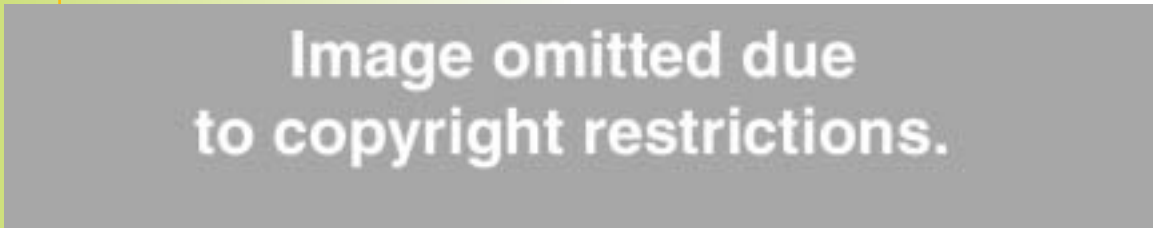
13 Therapies



If you read what is on the screen on the computer above, you, like many of us, have just been a voyeur on a chat line. Chat rooms are a 24-hour-a-day meeting place where you can talk to anyone about anything. It's no wonder then that many counsellors have started to offer their services online. But what about you? Are you a computer user? Do you use chat lines? Would you use an online counsellor?

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Some experts say that Web-based therapy is the wave of the future, but how does it stack up now? In a recent article, Rebecca Segall (2000) tried using several counsellors who offer their services on the Web. On the plus side was the potential for greater portability, greater accessibility, and more anonymity. Segall is a businesswoman who travels, but her computer goes wherever she goes. Having an online counsellor meant that she didn't have to be located in the same place, as traditional therapy would require, nor did she have to follow traditional office hours. She could contact a counsellor from any location at any time of day or night. She

also found that there was a large variety of services offered and that using her computer allowed her to store all her correspondence, which gave her a permanent written record that she could review at her convenience.

If this is sounding good, think again! Although there are lots of services advertised, the challenge of finding a qualified therapist is much greater online. You don't have physical access to these individuals, their diplomas, their office, or colleagues, which means that you do not have any tangible evidence of their qualifications. Because online services cross provincial and international boundaries, the standards that operate in your community do not necessarily affect the person you are contacting. That makes the search for a qualified practitioner quite a bit more challenging. Anyone can post a website. Anonymity works two ways on the Web–you can be whoever you want to be, and so can other people!

It's also good to remember that a therapist's understanding of what's happening to you is based on more than just what you say. He or she observes nonverbal communications as well. On the Web, it's only you and your words. And how comfortable are you spilling your heart out when you're not sure who else is reading your mail? Although some websites are secure, you always run the risk of undesired external parties looking in on your most personal exchanges. Finally, limitations of servers, system crashes, and other unforeseen technical problems also exist on the Web and can interfere with access to the counsellor.

Although online services may seem attractive on the surface, they have yet to be proven an effective method of therapy. In this chapter we will discuss a variety of recognized and well-researched therapies designed to treat psychological disorders.

Insight Therapies

What comes into your mind when you hear the word ***psychotherapy***? Many people picture a patient on a couch talking to a grey-haired, bearded therapist with a heavy accent. But that picture is hopelessly out of date, as you will see. **Psychotherapy** uses psychological rather than biological means to treat emotional and behavioural disorders; it usually involves a conversation between the client and the therapist. There are therapies for every trouble, techniques for every taste—over 450 different psychotherapies (Karasu, 1986). Today, the couch has generally been replaced by a comfortable chair. And psychotherapy is now relatively brief, averaging about 18 sessions, with private therapists, instead of years (Goode, 1987). Furthermore, modern psychotherapy is not completely dominated by men—more women are becoming therapists.

Some forms of psychotherapy are collectively referred to as **insight therapies** because their assumption is that our psychological well-being depends on self-understanding—understanding of our thoughts,

emotions, motives, behaviour, and coping mechanisms. The major insight therapies are psychoanalysis, person-centred therapy, existential therapy, and Gestalt therapy.

Psychodynamic Therapies: Freud Revisited

Freud proposed that the cause of psychological disorders lies in early childhood experiences and in unresolved, unconscious conflicts, usually of a sexual or aggressive nature. **Psychoanalysis** was the first formal psychotherapy, and it was the dominant influence on psychotherapy in the 1940s and 1950s (Garfield, 1981). The goals of psychoanalysis are to uncover repressed memories and to bring to consciousness the buried, unresolved conflicts believed to lie at the root of the person's problem.

Psychoanalysis: From the Couch of Freud

What are the four basic techniques of psychoanalysis, and how are they used to help disturbed patients?

Freudian psychoanalysis uses four basic techniques: free association, analysis of resistance, dream analysis, and analysis of transference.

FREE ASSOCIATION The central technique of psychoanalytic therapy is **free association**, in which the patient is instructed to reveal whatever thoughts, feelings, or images come to mind, no matter how embarrassing, terrible, or trivial they might seem. Freud believed that free assoc iation allows important unconscious material to surface—for example, repressed memories, threatening impulses, and traumatic episodes of childhood. The analyst pieces together the free-flowing associations, explains their meaning, and helps patients gain insight into the thoughts and behaviours that are troubling them.

ANALYSIS OF RESISTANCE How do you think you would react if an analyst told you to express *everything* that came into your mind? Would you try to avoid revealing certain painful or embarrassing thoughts? Freud's patients did, and he called this **resistance**.

If the patient hesitates, balks, or becomes visibly upset about any topic touched on, the analyst assumes that the topic is emotionally important to the patient. Freud also pointed out other forms of resistance, such as "forgetting" appointments with the analyst or arriving late.

DREAM ANALYSIS Freud believed that areas of emotional concern repressed in waking life are sometimes expressed in symbolic form in dreams. He believed that dreams convey hidden meanings and identify important repressed thoughts, memories, and emotions.

