Using this technique, the therapist paraphrases the client's statements. Rogers called this
   - **a.** client-centered therapy.
   - **b.** reflection of feeling.
   - **c.** unconditional positive regard.
   - **d.** self-actualization.
   - **e.** analysis.

5. **RECALL:** Which form of therapy directly confronts a client's self-defeating thought patterns?
   - **a.** humanistic therapy
   - **b.** behavioral therapy
   - **c.** participant modeling
   - **d.** psychoanalytic therapy
   - **e.** rational–emotive behavior therapy

6. **RECALL:** Eysenck caused a furor with his claim that people who receive psychotherapy
   - **a.** are just looking for a paid friend.
   - **b.** really should seek medical treatment for their disorders.
   - **c.** are usually just pampered rich people who have nothing better to do with their lives.
   - **d.** get better no more often than people who receive no therapy at all.
   - **e.** respond only to psychoanalysis.

7. **UNDERSTANDING THE CORE CONCEPT:** A phobia would be best treated by _____, whereas a problem of choosing a major would be better suited for _____.
   - **a.** behavioral therapy/insight therapy
   - **b.** cognitive therapy/psychoanalysis
   - **c.** insight therapy/behavioral therapy
   - **d.** humanistic therapy/behavioral therapy
   - **e.** psychoanalysis/humanistic therapy

ANSWERS: 1. b 2. e 3. b 4. b 5. e 6. d 7. a

HOW IS THE BIOMEDICAL APPROACH USED TO TREAT PSYCHOLOGICAL DISORDERS?

KEY QUESTION

The mind exists in a delicate biological balance. It can be upset by irregularities in our genes, hormones, enzymes, and metabolism, as well as by damage from accidents and disease. When something goes wrong with the brain, we can see the consequences in abnormal patterns of behavior or peculiar cognitive and emotional reactions. The biomedical therapies, therefore, attempt to treat these mental disorders by intervening directly in the brain. Our Core Concept specifies the targets of these therapies:

CORE CONCEPT

Biomedical therapies seek to treat psychological disorders by changing the brain's chemistry with drugs, its circuitry with surgery, or its patterns of activity with pulses of electricity or powerful magnetic fields.

Each of the biomedical therapies emerges from the *medical model* of abnormal mental functioning, which assumes an organic basis for mental illnesses and treats them as diseases—as we saw in Chapter 12. We begin our examination of these biomedical therapies with the powerful arsenal of prescription psychoactive drugs.

Drug Therapy/Psychopharmacology

In the history of the treatment of mental disorder, nothing has ever rivaled the revolution created by the discovery of drugs that could calm anxious patients, restore contact with reality in withdrawn patients, and suppress hallucinations in psychotic patients. This brave new therapeutic era began in 1953 with the introduction of the first antipsychotic drugs (often called tranquilizers). As

■ **Psychopharmacology** The prescribed use of drugs to help treat symptoms of mental illness ostensibly to ensure that individuals are more receptive to talk therapies.

● What will be the effect of prescribing mood-altering drugs such as Prozac to millions of people?

these drugs found wide application, many unruly, assaultive patients almost miraculously became cooperative, calm, and sociable. In addition, many thought-disordered patients, who had previously been absorbed in their delusions and hallucinations, began to respond to the physical and social environment around them.

The effectiveness of drug therapy had a pronounced effect on the census of the nation's mental hospitals. In 1955, over half a million Americans were living in mental institutions, each staying an average of several years. Then, with the introduction of tranquilizers, the numbers began a steady decline. In just over 10 years, fewer than half the number of the country's formerly hospitalized mental patients actually resided in mental hospitals, and those who did were usually kept for only a few months.

Drug therapy has long since steamrolled out of the mental hospital and into our everyday lives. Currently, millions of people take drugs for anxiety, stress, depression, hyperactivity, insomnia, fears and phobias, obsessions and compulsions, addictions, and numerous other problems. Clearly, a drug-induced revolution has occurred. But what are these miraculous drugs?

Drug Therapies
- Antipsychotic drugs
- Antidepressants and mood stabilizers
- Antianxiety drugs
- Stimulants

You have probably heard of Prozac and Valium, but those are just two of scores of psychoactive drugs that can alter your mood, your perceptions, your desires, and perhaps your basic personality. Here we will consider four major categories of drugs used today: *antipsychotics, antidepressants and mood stabilizers, antianxiety drugs,* and *stimulants.* (See the chart in the margin.)

Antipsychotic Drugs The purpose of the **antipsychotic drugs** is to treat the symptoms of psychosis: delusions, hallucinations, social withdrawal, and agitation (Dawkins et al., 1999; Gitlin, 1990; Holmes, 2001; Kane & Marder, 1993). Most work by reducing the activity of the neurotransmitter dopamine in the brain—although the precise reason why this has an antipsychotic effect is not known. For example, *chlorpromazine* (sold under the brand name Thorazine) and *haloperidol* (brand name: Haldol), for example, are known to block dopamine receptors in the synapse between nerve cells. A newer antipsychotic drug, *clozapine* (Clozaril), both decreases dopamine activity and increases the activity of another neurotransmitter, serotonin, which inhibits the dopamine system (Javitt & Coyle, 2004; Sawa & Snyder, 2002). These drugs reduce overall brain activity, but they do not merely "tranquilize" the patient. Rather, they reduce the positive symptoms of psychosis, although they do little for the social distance, jumbled thoughts, and poor attention spans seen in patients with negative symptoms of schizophrenia (Wickelgren, 1998b).

CONNECTION CHAPTER 12

Positive symptoms of *schizophrenia* include active hallucinations, delusions, and extreme emotions; negative symptoms include withdrawal and "flat" emotions.

Unfortunately, long-term administration of antipsychotic drugs can have several negative side effects. Physical changes in the brain have been noted (Gur & Maany, 1998). Most worrisome is **tardive dyskinesia,** which produces an incurable disturbance of motor control, especially of the facial muscles. Although the newer drug, clozapine, has reduced motor side effects because of its more selective dopamine blocking, its use involves a small risk of *agranulocytosis,* a blood disease caused by bone marrow dysfunction. With the possibility of such side effects, are antipsychotic drugs worth the risk? There is no easy answer. The risks must be weighed against the severity of the patient's current suffering.

■ **Antipsychotic drugs** Medicines that diminish psychotic symptoms, usually by their effect on the dopamine pathways in the brain.
■ **Tardive dyskinesia** An incurable disorder of motor control, especially involving muscles of the face and head, resulting from long-term use of antipsychotic drugs.

