Treatment of Psychological Disorders

CHAPTER 13

KEY TERMS

Trephining
Deinstitutionalization
Prevention
Psychotherapy
Freud's psychoanalysis
Free association
Dream analysis
Manifest content
Latent content
Resistance
Transference
Insight therapies
Humanistic therapies
Rogers' client or person-centered therapy
Unconditional positive regard
Active or reflective listening
Gestalt therapy
Existential therapies
Behaviorist therapies
Counterconditioning
Systematic desensitization
Anxiety hierarchy
Flooding
Aversive conditioning
Token economy
Cognitive therapies
Attributional style
Beck's cognitive therapy
Cognitive behavioral therapy (CBT)
Ellis' rational emotive behavior therapy (REBT)
Group therapies
Somatic therapies
Psychopharmacology
Antipsychotic drugs
Antidepressants
Antianxiety drugs
Electroconvulsive therapy (ECT)
Psychosurgery
Psychiatrists
Clinical psychologists
Counseling psychologists
Psychoanalysts

OVERVIEW

Just as there are many different views about the cause of mental disorders, many different beliefs exist about the appropriate way to treat psychological illness. All the methods of treatment, however, share a common purpose: to alter the client's behavior, thoughts, and/or feelings.

HISTORY

People have always suffered from psychological problems, but the attitudes toward and treatment of these people have changed dramatically. In many early societies, the mentally ill were seen as possessed by evil spirits. Archaeologists have unearthed

human skulls with regularly shaped holes that seem to have been purposefully made. Researchers theorize that the making of the holes, a process called *trephining* was an early form of treatment that was supposed to let the harmful spirits escape.

Although both Hippocrates, who lived in Ancient Greece circa 500 B.C., and Galen, who lived in Rome circa 200 A.D., posited that psychological illnesses were influenced by biological factors and could therefore be treated, Europeans during the Middle Ages returned to the belief that demons and spirits were the cause. Persecution, rather than treatment, usually resulted.

The Enlightenment led to a more sympathetic view. Leading the call to treat victims of mental illness more humanely at the turn of the nineteenth century were Philippe Pinel in France and Dorothea Dix in the United States. These reformers railed against a system that treated the mentally ill as if they were criminals, even caging and beating them. These two helped bring about the development of separate and kinder institutions for people with severe psychological disorders.

Several recent trends in the field of mental health in the United States must also be mentioned. Following the development of drugs in the 1950s that could moderate the effects of severe disorders, many people were released from mental institutions. This phenomenon, called *deinstitutionalization*, was intended to save money as well as benefit the former inpatients. Unfortunately, deinstitutionalization was far less successful than initially hoped. Once released, many of the former patients were unable to care for themselves. Their psychological needs were supposed to be met by local clinics on an outpatient basis. Many of the people released, however, were schizophrenics who ended up homeless and delusional, unable to secure the psychological or the financial care they needed.

Recently, in the United States, a growing emphasis has been placed on *preventative efforts*. If psychological problems can be treated proactively, or before they become severe, the suffering of the client as well as the cost of providing care can be reduced. Preventative efforts can be described as primary, secondary, or tertiary. *Primary prevention* efforts attempt to reduce the incidence of societal problems, such as joblessness or homelessness, that can give rise to mental health issues. *Secondary prevention* involves working with people at-risk for developing specific problems. One example would be counseling people who live in an area that has experienced a trauma such as a natural disaster or terrorist attack. Finally, *tertiary prevention* efforts aim to keep people's mental health issues from becoming more severe, for instance, working with earthquake survivors who are already suffering from an anxiety disorder in the hopes of preventing the disorder from becoming more severe.

TYPES OF THERAPY

Clearly, people's beliefs about effective treatment are grounded in their ideas about the cause of the problem. Psychoanalytic, humanistic, behavioral, and cognitive psychologists share a belief in the power of *psychotherapy* to treat mental disorders. On the other hand, psychologists who subscribe to a biomedical model assert that such problems require *somatic treatments* such as drugs. Psychotherapies, except for behavioral treatments, largely consist of talking to a psychologist. Behaviorists, as you know, believe that psychological problems result from the contingencies of

reinforcement to which a person has been exposed. Therefore, behavioral therapy focuses on changing these contingencies.