ANALYSIS OF TRANSFERENCE Freud said that at some point during psychoanalysis, the patient inevitably begins to react to the analyst with the same feelings and attitudes that were present in another significant

Freud's famous couch was used by his patients during psychoanalysis.

psychotherapy: The treatment for psychological disorders that uses psychological rather than biological means and primarily involves conversations between patient and therapist.

insight therapy: Any type of psychotherapy based on the notion that psychological well-being depends on self-understanding.

psychoanalysis (SY-ko-uh-NAL-ul-sis): The psychotherapy that uses free association, dream analysis, and analysis of resistance and transference to uncover repressed memories, impulses, and conflicts thought to cause psychological disorder.

free association: A psychoanalytic technique used to explore the unconscious; patients reveal whatever thoughts or images come to mind.

resistance: In psychoanalytic therapy, the patient's attempts to avoid expressing or revealing painful or embarrassing thoughts or feelings.

relationship—usually with the mother or father. This reaction he called **transference**. Transference allows the patient to relive or re-enact troubling experiences from the past with the analyst as parent substitute. The unresolved childhood conflicts can then be replayed in the present, this time with a parent figure who does not reject, provoke guilt, or punish as the actual parent did.

Psychodynamic Therapy Today: The New View

Traditional psychoanalysis can be a long and costly undertaking. Patients attend four or five therapy sessions per week for two to four years. In the mid-1980s, only about 2 percent of people undergoing psychotherapy chose classical psychoanalysis (Goode, 1987) and the numbers declined in the 1990s (Grünbaum, 1994). Psychoanalysis is most suitable for those with average or higher intelligence who are not severely disturbed, but who are interested in extensive self-exploration.

Many psychoanalysts practise brief psychodynamic therapy, which is also aimed at gaining insight into unconscious conflicts. The therapist and patient decide on the issues to explore at the outset rather than waiting for them to emerge in the course of treatment. The therapist assumes a more active role and places more emphasis on the present than is the case in traditional psychoanalysis (Davanloo, 1980). Brief psychodynamic therapy may require only one or two visits per week for as few as 12 to 20 weeks (Altshuler, 1989). In an analysis of 11 well-controlled studies, Crits-Christoph (1992) found brief psychodynamic therapy to be as effective as other kinds of psychotherapy.

Criticisms of Psychoanalytic Therapy

Traditional psychoanalysis has been criticized for its emphasis on the unconscious and the past and its virtual neglect of the conscious and the present. Moreover, the focus on unconscious motives as the major determinants of behaviour minimizes patients' responsibility for their behaviour and their choices. And from a practical standpoint, research does not suggest that the tremendous cost of psychoanalysis yields results that are superior to briefer, less costly therapy.

The Humanistic and Existential Therapies

Humanistic and existential therapies stand in stark contrast to psychoanalysis in that they are based on a more optimistic and hopeful picture of human nature and human potential. Individuals are viewed as unique and basically self-determining, with the ability and freedom to lead rational lives and make rational choices. Humanistic and existential therapists encourage personal growth; they seek to teach clients how to fulfill their potential and take responsibility for their behaviour and for what they become in life. The focus is primarily on current relationships and experiences.

LINK IT!

ahpweb.org/index.html
Association for Humanistic Psychology Home Page

Person-Centred Therapy: The Patient Becomes the Person

What is the role of the therapist in person-centred therapy?

Person-centred therapy, developed by Carl Rogers (1951), is based on the humanistic view of human nature. According to this view, people are innately good and, if allowed to develop naturally, will grow toward **self-actualization** (the realization of their inner potential).

If people grow naturally toward self-actualization, then why is everyone not self-actualized? The humanistic perspective suggests that psychological disorders result when a person's natural tendency toward self-actualization is blocked. Rogers (1959) insisted that individuals block their natural tendency toward growth and self-actualization when they act in ways

Carl Rogers (at upper right) facilitates discussion in a therapy group.

that are inconsistent with their true self in order to gain the positive regard of others.

In person-centred therapy, the focus is on conscious thoughts and feelings. The therapist attempts to create a warm, accepting climate in which clients are free to be themselves so that their natural tendency toward growth can be released. Person-centred therapy is a **non-directive therapy**. The direction of the therapy sessions is controlled by the client. The therapist acts as a facilitator of growth, giving understanding, support, and encouragement rather than proposing solutions, answering questions, or actively directing the course of therapy. Rogers rejected all forms of therapy that casts the therapist in the role of expert and clients in the role of patients who expect the therapist to tell them something or prescribe something that "cures" their problem.

According to Rogers, only three things are required of therapists. First, the therapist must have **unconditional positive regard** for, or total acceptance of, the client, regardless of the client's feelings, thoughts, or behaviour. In such an atmosphere, clients feel free to reveal their weakest points, relax their defences, and begin to accept and value themselves. Second, the therapist's feelings toward the client must be genuine—no façade, no putting up a professional front. Third, therapists must have empathy with the client—that is, they must be able to put themselves in the client's place. Therapists must show that they comprehend the client's feelings, emotions, and experiences, and that they understand and see the client's world as the client sees it. When clients speak, the therapist follows by restating or reflecting back their ideas and feelings. In this way clients begin to see themselves more clearly; eventually, they resolve their own conflicts and make positive decisions about their lives.

In the 1940s and 1950s, person-centred therapy was the only psychotherapy, other than psychoanalysis, with any following among psychologists. In the early 1980s a survey of 400 psychologists and counsellors revealed that Rogers was the most influential figure in counselling and psychotherapy (Smith, 1982).

Existential Therapy: Finding Meaning in Life

Existential therapy helps people to deal with the issues that are part of the human condition—to find meaning in life, to find values that are worth living and even dying for. The existential point of view tries to deal with alienation: the feeling that we are disconnected from the rest of the world, that we don't fit in, that we are lonely and stand apart.

The existential therapist stresses that we have both the freedom and the responsibility to choose the kind of person we want to become. Because each of us is unique, we must find our own personal meaning in our existence.

Gestalt Therapy: Getting in Touch with Your Feelings

What is the major emphasis in Gestalt therapy?

Gestalt therapy, developed by Fritz Perls (1969), emphasizes the importance of clients' fully experiencing, in the present moment, their feelings, thoughts, and actions, and then taking responsibility for both their feelings and their behaviour. Perls maintains that many of us block out aspects of our experience and are often not aware of how we really feel.