Antidepressants and Mood Stabilizers The drug therapy arsenal also includes several compounds that have revolutionized the treatment of depression and bipolar disorder. As with other psychoactive drugs, neither the antidepressants

nor the mood stabilizers can provide a "cure." Their use, however, has made a big difference in the lives of many people suffering from mood disorders.

Antidepressant Drugs All three major classes of **antidepressant drugs** work by "turning up the volume" on messages transmitted over certain brain pathways, especially those using norepinephrine and serotonin (Holmes, 2001). *Tricyclic* compounds such as Tofranil and Elavil reduce the neuron's reabsorption of neurotransmitters after they have been released in the synapse between brain cells—a process called *reuptake.* A second group includes the famous antidepressant Prozac (fluoxetine). These drugs are known as *SSRIs* (selective serotonin reuptake inhibitors) because they selectively focus on preventing the reuptake of serotonin. As a result, SSRIs keep serotonin available in the synapse longer by preventing its inactivation and removal. For many people, this prolonged serotonin effect dramatically lifts depressed moods (Hirschfeld, 1999; Kramer, 1993). The third group of antidepressant drugs are *monoamine oxidase (MAO) inhibitors,* which limit the activity of the enzyme MAO, a chemical that breaks down norepinephrine in the synapse. When MAO is inhibited, more norepinephrine is available to carry neural messages across the synapse.

The possibility of suicide is a special concern when considering antidepressant therapy. It usually takes a few weeks for antidepressants to have an effect—a long time to wait if the patient has suicidal tendencies, which are common in depressed patients. This delayed effect may account for the findings of a new study that shows an alarming increase in suicides in the month after patients begin taking antidepressants (Jick et al., 2004). Even more worrisome, according to some critics, is the possibility that the drugs themselves may sometimes contribute to suicidal thoughts by making depression worse before it gets better (Bower, 2004). While we wait for more research on this important issue, the U.S. Food and Drug Administration currently requires makers of antidepressant medications to warn physicians that patients taking these medications need close monitoring for suicidal tendencies.

Controversy over SSRIs In his book *Listening to Prozac,* psychiatrist and Prozac advocate Peter Kramer (1993) encourages the use of the drug to deal not only with depression but also with general feelings of social unease and fear of rejection. Such claims have brought heated replies from therapists who fear that drugs may merely mask the psychological problems that people need to face and resolve. Some worry that the wide use of antidepressants may produce changes in the personality structure of a huge segment of our population—changes that could bring unanticipated social consequences (Breggin & Breggin, 1994; Sleek, 1994). In fact, more prescriptions are being written for antidepressants than there are people who are clinically depressed (Coyne, 2001). The problem seems to be especially acute on college and university campuses, where increasing numbers of students are taking antidepressants (Young, 2003). At present, no one knows what the potential dangers might be of altering the brain chemistry of large numbers of people over long periods.

Mood Stabilizers A simple chemical, *lithium* (in the form of **lithium carbonate**) has proved highly effective as a mood stabilizer in the treatment of bipolar disorder (Schou, 1997). Lithium is not just an antidepressant, however. It affects both ends of the emotional spectrum, dampening swings of mood that would otherwise range from uncontrollable periods of hyperexcitement to the lethargy and despair of depression. But lithium, unfortunately, has a serious drawback: In high concentrations, it is toxic. Physicians have learned that safe therapy requires that small doses be given to build up therapeutic concentrations in the blood over a period of a week or two. Then, as a precaution, patients must have periodic blood analyses to ensure that lithium concentrations have not risen to dangerous levels. In a welcome development, researchers have

CONNECTION CHAPTER 3

Reuptake is a process by which neurotransmitters are taken intact from the synapse and cycled back into the terminal buttons of the axon. Reuptake, therefore, "tones down" the message being sent from one neuron to another.

■ **Antidepressant drugs** Medicines that affect depression, usually by their effect on the serotonin and/or norepinephrine pathways in the brain.

■ **Lithium carbonate** A simple chemical compound that is highly effective in dampening the extreme mood swings of bipolar disorder.

found a promising alternative to lithium for the treatment of bipolar disorder (Azar, 1994; Walden et al., 1998). Divalproex sodium (brand name: Depakote), originally developed to treat epilepsy, seems to be more effective than lithium for most patients, and with fewer dangerous side effects (Bowden et al., 2000).

Antianxiety Drugs To reduce stress and suppress anxiety associated with everyday hassles, untold millions of Americans take **antianxiety drugs.** Many psychologists believe, however, that these drugs—like the antidepressants—are too often prescribed for problems that people should face, rather than mask with chemicals. Nevertheless, antianxiety compounds can be useful in helping people deal with specific situations, such as anxiety prior to surgery or an airplane flight.

The most commonly prescribed classes of antianxiety compounds are *barbiturates* and *benzodiazepines.* Barbiturates act as central nervous system depressants, so they have a relaxing effect. But barbiturates can be dangerous if taken in excess or in combination with alcohol. By contrast, the benzodiazepines, such as Valium and Xanax, work by increasing the activity of the neurotransmitter GABA, thereby decreasing activity in brain regions more specifically involved in feelings of anxiety. The benzodiazepines are sometimes called "minor tranquilizers."

CONNECTION CHAPTER 3
GABA is the major *inhibitory* neurotransmitter in the brain.

Here are some cautions to bear in mind about the antianxiety drugs (Hecht, 1986):

- In general, the antianxiety drugs work by sedating the user; if used over long periods, these drugs can be physically and psychologically addicting (Holmes, 2001; Schatzberg, 1991).
- These medicines should not be taken to relieve anxieties that are part of the ordinary stresses of everyday life.
- When used for extreme anxiety, these drugs should not normally be taken for more than a few days at a time. If used longer than this, their dosage should be gradually reduced by a physician. Abrupt cessation after prolonged use can lead to withdrawal symptoms, such as convulsions, tremors, and abdominal and muscle cramps.
- Because the antianxiety drugs depress the central nervous system, they can impair one's ability to drive, operate machinery, or perform other tasks that require alertness (such as studying or taking exams).
- In combination with alcohol (also a central nervous system depressant) or with sleeping pills, antianxiety drugs can lead to unconsciousness and even death.