Both psychologists with a biomedical orientation and psychoanalysts generally refer to the people who come to them for help as *patients*. Other therapists, humanistic therapists in particular, prefer the term *clients*. In discussing the various types of therapy, we will follow these conventions.

HINT

Some students confuse psychotherapy, a general term used to describe any kind of therapy that treats the mind and not the body, with psychoanalysis, a specific kind of psychotherapy pioneered by Sigmund Freud.

Psychoanalytic Therapy

Psychoanalysis is a therapeutic technique developed by Freud. A patient undergoing psychoanalysis will usually lie on a couch while the therapist sits in a chair out of the patient's line of vision.

Psychoanalytic theorists view the cause of disorders as unconscious conflicts. As a result, their focus is on identifying the underlying cause of the problem. Psychoanalysts believe that other methods of therapy may succeed in ridding a client of a particular symptom but do not address the true problem. As a result, psychoanalysts assert that patients will suffer from *symptom substitution*. Symptom substitution is when, after a person is successfully treated for one psychological disorder, that person begins to experience a new psychological problem. Psychoanalytic therapists argue that a person's symptoms are the outward manifestations of deeper problems that can be cured only through analysis. Often, this approach entails a lengthy and therefore expensive course of therapy.

To delve into the unconscious minds of his patients, Freud developed a number of techniques including hypnosis, free association, and dream analysis. *Hypnosis*, as described in the chapter "States of Consciousness," is an altered state of consciousness. When in this state, psychoanalysts believe that people are less likely to repress troubling thoughts. More commonly, psychoanalysts ask patients to *free associate*—to say whatever comes to mind without thinking. This technique is based on the idea that we all constantly censor what we say, thereby allowing us to hide some of our thoughts from ourselves. If we force ourselves to say whatever pops into our minds, we are more likely to reveal clues about what is really bothering us by eluding the ego's defenses. When psychoanalysts use *dream analysis*, discussed further in Chapter 5, they ask their patients to describe their dreams. Again, since the ego's defenses are relaxed during sleep, they hope the dreams will help the therapist see what is at the root of the patient's problem.

All three of these techniques rely heavily on the *interpretations* of the therapists and are criticized for their inherent subjectivity. In dream analysis, what the patient reports is called the *manifest content* of the dream. What is really of interest to the analyst is the *latent* or hidden content. The latent content of the dream is revealed only as a result of the therapist's interpretive work.

Sometimes patients may disagree with their therapists' interpretations. Psychoanalysts may see such objections as signs of *resistance*. Since psychoanalysis can be a painful process of coming to terms with deeply repressed, troubling thoughts, people are thought to try to protect themselves through resistance. In fact, a particularly strongly voiced disagreement to an analyst's suggestion is often

viewed as an indication that the analyst is closing in on the source of the problem.

One final aspect of psychoanalysis involves *transference.* Transference is when, in the course of therapy, patients begin to have strong feelings toward their therapists. Patients may think they are in love with their therapists, may view their therapists as parental figures, or may seethe with hatred toward them. Psychoanalysts believe that, in the process of therapy, patients often redirect strong emotions felt toward people with whom they have had troubling relationships (often their parents) onto their therapists. Analysts try to interpret their patients' transference as a further technique to reveal the source of the problem.

As discussed earlier in this book, while strict adherents to Freudian theory are still known as psychoanalysts, many other psychologists have been influenced by Freud's work but have significantly modified his original theory. Such psychologists are known as *psychodynamic* theorists. While psychodynamic psychologists generally still see the unconscious as an important element in understanding a person's difficulties, they will be more likely to use a variety of techniques associated with other perspectives.

Psychoanalytic/psychodynamic treatments and the humanistic therapies that will be discussed in the next section are sometimes referred to as insight therapies. *Insight therapies* highlight the importance of the patients/clients gaining an understanding of their problems.