Gestalt therapy is a **directive therapy**, one in which the therapist takes an active role in determin-

transference: An intense emotional situation occurring in psychoanalysis when one comes to behave toward the analyst as one had behaved toward a significant figure from the past.

person-centred therapy: A non-directive, humanistic therapy in which the therapist creates a warm, accepting atmosphere, thus freeing clients to be themselves and releasing their natural tendency toward positive growth; developed by Carl Rogers.

self-actualization: Developing to one's fullest potential.

non-directive therapy: An approach in which the therapist acts to facilitate growth, giving understanding and support rather than proposing solutions, answering questions, or actively directing the course of therapy.

unconditional positive regard: A condition required of person-centred therapists, involving a caring for and acceptance of clients regardless of their feelings, thoughts, or behaviour.

existential therapy: A therapy that places an emphasis on finding meaning in life.

Gestalt therapy: A therapy originated by Fritz Perls that emphasizes the importance of clients' fully experiencing, in the present moment, their feelings, thoughts, and actions and taking personal responsibility for their behaviour.

directive therapy: An approach to therapy in which the therapist takes an active role in determining the course of therapy sessions and provides answers and suggestions to the patient.

ing the course of therapy sessions. "Getting in touch with one's feelings" is an ever-present objective for those in Gestalt therapy. The therapist helps, prods, or badgers clients to experience their feelings as deeply and genuinely as possible and then admit responsibility for them.

Perls suggests that those of us who need therapy carry around a heavy load of unfinished business, which may be in the form of resentments or conflicts with parents, siblings, lovers, employers, or others. If not resolved, these conflicts are carried forward into our present relationships. One method of dealing with unfinished business is the "empty chair" technique, which is used to help clients express their true feelings about significant people in their lives. The client imagines, for example, that a wife, husband, father, mother, or friend sits in the empty chair. The client then proceeds to tell the "chair" what he or she truly feels about that person. Then the client trades places and sits in the empty chair and role-plays the imagined person's response to what the client has said.

The ultimate goal of Gestalt therapy is not merely to relieve symptoms. Rather, it is to help clients achieve a more integrated self and become more authentic and self-accepting. In addition, clients must learn to assume personal responsibility for their behaviour rather than blame society, past experiences, parents, or others.

LINK IT!

www.g-g.org/aagt
Association for the Advancement of Gestalt Therapy (AAGT) Home Page

Therapies Emphasizing Interaction with Others

Some therapies look not only at the individual's internal struggles but also at interpersonal relationships.

Interpersonal Therapy: Short Road to Recovery

What four problems commonly associated with major depression is interpersonal therapy designed to treat?

Interpersonal therapy (IPT) is a brief psychotherapy that has proven very effective in the treatment of depression (Elkin et al., 1989; Klerman et al., 1984). Interpersonal therapy is designed specifically to help patients cope with four types of problems commonly associated with major depression:

1. *Unusual or severe responses to the death of a loved one.* The therapist seeks to help the patient release strong negative feelings (e.g., guilt) and develop an active interest in the present.

Remember It! Psychodynamic, Humanistic, and Existential Therapies

1. In psychoanalysis the technique whereby a patient reveals every thought, idea, or image that comes to mind is called _____; the patient's attempt to avoid revealing certain thoughts is called _____.
   a. transference; resistance
   b. free association; transference
   c. revelation; transference
   d. free association; resistance
2. What is the directive therapy that emphasizes the importance of the client's fully experiencing, in the present moment, his or her thoughts, feelings, and actions?
   a. person-centred therapy
   b. Gestalt therapy
   c. existential therapy
   d. psychoanalytic therapy
3. What is the non-directive therapy developed by Carl Rogers in which the therapist creates a warm, accepting atmosphere so that the client's natural tendency toward positive change can be released?
   a. person-centred therapy
   b. Gestalt therapy
   c. existential therapy
   d. psychoanalytic therapy
4. Which therapy presumes that the causes of the patient's problems are repressed memories, impulses, and conflicts?
   a. person-centred therapy
   b. Gestalt therapy
   c. existential therapy
   d. psychoanalytic therapy

Answers: 1. d 2. b 3. a 4. d

2. *Interpersonal role disputes.* Depression is often associated with mutually incompatible expectations about roles or responsibilities between patients and their partners, children, parents, co-workers or employers. These may be a source of conflict, resentment, and even hostility. The therapist helps the patient to comprehend what is at stake for those involved and to explore options for bringing about change. If the problem involves a family member, it is often helpful for that person also to attend a therapy session.
3. *Difficulty in adjusting to role transitions such as divorce, career change, and retirement.* Role transitions may involve a loss, such as a life change resulting from an illness or injury or the loss of a job. Other role transitions involve positive events, such as marriage, a new baby, or a promotion. Patients are helped to see the change not as a threat but as a challenge and an opportunity for growth.
4. *Deficits in interpersonal skills.* Some people lack the skills to make friends and are unable to sustain intimate relationships. Through role-playing and analysis of the patient's communication style, the therapist tries to help the patient develop the interpersonal skills necessary to initiate and sustain relationships.

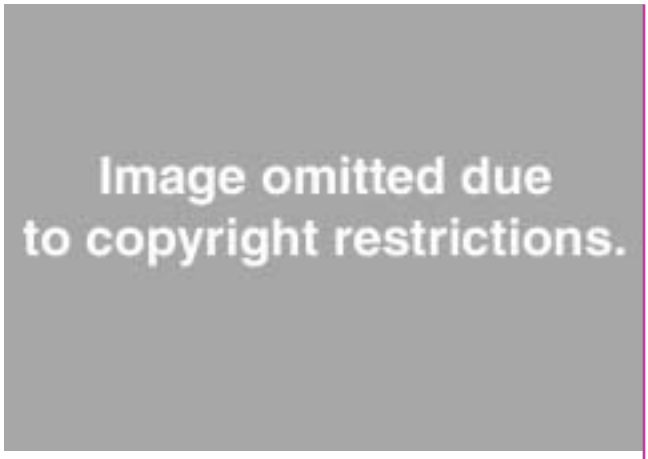
Interpersonal therapy is brief, consisting of 12 to 16 weekly sessions. A large study conducted in the United States by the National Institute of Mental Health found IPT to be effective even for severe depression and to have a low dropout rate (Elkin et al., 1989, 1995). Research also indicates that patients who recover from major depression can enjoy a longer period without relapse when they continue with monthly sessions of IPT (Frank et al., 1991).