Finally, we should mention that some antidepressant drugs have also been found useful for reducing the symptoms of certain anxiety disorders, such as panic disorders, agoraphobia, and obsessive–compulsive disorder. (A modern psychiatrist might well have prescribed antidepressants for Freud's obsessive patient.) Because these problems may arise from low levels of serotonin, they may also respond well to drugs like Prozac that specifically affect serotonin function.

Antianxiety drugs A category of drugs that includes the barbiturates and benzodiazepines, drugs that diminish feelings of anxiety.

Stimulants Drugs that normally increase activity level by encouraging communication among neurons in the brain. Stimulants, however, have been found to suppress activity level in persons with attention-deficit/hyperactivity disorder.

Attention-deficit/hyperactivity disorder (ADHD) A common problem in children who have difficulty controlling their behavior and focusing their attention.

Stimulants Ranging from caffeine to nicotine to amphetamines to cocaine—any drug that produces excitement or hyperactivity falls into the category of **stimulants.** We have noted that stimulants find some use in the treatment of narcolepsy. They also have an accepted niche in treating **attention-deficit/hyperactivity disorder (ADHD)**. While it may seem strange to prescribe stimulants (a common one is Ritalin) for hyperactive children, studies comparing stimulant therapy with behavior therapy and with placebos have shown a clear role for stimulants (American Academy of Pediatrics, 2001; Henker & Whalen, 1989; Poling et al., 1991; Welsh et al., 1993). Although the exact mechanism is

unknown, stimulants may work in hyperactive children by increasing the availability of dopamine, glutamate, and/or serotonin in their brains (Barkley, 1998; Gainetdinov et al., 1999; Wu, 1998).

As you can imagine, the use of stimulants to treat ADHD has generated controversy (O'Connor, 2001). Some objections, of course, stem from ignorance of the well-established calming effect these drugs have in children with this condition. Other worries have more substance. For some, the drug will interfere with normal sleep patterns. Additionally, there is evidence that stimulant therapy can slow the growth of children (NIMH, 2004). There are also legitimate concerns that a potential for abuse exists in the temptation to see every child's behavior problem as a symptom of ADHD (Angold et al., 2000; Marshall, 2000; Smith, 2002). Critics also suggest that the prescription of stimulants to children might encourage later drug abuse (Daw, 2001).

Evaluating the Drug Therapies The drug therapies have caused a revolution in the treatment of severe mental disorders, starting in the 1950s, when virtually the only treatments available were talk therapies, hospitalization, restraints, "shock treatment," and lobotomies. Of course, none of the drugs discovered so far can "cure" any mental disorder. Yet in many cases they can alter the brain's chemistry to suppress symptoms.

But is all the enthusiasm warranted? According to neuroscientist Elliot Valenstein, a close look behind the scenes of drug therapy raises important questions (Rolnick, 1998; Valenstein, 1998). Valenstein believes that much of the faith in drug therapy for mental disorders rests on hype. He credits the wide acceptance of drug therapy to the huge investment drug companies have made in marketing their products. Particularly distressing are concerns raised recently about the willingness of physicians to prescribe drugs for children—even though the safety and effectiveness of many drugs have not been established in young people (K. Brown, 2003a).

Few question that drugs are the proper first line of treatment for certain conditions, such as bipolar disorder and schizophrenia. In other cases, however, the apparent advantages of drug therapy are quick results and low cost. Yet some research raises doubts about simplistic time-and-money assumptions. Studies show, for example, that treating depression, anxiety disorders, and eating disorders with cognitive–behavioral therapy—alone or in combination with drugs—may be both more effective and economical in the long run than relying on drugs alone (Barlow, 1996; Clay, 2000; Hollon, 1996).

Other Medical Therapies for Psychological Disorder

Describing a modern-day counterpart to Phineas Gage, the headline in the *Los Angeles Times* read, "Bullet in the Brain Cures Man's Mental Problem" (February 23, 1988). The article revealed that a 19-year-old man suffering from severe obsessive–compulsive disorder had shot a .22 caliber bullet through the front of his brain in a suicide attempt. Remarkably, he survived, his pathological symptoms were gone, and his intellectual capacity was not affected.

CONNECTION CHAPTER 3
Phineas Gage survived–with a changed personality–after a steel rod was blasted through his frontal lobe.

We don't recommend this form of therapy, but the case illustrates the potential effects of physical intervention in the brain. Accordingly, we will look briefly at two medical alternatives to drug therapy that were conceived to alter the brain's structure and function: psychosurgery and direct stimulation of the brain.

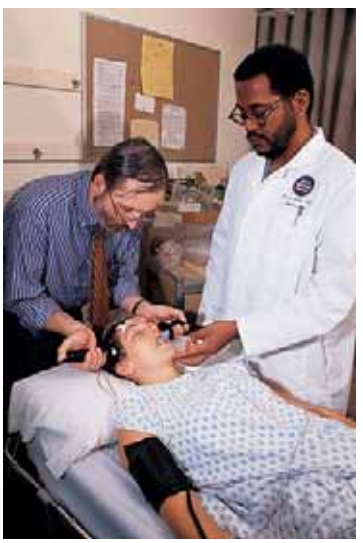
Psychosurgery With scalpels in place of bullets, surgeons have long aspired to treat mental disorders by severing connections between parts of the brain or by removing small sections of brain. In modern times, **psychosurgery,** the general term for such procedures, is usually considered a method of last resort.

■ **Psychosurgery** The general term for surgical intervention in the brain to treat psychological disorders.

Nevertheless, psychosurgery has a long history, dating back at least to medieval times, when surgeons might open the skull to remove "the stone of folly" from an unfortunate madman. (There is, of course, no such "stone"—and there was no anesthetic except alcohol for these procedures.)

In modern times, the best-known form of psychosurgery involved the now-abandoned *prefrontal lobotomy.* This operation, developed by Portuguese psychiatrist Egas Moñiz,[2] severed certain nerve fibers connecting the frontal lobes with deep brain structures, especially those of the thalamus and hypothalamus—much as happened by accident to Phineas Gage, whom we discussed in Chapter 3. The original candidates for Moñiz's scalpel were agitated schizophrenic patients and patients who were compulsive and anxiety-ridden. The effects of this rather crude operation were often a dramatic reduction in agitation and anxiety. On the other hand, the operation permanently destroyed basic aspects of the patients' personalities. Frequently, they emerged from the procedure with loss of interest in their personal well-being and their surroundings. Further, a lobotomy usually produced an inability to plan ahead, an indifference to the opinions of others, childlike actions, and the intellectual and emotional flatness of a person without a coherent sense of self. Not surprisingly, when the new drug therapies promised to control psychotic symptoms with less risk of permanent loss, the era of lobotomy came to a close in the 1950s (Valenstein, 1980).