Humanistic Therapies

Humanistic therapies focus on helping people to understand and accept themselves, and strive to *self-actualize.* Self-actualization means to reach one's highest potential. Humanistic psychologists view it as a powerful motivational goal. Humanistic therapists operate from the belief that people are innately good and also possess *free will.* A belief that people have free will means that they are capable of controlling their own destinies. *Determinism* is the opposite belief. It holds that people have no influence over what happens to them and that their choices are predetermined by forces outside of their control. Humanistic psychologists' belief in human goodness and free will leads these psychologists to assert that if people are supported and helped to recognize their goals, they will move toward self-fulfillment.

One of the best known of humanistic therapists is Carl Rogers. Rogers created *client-centered therapy,* also known as *person-centered therapy.* This therapeutic method hinges on the therapist providing the client with what Rogers termed *unconditional positive regard.* Unconditional positive regard is blanket acceptance and support of a person regardless of what the person says or does. Rogers believes that unconditional positive regard is essential to healthy development. People who have not experienced it may come to see themselves in the negative ways that others have made them feel. By providing unconditional positive regard, humanistic therapists seek to help their clients accept and take responsibility for themselves.

In stark contrast to the cognitive therapies to be discussed later, client-centered therapy, and humanistic therapies in general, are *non-directive.* In other words, Rogerian therapists would not tell their clients what to do but, rather, would seek

to help the clients choose a course of action for themselves. Often, client-centered therapists say very little. They encourage the clients to talk a lot about how they feel and sometimes mirror back those feelings ("So what I'm hearing you say is . . .") to help clarify the feelings for the client. This technique is known as *active listening.*

Another type of humanistic therapy is *Gestalt therapy,* developed by Fritz Perls. As we have discussed, Gestalt psychologists emphasize the importance of the whole. These therapists encourage their clients to get in touch with their whole selves. For example, Gestalt therapists encourage their clients to explore feelings of which they may not be aware and emphasize the importance of body position and seemingly minute actions. These therapists want their clients to integrate all of their actions, feelings, and thoughts into a harmonious whole. Gestalt therapists also stress the importance of the present because one can best appreciate the totality of an experience as it occurs.

Existential therapies are humanistic therapies that focus on helping clients achieve a subjectively meaningful perception of their lives. Existential therapists see clients' difficulties as caused by the clients having lost or failed to develop a sense of their lives' purpose. Therefore, these therapists seek to support clients and help them formulate a vision of their lives as worthwhile.

Behavioral Therapies

Behaviorists believe that all behavior is learned. In Chapter 6, we discussed various ways that people learn including classical conditioning, operant conditioning, and modeling. Behaviorists base their therapies upon these same learning principles.

One such technique is *counterconditioning,* a kind of classical conditioning developed by Mary Cover Jones in which an unpleasant conditioned response is replaced with a pleasant one. For instance, suppose Charley is afraid of going to the doctor and cries hysterically as soon as he enters the doctor's office. His mother might attempt to replace the conditioned response of crying with contentment by bringing Charley's favorite snacks and toys with them every time they go to the office.

One behaviorist method of treatment involving counterconditioning has had considerable success in helping people with anxiety disorders, especially phobias. It was developed by Joseph Wolpe and is called *systematic desensitization.* This process involves teaching the client to replace the feelings of anxiety with *relaxation.* The first step in systematic desensitization is teaching the client to relax. A variety of techniques can be used such as breathing exercises and meditation. Next the therapist and client work together to construct what is called an anxiety hierarchy. An *anxiety hierarchy* is a rank-ordered list of what the client fears, starting with the least frightening and ending with the most frightening. In the process of *in vivo desensitization,* the client confronts the actual feared objects or situations, while in *covert desensitization,* the client imagines the fear-inducing stimuli.