Family and Marital Therapy: Healing Our Relationships

For most of us, the most significant group to which we will ever belong is the family. But even the strongest families sometimes have problems, and there are therapists of all types who specialize in treating troubled families. Families who come to therapists include those in which abuse is occurring and those with troubled or troublesome teenagers or alcoholic parents. In **family therapy**, parents and children enter therapy as a group with one therapist, or perhaps more (in conjoint therapy). As you can imagine, there are some things a family member may want to discuss privately with the therapist. Family therapists realize this and do not conduct every session with the entire family together. Sometimes they work with only one or a few family members at a time.

The therapist's goal is to help the family reach agreement on certain changes that will help heal the wounds of the family unit, improve communication patterns, and create more understanding and harmony.

Therapists who work with married couples help them resolve their difficulties and stay together; or ease the emotional turmoil if a breakup is the best answer for the couple. Dr. Donald Meichenbaum at the University of Waterloo has contributed greatly to our understanding of family therapy and, in addition, has developed a stress inoculation technique for handling anxiety (see Chapter 11).



Family and marital therapists pay attention to the dynamics of the family unit–how members communicate, act toward each other, and view each other.

interpersonal therapy (IPT): A brief psychotherapy designed to help depressed people understand their problems in interpersonal relationships and develop more effective ways to solve them.

family therapy: Therapy based on the assumption that an individual's problem is caused and/or maintained in part by problems within the family unit; the entire family is involved in therapy.

Group Therapy: Helping One at a Time, Together

What are some advantages of group therapy?

Besides being less expensive than individual therapy, **group therapy** has other advantages. It gives the individual a sense of belonging and an opportunity to express feelings, get feedback from other members, and give and receive help and emotional support. Discovering that others share their problems leaves individuals feeling less alone and ashamed. Most of the therapies we have discussed can be used in a group setting; others are designed primarily for a group.

Psychodrama, originated by J.L. Moreno (1959) in the mid-1950s, is a technique whereby one client acts out a problem situation or relationship with the assistance and participation of the other group members. Sometimes the client plays the part of the person who is a problem—a technique called "role reversal." In doing so he or she may gain some understanding of the other person's feelings. When group members act out their own frustrations and role-play the frustrations of others, they often gain insight into the nature of their problems and troublesome relationships.

Group Help of a Different Sort

Some people seek help for their problems from sources other than mental health professionals, through encounter groups and self-help groups.

ENCOUNTER GROUPS: WHERE ANYTHING GOES **Encounter groups** claim to promote personal growth and self-knowledge and to improve personal relationships through intense emotional encounters with other group members. Groups are composed of 10 to 20 people who meet with a leader or leaders over a period of several weeks or months. Encounter group participants are urged to express their true feelings about themselves and others. Not all exchanges are oral. Relating to others physically (i.e., touching, hugging) is also encouraged.

Some studies indicate that about one-third of encounter group participants benefit from the experience, one-third are unaffected, and one-third are harmed (Lieberman et al., 1973).

SELF-HELP GROUPS: LET'S DO IT OURSELVES Self-help groups are not usually led by professional therapists. They are simply groups of people who share a common problem and meet to support one another.

One of the oldest and best-known self-help groups is Alcoholics Anonymous, which is believed to have 1.5 million members worldwide (Hurley, 1988). Other self-help groups, patterned after AA, have been formed to help individuals overcome many other addictive behaviours—for example, Overeaters Anonymous, Gamblers Anonymous, and Cocaine Anonymous. There are self-help groups for people with a variety of physical and mental illnesses, and groups to help people deal with crises, from divorce and bereavement to victimization.

Self-help groups offer comfort because people can talk about their problems with others who have "been there." They can exchange useful information, discuss their coping strategies, and gain hope by seeing

Remember It!

Interpersonal Therapies

1. Which depressed person would be *least* likely to be helped by interpersonal therapy (IPT)?
   a. Kirk, who is unable to accept the death of his wife
   b. Martha, who has been depressed since she was forced to retire
   c. Sharon, who was sexually abused by her father
   d. Tony, who feels isolated and alone because he has difficulty making friends
2. All of the following are true of group therapy *except* that it
   a. allows individuals to get feedback from other members.
   b. allows individuals to receive help and support from other members.
   c. is not conducted by trained therapists.
   d. is less expensive than individual therapy.
3. Self-help groups are generally ineffective, because they are not led by professionals. (true/false)

Answers: 1. c 2. c 3. false

people who are coping with the same problems successfully (Galanter, 1988). Lieberman (1986), after reviewing a number of studies of self-help groups, concluded that the results tend to be positive. For problems such as alcoholism and obesity, self-help groups are often as effective as psychotherapy (Zilbergeld, 1986).

Behaviour Therapy: Unlearning the Old, Learning the New

What is behaviour therapy?

Behaviour therapy is a treatment approach associated with the learning perspective on psychological disorders—the perspective that holds that abnormal behaviour is learned. According to the behaviourists, unless people are suffering from some physiological disorder, such as brain pathology, those who seek therapy need it for one of two reasons: (1) they have learned inappropriate or maladaptive responses, or (2) they have never had the opportunity to learn appropriate behaviour in the first place. Instead of viewing the maladaptive behaviour as a symptom of some underlying disorder, the behaviour therapist sees the behaviour itself as the disorder. Thus, if a person comes to a therapist with a fear of flying, that fear of flying is seen as the problem.

Behaviour therapy applies the principles of operant conditioning, classical conditioning, and/or observational learning to eliminate inappropriate or maladaptive behaviours and replace them with more adaptive responses. Sometimes this approach is referred to as **behaviour modification.** The goal is to change the troublesome behaviour, not to change the individual's personality structure or to search for the origin of the problem behaviour. "Behaviour therapy is educational rather than 'healing' " (Thorpe & Olson, 1990, p. 15). The therapist's role is active and directive.