Psychosurgery is still occasionally done, but it is now much more limited to precise and proven procedures for very specific brain disorders. In the "split-brain" operation, for example, severing the fibers of the corpus callosum can reduce life-threatening seizures in certain cases of epilepsy, with relatively few side effects. Psychosurgery is also done on portions of the brain involved in pain perception in cases of otherwise intractable pain. Today, however, no *DSM-IV* diagnoses are routinely treated with psychosurgery.



● A sedated patient about to receive ECT. Electroconvulsive therapy involves a weak electrical current to a patient's temples, causing a convulsion. Some psychiatrists have found ECT successful in alleviating symptoms of severe depression, but most therapists regard it as a treatment of last resort.

Brain-Stimulation Therapies Electrical stimulation of the brain in the form known as **electroconvulsive therapy (ECT)** is still widely used, especially in patients who have not responded to drug treatment for depression. ECT induces a convulsion by applying an electric current (75 to 100 volts) to a patient's temples briefly—from one-tenth to a full second. The convulsion usually runs its course in less than a minute. Patients are prepared for this traumatic intervention by sedating them with a short-acting barbiturate and a muscle relaxant. This renders them unconscious and minimizes violent, uncontrolled physical spasms during the seizure (Abrams, 1992; Malitz & Sackheim, 1984). Within half an hour the patient awakens but has no memory of the seizure or of the events preparatory to treatment.

■ **Electroconvulsive therapy (ECT)** A treatment used primarily for depression and involving the application of an electric current to the head, producing a generalized seizure. Sometimes called "shock treatment."

Does it work? Crude as this treatment may seem—sending an electric current through the skull and brain—studies have shown ECT to be a useful tool in treating depression, especially in patients with suicidal tendencies that demand an intervention that works more rapidly than medication or psychotherapy (Glass, 2001; Holden, 2003; Hollon et al., 2002; Sackheim et al., 2000). Typically, the symptoms of depression are reduced in a three- or four-day course of treatment, in contrast with the one- to two-week period required for drug therapy to be effective. Speed can be a major concern in depression, where suicide is always a possibility.

[2]In an ironic footnote to the history of psychosurgery, Moñiz was shot by one of his disgruntled patients, who apparently was not pacified as much as Moñiz had expected. This fact, however, did not prevent Moñiz from being awarded the Nobel Prize for medicine in 1949.

Some critics fear that ECT might be abused to silence dissent or punish patients who are uncooperative (Holmes, 2001). Other worries about ECT stem from the fact that its effects are not well understood. To date no definitive theory explains why inducing a mild convulsion should alleviate disordered symptoms.

Most worrisome, perhaps, are the memory deficits sometimes caused by electroconvulsive therapy (Breggin, 1979, 1991). Proponents claim, on the other hand, that patients generally recover full memory functions within months of the treatment (Calev et al., 1991). In the face of such concerns, the National Institute of Mental Health (1985) investigated the use of ECT and gave it a cautious endorsement for treating a narrow range of disorders, especially severe depression. Then, in 1990, the American Psychiatric Association also proclaimed ECT to be a valid treatment option. To minimize even short-term side effects, however, ECT is usually administered "unilaterally"—and only to the right temple, in order to reduce the possibility of speech impairment (Scovern & Kilmann, 1980).

CONNECTION CHAPTER 3
Speech is controlled by the left hemisphere in most people.

A promising new therapeutic tool for stimulating the brain with magnetic fields may offer all the benefits of ECT without the unwanted side effects of memory loss. Still in the experimental stages, **transcranial magnetic stimulation (TMS)** involves directing high-powered magnetic stimulation to specific parts of the brain. Studies indicate that TMS may be useful for treating not only depression but also schizophrenia and bipolar disorder (George, 2003; George et al., 1999; Helmuth, 2001b; Travis, 2000b; Wassermann & Lisanby, 2001). Because most applications of TMS therapy do not require the induction of a seizure, researchers hope also that it offers a safer alternative to ECT.

Hospitalization and the Alternatives

We have seen that mental hospitals were originally conceived as places of refuge—"asylums"—where disturbed people could escape the pressures of normal living. In fact, they often worked very well (Maher & Maher, 1985). But by the 20th century these hospitals had become overcrowded and, at best, little more than warehouses for the disturbed with nowhere else to go. Rarely were people of means committed to mental hospitals; instead, they were given private care, including individual psychotherapy (Doyle, 2002a). By contrast, in the large public mental hospitals, a feeble form of "group therapy" was often done with a whole ward—perhaps 50 patients—at a time. But too many patients and too few therapists meant that little, if any, real therapy occurred. The drugs that so profoundly altered treatment in mental hospitals did not appear until the 1950s, so prior to that time institutionalized patients were often controlled by straitjackets, locked rooms, and, sometimes, lobotomies. It's too bad that Maxwell Jones didn't come to the rescue a half-century earlier, with his frontal attack on the mental hospital system.

The Therapeutic Community In 1953—at about the time antipsychotic drugs were introduced—psychiatrist Maxwell Jones proposed replacing traditional hospital "treatment" for mental disorders with a **therapeutic community** designed to bring meaning to patients lives. He envisioned the daily hospital routine itself structured as a therapy that would help patients learn to cope with the world outside. With these goals in mind, he abolished the dormitory accommodations that had been typical of mental hospitals and gave patients more private living quarters. He required that they make decisions about meals and daily activities. Then, as they were able to take more responsibilities, patients assumed the tasks of everyday living, including laundry, housekeeping,

■ **Transcranial magnetic stimulation (TMS)** A treatment that involves magnetic stimulation of specific regions of the brain. Unlike ECT, TMS does not produce a seizure.

■ **Therapeutic community** Jones's term for a program of treating mental disorder by making the institutional environment supportive and humane for patients.

and maintenance. Further, Jones involved them in helping to plan their own treatment, which included not only group psychotherapy but occupational therapy and recreational therapy as well (Jones, 1953).