Imagine that Penelope has gone to a therapist for help with her arachnophobia (fear of spiders) and that she elects to try covert desensitization. At the bottom of Penelope's anxiety hierarchy is looking at a photograph of a small spider in a maga-

zine while at the top is thinking of a number of larger, but harmless, spiders crawling all over her. Other possible steps in the anxiety hierarchy include imagining engaging in behaviors such as looking at a live spider in a tank, touching a live spider while wearing gloves, and allowing one small spider to crawl on her leg. Once Penelope has learned some relaxation techniques and constructed an anxiety hierarchy with the therapist, she can begin to use *counterconditioning* to replace her fear of spiders with relaxation.

The therapist will ask Penelope to relax and then will ask her to imagine the first step on the anxiety hierarchy. In this case, she imagines looking at a picture of a small spider in a magazine. When Penelope can accomplish this task without feeling fear, the therapist will ask her to imagine the second step on the anxiety hierarchy. Penelope will continue to climb up the hierarchy until she feels anxious. As soon as she experiences anxiety, the therapist will tell her to take a step back down on the hierarchy until she feels calm again. This process will continue throughout Penelope's sessions with the therapist until she feels no anxiety, even when reaching the top of the hierarchy. This process is effective because learning through classical conditioning is strengthened by repeated pairings. Thus, the more times relaxation is paired with the feared stimuli, the stronger the relaxation response becomes.

Another method of treating anxiety disorders that uses classical conditioning techniques is called *flooding*. Flooding, like systematic desensitization, can be in vivo or covert. Unlike the gradual process of systematic desensitization, flooding involves having the client address the most frightening scenario first. As one might expect, this technique produces tremendous anxiety. The idea, however, is that if clients face their fears and do not back down, they will soon realize that their fears are, in fact, irrational. In Penelope's case, if she were to begin by imagining that large spiders were crawling on her but that nothing bad was happening as a result, her fear would soon be *extinguished*.

Alternatively, Penelope's therapist could try to cure the phobia by using modeling. Modeling, as you will recall from Chapter 6, is a process through which one person learns by observing and then imitating the behavior of another. Unlike the other techniques described in this section, modeling is a melding of cognitive and behavioral ideas, but it makes sense to discuss it with systematic desensitization and flooding because all three are exposures therapies; all involve some degree of contact with the feared stimuli. Modeling could be used to treat Penelope's phobia by having her watch someone else interact calmly and without ill effect with various spiders and then asking her to reenact what she had witnessed. Modeling can also be used to help people with a host of other difficulties, as well.

Another way that classical conditioning techniques can be used to treat people is called *aversive conditioning*. This process involves pairing a habit a person wishes to break such as smoking or bed-wetting with an unpleasant stimulus such as electric shock or nausea.

Operant conditioning can also be used as a method of treatment. This process involves using rewards and/or punishments to modify a person's behavior. One form of instrumental conditioning used in mental institutions, schools, and even in some people's homes is called a *token economy*. In a token economy, desired behaviors are identified and rewarded with tokens. The tokens can then be exchanged for various objects or privileges.

Cognitive Therapies

As cognitive therapists locate the cause of psychological problems in the way people think, their methods of therapy concentrate on changing these unhealthy thought patterns. Cognitive therapy is often quite combative as therapists challenge the irrational thinking patterns of their clients. An example of an unhealthy way of thinking is to attribute all failures to internal, global, and permanent aspects of the self. Assume Josephine fails a psychology test. She can explain this failure in many ways. A pessimistic and unhealthy *attributional style* would involve thinking that she is an idiot who will fail all tests in all subjects all the time. A healthier attributional style would view the cause of the failure as external (the test was difficult), specific (this topic was particularly difficult), and temporary (she will do better next time).

Aaron Beck created *cognitive therapy*, a process most often employed in the treatment of depression. This method involves trying to get clients to engage in pursuits that will bring them success. This will alleviate the depression while also identifying and challenging the irrational ideas that cause their unhappiness. Beck explains depression using the *cognitive triad*, people's beliefs about themselves, their worlds, and their futures. People suffering from depression often have irrationally negative beliefs about all three of these areas. Cognitive therapy aims to make these beliefs more positive.