LINK IT!

www.aabt.org
Association for Advancement of Behavior Therapy (AABT)

Behaviour Modification Techniques Based on Operant Conditioning

How do behaviour therapists modify behaviour using operant conditioning techniques?

Behaviour modification techniques based on operant conditioning seek to control the consequences of behaviour. Undesirable behaviour is eliminated by withholding or removing reinforcement for the behaviour. If children are showing off to get attention, behaviour therapists may recommend ignoring the behaviour. If children are whining or having temper tantrums to get their way, therapists will try to make sure that the whining and temper tantrums do not pay off. As you have learned, behaviour that is not reinforced will eventually stop.

Behaviour therapists also seek to reinforce desirable behaviour in order to increase its frequency; and they use reinforcement to shape entirely new behaviours. The process works best when it is applied consistently. Institutional settings such as hospitals, prisons, and school classrooms lend themselves well to these techniques, because they provide a restricted environment in which the consequences (or contingencies) of behaviour can be more tightly controlled.

group therapy: A form of therapy in which several clients (usually between seven and ten) meet regularly with one or two therapists to resolve personal problems.

psychodrama: A group therapy in which one group member acts out a personal problem situation or relationship, assisted by other members, to gain insight into the problem.

encounter group: An intense emotional group experience designed to promote personal growth and self-knowledge; participants are encouraged to let down their defences and relate honestly and openly with one another.

behaviour therapy: A treatment approach that employs the principles of operant conditioning, classical conditioning, and/or observational learning theory to eliminate inappropriate or maladaptive behaviours and replace them with more adaptive responses.

behaviour modification: The systematic application of learning principles to help a person eliminate undesirable behaviours and/or acquire more adaptive behaviours; sometimes the term is used interchangeably with "behaviour therapy."

Token Economies: What Would You Do for a Token?

Some institutions use behaviour modification programs called **token economies** that reward appropriate behaviour with poker chips, play money, gold stars, and the like. These can later be exchanged for desired goods (candy, gum, cigarettes) and/or privileges (weekend passes, free time, participation in desirable activities). For decades, mental hospitals have used token economies with chronic schizophrenics to improve self-care skills and social interaction, with good results (Ayllon & Azrin, 1965, 1968). Patients tend to perform chores when reinforced, and not to perform them when not reinforced. Symptoms of schizophrenia such as delusions and hallucinations, of course, are not affected.

Time Out: All Alone with No Reinforcers

Another effective method used to eliminate undesirable behaviour, especially in children and adolescents, is **time out** (Brantner & Doherty, 1983). The principle is simple. Children are told in advance that if they engage in certain undesirable behaviours, they will be removed calmly from the situation and will have to pass a period of time (usually no more than 15 minutes) in a place containing no reinforcers (no television, books, toys, friends, and so on). Theoretically, the undesirable behaviour will stop if it is no longer followed by attention or any other positive reinforcers.

Stimulus Satiation: Too Much of a Good Thing

Another behaviour modification technique, **stimulus satiation**, attempts to change problem behaviours by giving people too much of whatever they find reinforcing. The idea is that the reinforcer will lose its attraction and become something to be avoided.

The Effectiveness of Operant Approaches: Do They Work?

Behaviour therapies based on operant conditioning have been particularly effective in modifying some behaviours of seriously disturbed individuals (Ayllon & Azrin, 1968; Paul & Lentz, 1977). Although these techniques do not presume to cure severe psychological disorders, they can increase the frequency of desirable behaviours and decrease the frequency of undesirable ones.

Behaviour modification techniques can also be used to break bad habits such as smoking and overeating, or to develop good habits such as a regular exercise regime. If you want to modify any of your behaviours, devise a reward system for desirable behaviours, and remember the principles of shaping. Reward gradual changes in the direction of your ultimate goal. If you are trying to develop better eating habits, don't try to change a lifetime of bad habits all at once. Begin with a small step such as substituting frozen yogurt for ice cream. Set realistic and achievable weekly goals.

Therapies Based on Classical Conditioning

What behaviour therapies are based on classical conditioning?

Some behaviour therapies are based mainly on the principles of classical conditioning, which can account for how we acquire many of our emotional reactions. In classical conditioning, a neutral stimulus—some object, person, or situation that initially does not elicit any strong positive or negative emotional reaction—is paired with either a very positive or a very negative stimulus. After conditioning, our strong feeling toward the positive or negative stimulus transfers to the original, neutral stimulus.

Therapies based on classical conditioning can be used to rid people of fears and other undesirable behaviours. We will discuss four types of therapy based primarily on classical conditioning: systematic desensitization, flooding, exposure and response prevention, and aversion therapy.

Systematic Desensitization: Overcoming Fears One Step at a Time

How do therapists use systematic desensitization to rid people of fears?

Have you ever been both afraid and relaxed at the same time? Psychiatrist Joseph Wolpe (1958, 1973) came to the conclusion that these two responses are incompatible—that is, one inhibits the other. On the basis of this, he developed a therapy to treat fears and phobias, reasoning that if he could get you to relax and *stay* relaxed while you thought about a feared object, person, place, or situation, you could conquer your fear or phobia.

In Wolpe's therapy, **systematic desensitization**, clients are trained in deep muscle relaxation. Then

they confront a hierarchy of anxiety-producing situations—either in real life or in their imagination—until they can remain relaxed even in the presence of the most feared situation. The therapy can be used for everything from fear of animals to acrophobia (fear of high places), claustrophobia (fear of enclosed places), test anxiety, and social and other situational fears.

What do you fear most? Many students would say that they fear speaking in front of a group. If that were your fear and you went to a behaviour therapist who used systematic desensitization, here is what she or he would have you do. First the therapist would ask you to identify the fear causing your anxiety and everything connected with it. Then all the aspects of the fear would be arranged in a hierarchy from least to most anxiety-producing.