Eventually, variations on the therapeutic community concept were adopted across the United States, Canada, Britain, and Europe—sometimes more on paper than in reality, as we saw in Rosenhan's "pseudopatient" study. But the changes did not come cheaply. The newer approach obviously required more staff and more costly facilities. The high costs led to a search for still another alternative, which came in the form of community-based treatment—which began to look more and more attractive with the increasing availability of drug therapies.

Deinstitutionalization and Community Mental Health For mental health professionals of all stripes, the goal of **deinstitutionalization** was to remove patients from mental hospitals and return them to their communities for treatment in a more familiar and supportive environment. The concept of deinstitutionalization also gained popularity with politicians, who saw large sums of money being poured into mental hospitals (filled, incidentally, with nonvoting patients). Thus, by the 1970s, a consensus formed among politicians and the mental health community that the major locus of treatment should shift from mental hospitals back to the community. There both psychological and drug therapies would be dispensed from outpatient clinics, and recovering patients could live with their families, in foster homes, or in group homes. This vision became known as the **community mental health movement.**

● Deinstitutionalization put mental patients back in the community–but often without adequate resources for continued treatment.

Unfortunately, the reality did not match the vision (Doyle, 2002a; Torrey, 1996, 1997). Community mental health clinics—the centerpieces of the community mental health movement—rarely received the full funding they needed. Chronic patients were released from mental hospitals, but they often returned to communities that could offer them few therapeutic resources and to families ill-equipped to cope with them (Arnhoff, 1975; Smith et al., 1993). Then, as patients returned to the community and needed care, they entered psychiatric wards at local general hospitals—rather than mental hospitals. As a result, hospital care has continued to consume most funding for mental health in the United States. Currently, mental patients account for about 25% of all hospital days (Kiesler, 1993).

Some disturbed individuals, who would have been hospitalized in an earlier time, have now all but disappeared from view within their communities. An estimated 150,000 persons, especially those with chronic schizophrenia, have ended up homeless, with no network of support (Torrey, 1997). Although estimates vary widely, up to 52% of homeless men and 71% of homeless women in the United States probably suffer from psychological disorders, and many of them are former mental hospital patients (Fischer & Breakey, 1991; Lamb, 1998). Many also have problems with alcohol or other drugs (Drake et al., 1991). Under these conditions, they survive by shuttling from agency to agency. With no one to monitor their behavior, they usually stop taking their medication, and so their condition deteriorates until they require a period of rehospitalization.

■ **Deinstitutionalization** The policy of removing patients, whenever possible, from mental hospitals.

■ **Community mental health movement** An effort to deinstitutionalize mental patients and to provide therapy from outpatient clinics. Proponents of community mental health envisioned that recovering patients could live with their families, in foster homes, or in group homes.

Despite the dismal picture we have painted, community treatment has not proved altogether unsuccessful. After a review of ten studies in which mental patients were randomly assigned to hospital treatment or to various community-based programs, Kiesler (1982a) reported that patients more often improved in

the community treatment programs. Further, those given community-based treatment were less likely to be hospitalized at a later date. When community health programs have adequate resources, they can be highly effective (McGuire, 2000).

PSYCHOLOGY IN YOUR LIFE: WHAT SORT OF THERAPY WOULD YOU RECOMMEND?

Now that we have looked at both the psychological and biomedical therapies, consider the following situation. A friend tells you about some personal problems he or she is having and requests your help in finding a therapist. Because you are studying psychology, your friend reasons, you might know what kind of treatment would be best. How do you respond?

First, you can lend a friendly ear, using the techniques of active listening, acceptance, and exploration of alternatives, which we discussed earlier in the chapter. In fact, this may be all that your troubled friend needs. But if your friend wants to see a therapist or if the situation looks in any way like one that requires professional assistance, you can use your knowledge of mental disorders and therapies to help your friend decide what sort of therapist might be most appropriate. To take some of the burden off your shoulders, both of you should understand that any competent therapist will always refer the client elsewhere if the required therapy lies outside the therapist's specialty.

A Therapy Checklist Here, then, are some questions you will want to consider before you recommend a particular type of therapist:

- *Is medical treatment needed?* While you should not try to make a diagnosis, you should encourage your friend to see a psychiatrist for medical treatment if you suspect that the problem involves psychosis, mania, or bipolar disorder. Medical evaluation is also indicated if you suspect narcolepsy, sleep apnea, epilepsy, Alzheimer's disease, or other problems recognized to have a biological basis. If your suspicion is confirmed, the psychiatrist may employ a combination of drug therapy and psychotherapy.
- *Is there a specific behavior problem?* For example, does your friend want to eliminate a fear of spiders or a fear of flying? Is the problem a rebellious child? A sexual problem? Is she or he depressed—but not psychotic? If so, behavior therapy or cognitive–behavioral therapy with a counseling or clinical psychologist is probably the best bet. (Most psychiatrists and other medical practitioners are not trained in these procedures.) You can call the prospective therapist's office and ask for information on specific areas of training and specialization.
- *Would group therapy be helpful?* Many people find valuable help and support in a group setting, where they can learn not only from the therapist but also from other group members. Groups can be especially effective in dealing with shyness, lack of assertiveness, and addictions, and with complex problems of interpersonal relationships. (As a bonus, group therapy is often less expensive than individual therapy.) Professionals with training in several disciplines, including psychology, psychiatry, and social work, run therapy groups. Again, your best bet is a therapist who has had special training in this method and about whom you have heard good things from former clients.
- *Is the problem one of stress, confusion, or choice?* Most troubled people don't fall neatly into one of the categories that we have discussed in the previous

paragraphs. More typically, they need help sorting through the chaos of their lives, finding a pattern, and developing a plan to cope. This is the territory of the insight therapies.

Some Cautions We now know enough about human biology, behavior, and mental processes to know some treatments to avoid. Here are some particularly important examples:

- *Drug therapies to avoid:* The minor tranquilizers are too frequently prescribed for patients leading chronically stressful lives (Alford & Bishop, 1991). As we have said, because of their addicting and sedating effects, these drugs should only be taken for short periods—if at all. Similarly, some physicians ignore the dangers of sleep-inducing medications for their patients who suffer from insomnia. Although these drugs have legitimate uses, many such prescriptions carry the possibility of drug dependence and of interfering with the person's ability to alter the conditions that may have caused the original problem.
- *Advice and interpretations to avoid:* Although psychodynamic therapy can be helpful, patients should also be cautioned that some such therapists may give ill-advised counsel in problems of anger management. Traditionally, Freudians have believed that individuals who are prone to angry or violent outbursts harbor deep-seated aggression that needs to be vented. But, as we have seen, research shows that trying to empty one's aggressions through aggressive behavior, such as shouting or punching a pillow, may actually increase the likelihood of later aggressive behavior.