Cognitive Behavioral Therapies

One popular group of therapies combines the ideas and techniques of cognitive and behavioral psychologists. This approach to therapy is known as cognitive behavioral therapy or CBT.

An example of a specific type of CBT is *rational emotive behavior therapy* (also known as REBT and sometimes referred to as RET). REBT was developed by Albert Ellis. Therapists employing REBT look to expose and confront the dysfunctional thoughts of their clients. For instance, someone suffering from a social phobia might voice concern over being publicly embarrassed when giving a class presentation. By using REBT, a therapist would question both the likelihood of such embarrassment occurring and the impact that would result. The therapist's goal would be to show the client that not only is his or her failure an unlikely occurrence but that, even if it did occur, it would not be such a big deal.

Group Therapy

Psychotherapy can involve groups of people in addition to one-on-one client-therapist interactions. Therapists running groups can have any of the orientations described above or can be eclectic, as described in the last chapter. One common use of group therapy is in treating families. This form of treatment is known as *family therapy*. Since a client's problems do not occur in a vacuum, many therapists find meeting with the whole family helpful in revealing the patterns of interaction between family members and altering the behavior of the whole family rather than just one member.

Sometimes group therapy involves meeting with a number of people experiencing similar difficulties. Such an approach is less expensive for the clients and offers

them the insight and feedback of their peers in addition to that of the therapist. *Self-help groups* such as Alcoholics Anonymous (AA) are a form of group therapy that does not involve a therapist at all.

Somatic Therapies

Psychologists with a biomedical (biological) orientation, as mentioned earlier, see the cause of psychological disorders in organic causes. These include imbalances in neurotransmitters or hormones, structural abnormalities in the brain, or genetic predispositions that might underlie the other two. Therefore, these psychologists advocate the use of somatic therapies—therapies that produce bodily changes.

The most common type of somatic therapy is drug therapy or *psychopharmacology*, also known as *chemotherapy*. Drugs treat many kinds of psychological problems, ranging from anxiety disorders to mood disorders to schizophrenia. The more severe a disorder, the more likely that drugs will be used to treat it. Schizophrenia, for example, is almost always treated with drugs. A shortcoming of most kinds of psychotherapy is its limited use in dealing with patients unable to express themselves coherently. Since disordered thought is the primary symptom of schizophrenia, people suffering from this disorder overwhelmingly have difficulty communicating with others, thus rendering psychotherapy of limited use.

Schizophrenia is generally treated with *antipsychotic* drugs such as *Thorazine* or *Haldol*. These drugs generally function by blocking the receptor sites for dopamine. Their effectiveness therefore provides support for the dopamine hypothesis described in Chapter 12. An unfortunate side effect of antipsychotic medication is *tardive dyskinesia*, Parkinsonian-like, chronic muscle tremors.

Mood disorders often respond well to chemotherapy. The three most common kinds of drugs used to treat unipolar depression are *tricyclic antidepressants, monoamine oxidase (MAO) inhibitors*, and *serotonin-reuptake-inhibitor drugs* (most notably *Prozac*). All tend to increase the activity of serotonin, although tricyclics and MAO inhibitors seem to have wider effects. *Lithium*, a metal, is often used to treat the manic phase of bipolar disorder.

Anxiety disorders are also often treated with drugs. Essentially, these drugs act by depressing the activity of the central nervous system, thus making people feel more relaxed. Two main types of antianxiety drugs are *barbiturates*, such as *Miltown*, and *benzodiazepines*, including *Xanax* and *Valium*.

Table 13.1 lists the most common kinds of drugs used to treat many of the disorders discussed in Chapter 12.

Another kind of somatic therapy is *electroconvulsive therapy* (*ECT*). In bilateral ECT, electric current is passed through both hemispheres of the brain. Unilateral ECT involves running current through only one hemisphere. Bilateral ECT, although generally more effective, also has more significant negative side effects, most notably loss of memory. The electric shock causes patients to experience a brief seizure. Prior to administering ECT, patients are given a muscle relaxant to reduce the effects of the seizure. Usually, following the seizure, patients briefly lose consciousness. ECT is a less common treatment than chemotherapy. It is used, most often, for severe cases of depression after other methods have failed. Although the means by which ECT works is not completely understood, one theory suggests that the benefits are the result of a change in the brain's blood flow patterns.