After the hierarchy was prepared, you would be taught deep muscle relaxation—how to progressively relax parts of your body until you achieve a completely relaxed state. During the actual desensitization procedure, you would be asked to picture, as vividly as possible, the least fear-producing item on your hierarchy—for example, reading in the syllabus that the presentation will be assigned. Once you were able to remain relaxed while visualizing this item, the therapist would have you picture the next item—your professor assigning the oral presentation. This procedure would be followed until you were able to remain calm and relaxed while you vividly imagined the most fear-producing stimulus—actually making your presentation in class. If, during the desensitization process, anxiety crept in as you imagined items on the hierarchy, you would signal the therapist, who would instruct you to stop thinking about that item. You would then clear your mind, come back to a state of complete relaxation, and begin again. Try creating your own hierarchy in the next *Try It!*

How effective is systematic desensitization? Many experiments, demonstrations, and case reports confirm that it is highly successful in eliminating fears and phobias in a relatively short time (Kalish, 1981; Rachman & Wilson, 1980). It has proved effective for specific problems like test anxiety, stage fright, and anxiety related to sexual disorders such as impotence and frigidity.

Several other therapies used to treat phobias and obsessive-compulsive disorder use *exposure* as the key therapeutic element.

Try It!

Using Systematic Desensitization to Overcome Fear

Use what you have learned about systematic desensitization to create a step-by-step approach to help someone overcome a fear of making a class presentation. The person's hierarchy of fears begins with reading in the syllabus that an oral presentation will be assigned, and it culminates in actually making the oral presentation. Fill in the sequence of steps, according to a possible hierarchy of fears, that will lead to the final step. One possible solution appears here:

1. Being assigned the oral presentation and given a due date.
2. Preparing the oral presentation.
3. Practising the oral presentation one week before it is due.
4. Practising the oral presentation the night before it is due.
5. Waiting to give the presentation.
6. Walking to the front of the room to give the presentation.

token economy: A behavioural technique used to encourage desirable behaviours by reinforcing them with tokens that can be exchanged later for desired objects, activities, and/or privileges.

time out: A behavioural technique, used to decrease the frequency of undesirable behaviour, that involves withdrawing an individual from all reinforcement for a period of time.

stimulus satiation (say-she-A-shun): A behavioural technique in which a patient is given so much of a stimulus that it becomes something to avoid.

systematic desensitization: A behaviour therapy, used to treat phobias, that involves training clients in deep muscle relaxation and then having them confront a graduated series of anxiety-producing situations (real or imagined) until they can remain relaxed while confronting even the most feared situation.

Flooding: Confronting Our Fears All at Once

What is flooding?

Flooding is a behaviour therapy used in the treatment of phobias. Clients are exposed to the feared object or event (or asked to vividly imagine it) for an extended period until their anxiety decreases. Flooding is almost the opposite of systematic desensitization. The person is exposed to the fear all at once, not gradually and certainly not in a state of relaxation. A person with a fear of heights, for example, might have to go onto the roof of a tall building and remain there until the fear subsided.

The key to success is keeping the person in the feared situation long enough for it to become clear that none of the dreaded consequences actually come to pass (Marks, 1978). Flooding sessions typically last from 30 minutes to two hours and should not be terminated until patients are markedly less afraid than they were at the beginning of the session. It is rare for a patient to need more than six treatment sessions (Marshall & Segal, 1988).

Confronting the real object works faster and is more effective than simply imagining it, so this form of flooding should be used whenever possible (Chambless & Goldstein, 1979; Marks, 1972). Flooding may be quite painful for the patient. But flooding often works when other therapies have failed; and it works faster than other therapies, as you can see.

An acrophobic client wears a virtual-reality headset, which exposes him to the view from a high balcony (bottom) but allows him to experience moving toward or away from the railing. Such a realistic but safe exposure to the feared stimulus allows many people to overcome their phobias.

Exposure and Response Prevention: Cutting the Tie That Binds Fears and Rituals

How is exposure and response prevention used to treat people with obsessive-compulsive disorder?

Exposure and response prevention is a successful therapy for treating obsessive-compulsive disorder (Baer, 1996; Foa, 1995). The therapy consists of two components. The first involves *exposure*—patients are exposed to objects or situations they have been avoiding because they trigger obsessions and compulsive rituals. The second component is *response prevention*—patients agree to resist performing their compulsive rituals for progressively longer periods of time.

The therapist begins by identifying the thoughts, objects, or situations that trigger the compulsive ritual. For example, touching a doorknob, a piece of unwashed fruit, or garbage might ordinarily send people with a fear of contamination to the nearest bathroom to wash their hands. Patients are gradually exposed to stimuli that they find more and more distasteful and anxiety-provoking. They must agree not to perform the normal ritual (handwashing, bathing, or the like) for a specified period of time after exposure. Gradually, patients learn to tolerate the anxiety evoked by the various "contaminants." A typical treatment course—about 10 sessions over a period of three to seven weeks—can bring about considerable improvement in 60 to 70 percent of patients (Jenike, 1990).

Systematic desensitization, flooding, and exposure help people *stop* avoiding feared objects and situations. Even treatments using virtual reality as the

means of exposure have been successful (Carlin et al., 1997). But what type of therapy exists to help people *start* avoiding situations? The answer: aversion therapy.

Aversion Therapy: Making Us Sick to Make Us Better

How does aversion therapy rid people of a harmful or undesirable behaviour?

Aversion therapy rids clients of a harmful or socially undesirable behaviour by pairing that behaviour with a painful, sickening, or otherwise aversive stimulus. Electric shock, emetics (which cause nausea and vomiting), and other unpleasant stimuli are paired with the undesirable behaviour time after time until a strong negative association is formed and the person comes to avoid that behaviour, habit, or substance. Treatment continues until the bad habit loses its appeal because it has become associated with pain or discomfort.

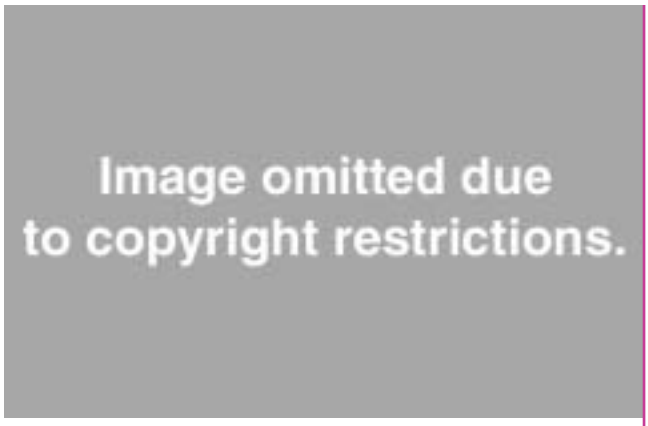
Alcoholics given a nausea-producing substance such as Antabuse (which reacts violently with alcohol) retch and vomit until their stomach is empty. Obviously the aversion therapist cannot show up at the alcoholic's house every morning with a bottle of Antabuse; however, nausea-based aversion therapy has produced abstinence rates of about 60 percent one year after treatment (Elkins, 1991; Parloff et al., 1986).