With these cautions in mind, then, your friend can contact several therapists to see which has the skills and the manner that offer the best fit for her or his problem and personality.

CHECK YOUR UNDERSTANDING

1. **RECALL:** Which class of drugs blocks dopamine receptors in the brain?
   a. antipsychotics
   b. antidepressants
   c. antianxiety drugs
   d. stimulants
   e. depressants

2. **RECALL:** A controversial treatment for attention-deficit/hyperactivity disorder involves
   a. antipsychotics.
   b. antidepressants.
   c. antianxiety drugs.
   d. stimulants.
   e. depressants.

3. **RECALL:** Which of the following medical treatments for mental disorder has now been largely abandoned as ineffective and dangerous?
   a. electroconvulsive therapy
   b. lithium
   c. prefrontal lobotomy
   d. the "split-brain" operation
   e. antipsychotics

4. **RECALL:** The community mental health movement followed a deliberate plan of _____ mental patients.
   a. hospitalizing
   b. deinstitutionalizing
   c. administering insight therapy to
   d. removing stressful events in the lives of
   e. lobotomizing

5. **UNDERSTANDING THE CORE CONCEPT:** Drug therapies, psychosurgery, and ECT all are methods of treating mental disorder
   a. by changing the chemistry of the body.
   b. by removing stress in the patient's life.
   c. that always succeed.
   d. that have no scientific basis.
   e. by directly altering the function of the brain.

ANSWERS: 1. a 2. d 3. c 4. b 5. e

THERAPIES: THE STATE OF THE ART

Prompted initially by questions about the effectiveness of therapy and later by a shift to managed health care, the mental health professions have begun to identify specific psychological and biomedical treatments that are effective for specific disorders. The disorders for which real help now exists include depression, phobias and other anxiety disorders, certain schizophrenias, ADHD, and autism. We can expect to see more and more such treatments identified, especially in the realm of drug therapies.

On the negative side, some drug therapies are overprescribed, as physicians and patients seek quick fixes for mental problems. The reality is that most *DSM-IV* disorders have no easy cures. For these, time is required for counseling or psychotherapy that may be necessary to sort through problems and examine alternative solutions.

USING PSYCHOLOGY TO LEARN PSYCHOLOGY

How Is Education Like Therapy?

Consider the ways in which psychotherapy is like your classroom experiences:

- Most therapists, like most teachers, are professionals with special training in what they do.
- Most patients/clients are like students in that they are seeking professional help to change their lives in some way.
- Much of what happens in therapy and in the classroom involves learning: new ideas, new behaviors, new insights, new connections.

It may help you learn psychology (and other subjects, as well) to think of teaching and learning in therapeutic terms. As we have seen, therapy seems to work best when therapist and client have a good working relationship and when the client believes in the value of the experience—and the same is almost certainly true for the student–teacher relationship. You can take the initiative in establishing a personal-but-professional relationship with your psychology teacher by doing the following two things: (1) asking questions or otherwise participating in class (at appropriate times and without dominating, of course) and (2) seeking your instructor's help on points you don't understand or on course-related topics you would like to pursue in more detail (doing so during regular office hours). The result will be learning more about psychology, because you will be taking a more active part in the learning process. Incidentally, an active approach to the course will also help you stand out from the crowd in the teacher's mind, which could be helpful if you later need a teacher recommendation for college.

Now consider a parallel between education and group therapy. In group therapy, patients learn from each other, as well as from the therapist. Much the same can occur in your psychology course, if you consider other students as learning resources. As we noted earlier in this book, the most successful students often spend part of their study time sharing information in groups.

One other tip for learning psychology we can borrow from the success of behavior therapies: the importance of changing behavior, not just thinking. It is easy to "intellectualize" a fact or an idea passively when you read about it or hear about it in class. But you are likely to find that the idea has little impact on you ("I know I *read* about it, but I can't *remember* it!") if you don't use it. The remedy is to do something with your new knowledge: Tell someone about it, come up with illustrations from your own experience, or try acting in a different way. For example, after reading about active listening in this chapter, try it the next time you talk to a friend. Educators sometimes speak of this as "active learning." And it works!

CHAPTER SUMMARY

WHAT IS THERAPY?

People seek therapy for a variety of problems, including *DSM-IV* disorders and problems of everyday living. Treatment comes in many forms, both psychological and biomedical, but most involve diagnosing the problem, finding the source of the problem, making a prognosis, and carrying out treatment. A variety of professionals work under this model. In earlier times, treatments for those with mental problems were usually harsh and dehumanizing, often based on the assumption of demon possession. Only recently have people with emotional problems been treated as individuals with "illnesses," which has led to more humane treatment.

Currently in the United States, there are two main approaches to therapy: the psychological and the biomedical therapies. Psychological therapies include insight therapy and behavior therapy—each of which, in turn, come in several forms. Other cultures often have different ways of understanding and treating mental disorders, often making use of the family and community. In the United States there is a trend toward increasing use of paraprofessionals as mental health care providers, and the literature generally supports their effectiveness.

Therapy for psychological disorders takes a variety of forms, but all involve some relationship focused on improving a person's mental, behavioral, or social functioning.

HOW DO PSYCHOLOGISTS TREAT PSYCHOLOGICAL DISORDERS?

The first of the insight therapies, psychoanalysis grew out of Sigmund Freud's theory of personality. Using such techniques as free association and dream interpretation, its goal is to bring repressed material out of the unconscious, where it can be interpreted and neutralized, particularly in the analysis of transference. Neo-Freudians typically emphasize the patient's current social situation, interpersonal relationships, and self-concept.

Among other insight therapies, humanistic therapy focuses on individuals becoming more fully self-actualized. In one form, client-centered therapists strive to be nondirective in helping their clients establish a positive self-image.

Another form of insight therapy, cognitive therapy concentrates on changing negative or irrational thought patterns about oneself and one's social relationships. The client must learn more constructive thought patterns in reference to a problem and apply the new technique to other situations. This has been particularly effective for depression.

Group therapy can take many approaches. Self-help support groups, such as AA, serve millions, even though they are not usually run by professional therapists. Family therapy and couples therapy usually concentrate on situational difficulties and interpersonal dynamics as a total system in need of improvement, rather than on internal motives.