TABLE 13.1

Chemotherapy

Type of Disorder	Type of Drug(s)
Anxiety disorders	Barbiturates, benzodiazepines
Unipolar depression	Monoamine oxidase (MAO) inhibitors, tricyclic antidepressants, serotonin-reuptake-inhibitors
Bipolar disorder	Lithium
Schizophrenia	Antipsychotics (neuroleptics)

The most intrusive and rarest form of somatic therapy is *psychosurgery*. Psychosurgery involves the purposeful destruction of part of the brain to alter a person's behavior. Clearly, such a procedure is used only as a last resort and only on people suffering to a great extent. An early, and unfortunately widespread, form of psychosurgery was the *prefrontal lobotomy*. This operation involved cutting the main neurons leading to the frontal lobe of the brain. Although this procedure often calmed the behavior of patients, it reduced their level of functioning and awareness to a vegetative state. Even today, when surgical procedures have grown much more precise, debate remains over the risks of psychosurgery, and such procedures are done as a last resort.

Eclectic Therapies

If you asked a therapist which of the preceeding orientations they use, you might hear something like: "It depends. I use what works." Many therapists do not exclusively use one type of therapy. Therapeutic orientations can be combined in effective ways. For example, cognitive behavioral therapies combine some of the techniques you read about in the cognitive and behavioral therapies sections. Research indicates that cognitive behavioral therapies can be particularly effective for some anxiety and some mood disorders. For example, to treat an anxiety disorder a therapist might combine a behavioral intervention, such as a systematic desensitization, with talk therapy that helps the client understand his or her unrealistic cognitions about the source of the anxiety.

Somatic cognitive therapy is another very common combination eclectic therapy. Many therapists combine drug therapy along with cognitive talk therapy for mood and other disorders. For example, a person diagnosed with unipolar depression might receive a prescription for one of the serotonin-reuptake inhibitor (SSRI) drugs, such as Prozac or Zoloft, while going through cognitive talk therapy to explore negative cognitions that might be contributing to his or her depression.

KINDS OF THERAPISTS

In addition to the different orientations discussed above, therapists have various levels and kinds of training.

- Psychiatrists are medical doctors and are therefore the only therapists permitted to prescribe medication in most U.S. states. Not surprisingly, because of their backgrounds, psychiatrists often favor a biomedical model of mental illness and are often less extensively trained in psychotherapy.
- Clinical psychologists earn doctoral degrees (Ph.D.s) that require four or more years of study. Part of their training involves an internship during which they are overseen by a more experienced professional. Clinical psychologists usually deal with people who are suffering from problems more severe than everyday difficulties with work or family.
- Counseling therapists or counseling psychotherapists typically have some kind of graduate degree in psychology. Their training also includes an internship overseen by a more experienced professional. Examples of counseling therapists include school psychologists and marriage and family therapists. Counseling therapists generally help people whose problems are less severe than those that bring people to clinical psychologists.
- Psychoanalysts are people specifically trained in Freudian methods. They may or may not hold medical degrees.

HOW EFFECTIVE IS THERAPY?

Although therapy is clearly not always successful and many people recover from a variety of disorders without any intervention, a number of studies have documented that therapy is generally effective. The success of the treatment process is also clearly affected by the relationship between client and therapist. Therefore, a person who has a bad experience with therapy with one therapist at one time might respond more positively to another practitioner in another situation.

Practice Questions

Directions: Each of the questions or incomplete statements below is followed by five suggested answers or completions. Select the one that is best in each case.

1. Which kind of therapist is most likely to analyze a client's dreams?

   (A) behaviorist
   (B) cognitive
   (C) humanistic
   (D) psychoanalytic
   (E) biomedical