Therapies Based on Observational Learning: Just Watch This!

How does participant modelling help people overcome fears?

A great deal of what we learn in life, we learn from watching and then copying or imitating others. Much positive behaviour is learned this way; but so are bad habits, aggressive behaviours, and fears and phobias. Therapies derived from Albert Bandura's work on observational learning are based on the belief that people can overcome fears and acquire social skills through modelling.

For example, therapists have effectively treated fears and phobias by having clients watch a model (on film or in real life) responding to a feared situation in appropriate ways with no dreaded consequences. Usually the model approaches the feared object in gradual steps. Bandura (1967) describes how nursery school children lost their fear of dogs after watching a film showing a child who was not afraid of dogs first approaching a dog, then playing with it, petting it, and so on. Modelling films have been used to reduce the fears of children preparing for surgery (Melamed & Siegel, 1975) and to reduce children's fear of the dentist (Shaw & Thoresen, 1974).



Most simple phobias, such as a fear of snakes, can be extinguished after only a few hours of modelling therapy with client participation.

The most effective type of therapy based upon observational learning is **participant modelling** (Bandura, 1977a; Bandura et al., 1975, 1977). Here the model demonstrates the appropriate response in graduated steps; the client attempts to imitate the model step by step while the therapist gives encouragement and support. The client benefits by being exposed to the feared stimulus.

flooding: A behavioural therapy used to treat phobias; clients are exposed to the feared object or event (or asked to imagine it vividly) for an extended period until their anxiety decreases.

exposure and response prevention: A behaviour therapy that exposes obsessive-compulsive disorder patients to stimuli generating increasing anxiety; patients must agree not to carry out their normal rituals for a specified period of time after exposure.

aversion therapy: A behaviour therapy used to rid clients of a harmful or socially undesirable behaviour by pairing it with a painful, sickening, or otherwise aversive stimulus until the behaviour becomes associated with pain and discomfort.

participant modelling: A behaviour therapy in which an appropriate response is modelled in graduated steps and the client attempts each step, encouraged and supported by the therapist.

Remember It!

Behaviour Therapy

1. Behaviour therapy techniques that try to change behaviour by reinforcing desirable behaviour and removing reinforcers for undesirable behaviour are based on
   a. operant conditioning.
   b. observational learning.
   c. classical conditioning.
   d. modelling.
2. Behaviour therapies based on classical conditioning are used mainly to
   a. shape new, more appropriate behaviours.
   b. rid people of fears and undesirable behaviours or habits.
   c. promote development of social skills.
   d. demonstrate appropriate behaviours.
3. Exposure and response prevention is a treatment for people with
   a. panic disorder.
   b. phobias.
   c. generalized anxiety disorder.
   d. obsessive-compulsive disorder.
4. Match the description with the therapy.

   ____ 1) flooding
   ____ 2) aversion therapy
   ____ 3) systematic desensitization
   ____ 4) participant modelling

   a. practising deep muscle relaxation during gradual exposure to feared object
   b. associating painful or sickening stimuli with undesirable behaviour
   c. being exposed directly to the feared object without relaxation
   d. imitating a model responding appropriately in the feared situation

Answers: 1. a 2. b 3. d 4. 1) c 2) b 3) a 4) d

Most specific phobias can be extinguished in only three or four hours of modelling therapy. Participant modelling is more effective than simple observation for some specific phobias (Bandura et al., 1969).

Cognitive Therapies: It's the Thought That Counts

We have seen that behaviour therapies based on classical and operant conditioning and modelling are effective in eliminating many types of troublesome behaviour. What if the problem is not an observable, undesirable behaviour but is rather in our thinking, attitudes, beliefs, or self-concept? There are therapies for these problems as well. **Cognitive therapies** assume that maladaptive behaviour can result from irrational thoughts, beliefs, and ideas, which the therapist tries to change. When cognitive therapy is combined with behavioural techniques such as relaxation training or exposure, it is called cognitive-behavioural therapy.

The emphasis in cognitive therapies is on conscious rather than unconscious processes, and on the present rather than the past. We will explore two types of cognitive therapy—rational-emotive therapy and Beck's cognitive therapy.

LINK IT!

iacp.asu.edu
International Association for Cognitive Psychotherapy Home Page

Rational-Emotive Therapy: Human Misery—The Legacy of False Beliefs

What is the aim of rational-emotive therapy?

Picture this scenario: Harry received two free tickets to a Saturday night concert featuring his favourite group. Excited and looking forward to a great time on Saturday, Harry called Sally, whom he had dated a couple of times, to ask her to share the evening with him. But she turned him down with some lame excuse like "I have to do my laundry." He was stunned and humiliated. "How could she do this to me?" he wondered. As the week dragged on, he became more and more depressed.