The behavior therapies apply the principles of learning—especially operant and classical conditioning—to problem behaviors. Among the classical conditioning techniques, systematic desensitization is commonly employed to treat fears. Aversion therapy may also be used for eliminating unwanted responses. Operant techniques include contingency management, which especially involves positive reinforcement and extinction strategies. And, on a larger scale, behavior therapy may be used to treat or manage groups in the form of a token economy. Participant modeling, based on observational learning therapy, may make use of both classical and operant principles, involving the use of models and social-skills training to help individuals practice and gain confidence about their abilities.

In recent years a synthesis of cognitive and behavior therapies has emerged, combining the techniques of insight therapy with methods based on observational learning theory. Rational–emotive behavior therapy helps clients recognize that their irrational beliefs about themselves interfere with life and helps them learn how to change those thought patterns.

The effectiveness of therapy was challenged in the 1950s by Eysenck. Since that time, however, research has shown that psychotherapy can be effective for a variety of psychological problems. Often it is more effective than drug therapy. As the research on mental disorders becomes more refined, we are learning to match specific psychotherapies to specific disorders.

Most people do not get psychological help from professionals. Rather, they get help from teachers, friends, clergy, and others in their community who seem sympathetic. Friends can often help through active listening, acceptance, and exploration of alternatives, but serious problems require professional assistance.

Psychologists employ two main forms of treatment: the insight therapies (focused on developing understanding of the problem) and the behavior therapies (focused on changing behavior through conditioning).

HOW IS THE BIOMEDICAL APPROACH USED TO TREAT PSYCHOLOGICAL DISORDERS?

Biomedical therapies concentrate on changing the physiological aspects of mental illness. Drug therapy includes antipsychotic, antidepressant, mood stabilizing, antianxiety, and stimulant medicines. Most affect the function of neurotransmitters, but the precise mode of action is not known for any of them. Nevertheless, such drugs have caused a revolution in the medical treatment of mental disorder, such as schizophrenia, depression, bipolar disorder, anxiety disorders, and ADHD. Critics, however, warn of their abuse, particularly in treating the ordinary stress of daily living.

Psychosurgery has lost much of its popularity in recent years because of its radical, irreversible side effects. Electroconvulsive therapy, however, is still widely used—primarily with depressed patients—although it remains controversial. A new and promising alternative involves transcranial magnetic stimulation of specific brain areas. Meanwhile, hospitalization has been a mainstay of medical treatment, although the trend is away from mental hospitals to community-based treatment. The policy of deinstitutionalization was based on the best intentions, but many mental patients have been turned back into their communities with few resources and little treatment. When the resources are available, however, community treatment is often successful.

If someone asks your advice on finding a therapist, you can refer him or her to any competent mental health professional. You should avoid trying to make a diagnosis or attempting therapy for mental disorders, but you may use your knowledge of psychology to steer the person toward a medical specialist, a behavior therapist, group therapy, or some other psychological treatment that you believe might be appropriate. There are, however, some specific therapies and therapeutic techniques to avoid.

● **Biomedical therapies seek to treat psychological disorders by changing the brain's chemistry with drugs, its circuitry with surgery, or its patterns of activity with pulses of electricity or powerful magnetic fields.**

REVIEW TEST

For each of the following items, choose the single correct or best answer. The answer key appears at the end of the test.

1. Despite the differences between various types of therapy, all therapeutic strategies are designed to
   a. make the client feel better about him- or herself.
   b. help the individual fit better into his or her society.
   c. change the individual's functioning in some way.
   d. educate the person without interfering with his or her usual patterns of behavior.
   e. utilize medication in arriving at a final therapy.
2. While professionals with somewhat different training and orientations can provide similar forms of therapy in which all of the following groups are trained practitioners, only _____ on the list below are qualified to prescribe medications for the treatment of mental or behavioral disorders.
   a. neuropharmacologists
   b. psychiatric social workers
   c. psychologists
   d. psychotherapists
   e. psychiatrists
3. Because a central goal of the therapist is to guide a patient toward understanding the connections between past origins and present symptoms, psychodynamic therapy is a form of _____ therapy.
   a. insight
   b. cognitive
   c. behavior
   d. rational–emotive behavior
   e. group
4. Lola has an irrational fear of speaking in front of others. With the support of her instructor and her entire psychology class, Lola confronts her fear by standing alone in front of her classmates and talking about her phobia. This strategy of placing the individual in the dreaded situation is called
   a. exposure therapy.
   b. catharsis.
   c. insight therapy.
   d. social-learning therapy.
   e. group.
5. To teach his young daughter not to be afraid to swim, a father tells her to "Watch me!" as he wades into the surf, then rolls with the waves, and finally invites her to join him if she wants to try. In behavioral therapy, this technique is known as
   a. clinical ecology.
   b. counterconditioning.
   c. behavioral rehearsal.
   d. participant modeling.
   e. systematic desensitization.
6. A patient finds herself feeling personally fond of her therapist, who reminds her of her father. This is an example of the psychoanalytic process known as
   a. resistance.
   b. reaction formation.
   c. regression.
   d. negative transference.
   e. transference.
7. Which of the following problems might best be corrected through rational–emotive behavior therapy (REBT)?
   a. An addicted smoker wants to quit.
   b. A young man has an extreme fear of heights.
   c. An average-weight woman diets constantly, believing that she must be thin in order to have anyone love her.
   d. A patient complains of continual "voices" in his head telling him that people are trying to harm him.
   e. An elderly male has memory problems.
8. In recent years, psychotherapy research has found
   a. drugs to be more effective than cognitive–behavioral therapy.
   b. insight therapy to be more effective than behavioral therapy for most disorders.
   c. most mental problems to have their roots in unconscious motives or emotions.
   d. specific therapies that are highly effective for specific disorders.
   e. that nearly all individuals eventually "get better" with or without therapy.
9. Valium, a drug with a high "abuse potential," is classified as an _____ medication.
   a. antianxiety
   b. antidepressant
   c. antipsychotic
   d. antihistamine
   e. stimulant

10. Which of the following statements about electroconvulsive therapy (ECT) is true?
    a. Proper ECT applies a very strong electric current directly to a patient's brain without the need for sedatives or anesthetic medication.
    b. Some studies have found ECT to be effective in the treatment of severe depression.
    c. ECT is known to work by increasing the stimulation of a particular neurotransmitter in the brain.
    d. ECT works best with manic patients.
    e. ECT is a sure way to "cure" resistant depression.

ANSWERS: 1. c 2. e 3. a 4. a 5. d 6. b 7. c 8. d 9. a 10. b

KEY TERMS

Therapy (p. 524)
Psychological therapies (p. 529)
Biomedical therapies (p. 529)
Insight therapies (p. 531)
Talk therapies (p. 531)
Psychoanalysis (p. 532)
Analysis of transference (p. 533)
Neo-Freudian psychodynamic therapies (p. 533)
Humanistic therapies (p. 534)
Client-centered therapy (p. 534)
Reflection of feeling (p. 534)
Cognitive therapy (p. 536)
Group therapy (p. 536)
Self-help support groups (p. 537)
Behavior modification (p. 538)
Behavior therapy (p. 538)
Systematic desensitization (p. 539)
Exposure therapy (p. 540)
Aversion therapy (p. 540)
Contingency management (p. 541)
Token economy (p. 541)
Participant modeling (p. 542)
Cognitive–behavioral therapy (p. 542)
Rational–emotive behavior therapy (REBT) (p. 543)
Active listener (p. 548)
Psychopharmacology (p. 549)
Antipsychotic drugs (p. 550)
Tardive dyskinesia (p. 550)
Antidepressant drugs (p. 551)
Lithium carbonate (p. 551)
Antianxiety drugs (p. 552)
Stimulants (p. 552)
Attention-deficit/hyperactivity disorder (ADHD) (p. 552)
Psychosurgery (p. 553)
Electroconvulsive therapy (ECT) (p. 554)
Transcranial magnetic stimulation (TMS) (p. 555)
Therapeutic community (p. 555)
Deinstitutionalization (p. 556)
Community mental health movement (p. 556)

AP* REVIEW: VOCABULARY

Match each of the following vocabulary terms to its definition.

1. Psychoanalysis
2. Client-centered therapy
3. Cognitive therapy
4. Behavior therapy
5. Aversion therapy
6. Psychopharmacology
7. REBT
8. Antianxiety drugs
9. Stimulant

_____ **a.** This therapy is essentially based on operant and classical conditioning.

_____ **b.** This therapy involves the prescribed use of drugs to help treat symptoms of mental illness so that individuals are more receptive to talk therapies.

_____ **c.** This therapy emphasizes an individual's tendency for healthy psychological growth.

_____ **d.** This is the category of drugs that includes benzodiazepines and barbiturates.

_____ **e.** This type of therapy is based on Albert Ellis's form of cognitive therapy.

_____ **f.** The goal of this therapy is to release conflicts and memories from the unconscious.

_____ **g.** This therapy pairs an attractive stimulus with an aversive one in order to condition revulsion.

_____ **h.** Chemical compounds that increase activity level by encouraging communication among neurons in the brain.

_____ **i.** This therapy focuses on rational thinking as the key to treating mental disorders.

AP* REVIEW: ESSAY

Use your knowledge of the chapter concepts to answer the following essay question.

Compare and contrast the ways in which a psychopharmacologist and a rational–emotive behavior therapy (REBT) therapist would treat a patient with bipolar disorder. Be sure that your response addresses diagnosis, methodology, and differences between the two therapies.

OUR RECOMMENDED BOOKS AND VIDEOS

BOOKS

Beam, A. (2001). *Gracefully insane: The rise and fall of America's premier mental hospital.* New York: PublicAffairs. This is a history of McLean Hospital outside Boston, Massachusetts, the mental hospital equivalent of a luxury hotel, which over the years offered "spa" treatments and retreat for wealthier patients and celebrities, including author Sylvia Plath, poet Anne Sexton, musicians Ray Charles and James Taylor, and Susanna Kaysen of the memoir and movie *Girl, Interrupted,* about her two-year stay in McLean.

Berger, L., & Vuckovic, A. (1995). *Under observation: Life inside the McLean Psychiatric Hospital.* New York: Penguin Books. This vivid portrayal of life in psychiatric institutions is illustrated with case histories and the personal stories of patients who emerge not as characters but as real people, disturbingly familiar and similar to ourselves.

Davidson, J., & Dreher, H. (2003). *The anxiety book: Developing strength in the face of fear.* New York: Riverhead Books/Penguin. This guide to identifying the level and sources of your own anxiety assesses its impact on your life and discusses using cognitive techniques, physical exercise, and professional resources for treatment.

Hesley, J. W., & Hesley, J. G. (2001). *Rent two films and let's talk in the morning: Using popular movies in psychotherapy,* 2nd edition. New York: John Wiley & Sons. The authors offer a wonderful guide to using therapeutic "videowork" to get more out of feature films whose plots and messages provide information and imagery of psychological disorders and treatment.

VIDEOS

Analyze This. (1999, color, 103 min.). Directed by Harold Ramis; starring Robert DeNiro, Billy Crystal, Lisa Kudrow. This is a comedy about an arrogant mob boss, overwhelmed by emotional reactions to his "work," who insists on the help of a psychotherapist reluctant to hear his tale of criminal woe. A funny satire, with insights into the ethical challenges of therapy, this film is better than its lame 2002 sequel, *Analyze That.* (*Rating R*)

Good Will Hunting. (1997, color, 126 min.). Directed by Gus Van Sant; starring Matt Damon, Robin Williams, Ben Affleck. A troubled working-class youth—and mathematical genius—is helped by a renowned MIT professor and an offbeat psychologist (Williams in his Oscar-winning role) to confront his painful past and discipline his talents. (*Rating R*)

Spellbound. (1945, black-and-white, 111 min.). Directed by Alfred Hitchcock; starring Gregory Peck, Ingrid Bergman, Leo G. Carroll. The classic mystery concerns an amnesic who may or may not be a murderer, helped by the psychoanalyst with whom he has fallen in love. The surreal dream sequences were designed by artist Salvador Dali. (*No Rating*)

What About Bob? (1991, color, 99 min.). Directed by Frank Oz; starring Bill Murray, Richard Dreyfuss, Julie Hagerty. A professional psychiatric patient proves the undoing of a pompous psychiatrist, pursued by the needy, neurotic man to his family summer vacation—where the patient proceeds to charm everyone, clarifying the psychiatrist's own inabilities as a father and husband. The film is a sometimes disturbing comedy about the artificial barriers blocking the unique therapist–client relationship. (*Rating PG*)