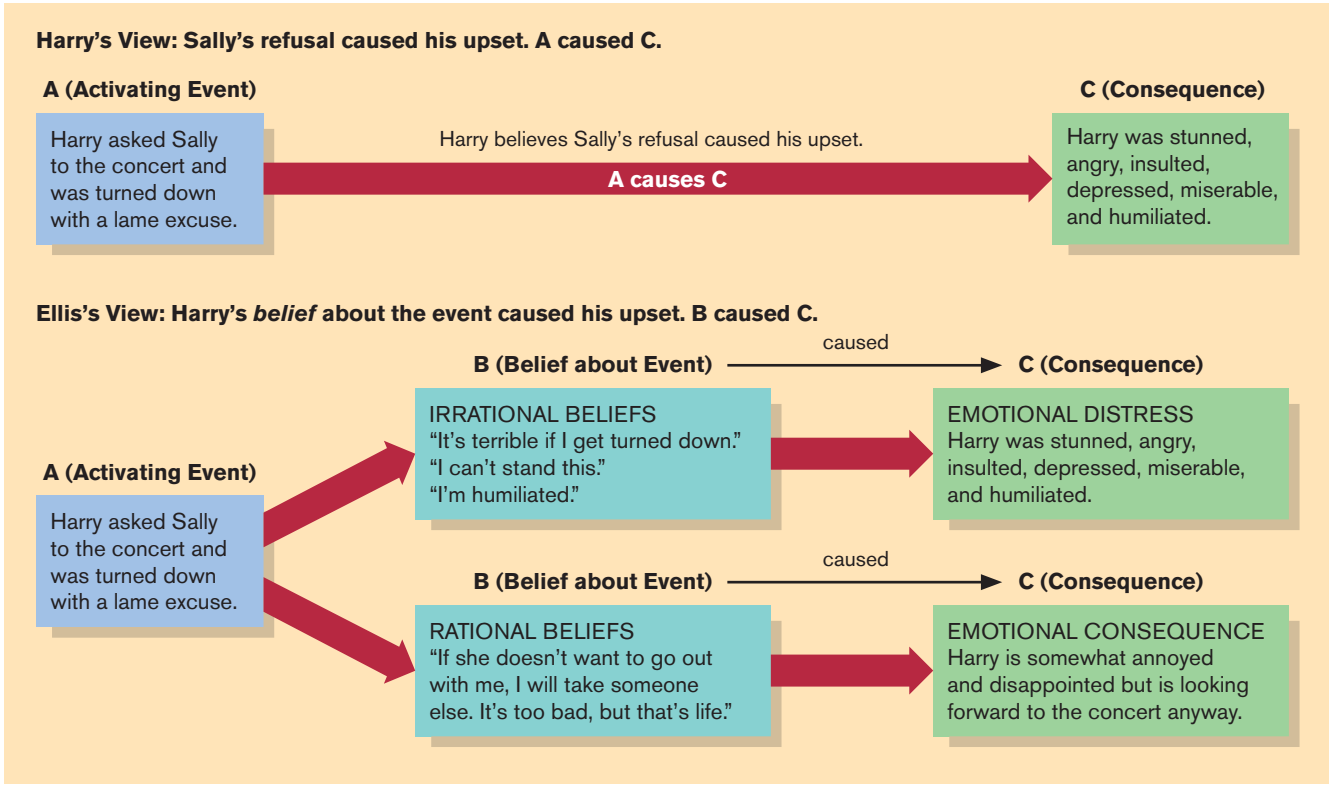


FIGURE 13.1

The ABCs of Albert Ellis's Rational-Emotive Therapy

Rational-emotive therapy teaches clients that it is not the activating event (A) that causes the upsetting consequences (C). Rather, it is the client's beliefs (B) about the activating event. Irrational beliefs cause emotional distress, according to Albert Ellis. Rational-emotive therapists help clients identify their irrational beliefs and replace them with rational ones.

What caused Harry's depression? Sally turning him down, right? Not according to Albert Ellis (1961, 1977, 1993), a clinical psychologist who developed **rational-emotive therapy** in the 1950s. Rational-emotive therapy is based on Ellis's ABC theory. A refers to the *activating* event, B to the person's *belief* about the event, and C to the emotional *consequence*. Ellis argues that it is not the event that causes the emotional consequence, but rather the person's belief about the event. In other words, A does not cause C; B causes C. If the belief is irrational, the emotional consequence can be extreme distress, as illustrated in Figure 13.1.

"Everyone should love me!" "I must be perfect!" Because reality does not conform to these and other irrational beliefs, people who hold them are doomed to frustration and unhappiness. Irrational beliefs cause people to view an undesirable event as a catastrophe rather than a disappointment or inconvenience; this leads them to say "I can't stand this," rather than "I don't like this." Irrational beliefs cause people to feel depressed, worthless, or enraged instead of simply disappointed or annoyed. To make matters worse, they go on to feel "anxious about their anxiety" and "depressed about their depression" (Ellis, 1987, p. 369).

Rational-emotive therapy is a directive, confrontational form of psychotherapy designed to challenge clients' irrational beliefs about themselves and

cognitive therapy: Any therapy designed to change maladaptive thoughts and behaviour, based on the assumption that maladaptive behaviour can result from one's irrational thoughts, beliefs, and ideas.

rational-emotive therapy: A directive, confrontational psychotherapy designed to challenge and modify the client's irrational beliefs, which are thought to cause their personal distress; developed by Albert Ellis.

others. As clients begin to replace irrational beliefs with rational ones, their emotional reactions become more appropriate, less distressing, and more likely to lead to constructive behaviour.

Try challenging an irrational belief of your own in the *Try It!*

Most clients in rational-emotive therapy are seen individually, once a week, for 5 to 50 sessions. In stark contrast to person-centred therapists (and most other therapists, for that matter), "rational-emotive therapists do not believe a warm relationship between counsellee and counsellor is a necessary or a sufficient condition for effective personality change" (Ellis, 1979, p. 186). In Ellis's view, "giving a client RET [rational-emotive therapy] with a good deal of warmth, approval and reassurance will tend to help this client 'feel better' rather than 'get better'" (p. 194).

One meta-analysis of 28 studies showed that patients receiving rational-emotive therapy did better than those receiving no treatment or a placebo, and about the same as those receiving systematic desensitization (Engles et al., 1993).

Try It!

Using Rational-Emotive Therapy

Use what you have learned about Albert Ellis's rational-emotive therapy to identify–and perhaps even eliminate–an irrational belief that *you* hold about yourself.

First, identify an irrational belief, preferably one that causes some stress in your life. For example, perhaps you feel that you must earn all A's in order to think of yourself as a good person.

Ask yourself the following questions, and write down your answers in as much detail as possible.

- Where does this belief come from? Can you identify the time in your life when it began?
- Why do you think this belief is true? What evidence can you provide that "proves" your belief?
- Can you think of any evidence to suggest that this belief is false? What evidence contradicts your belief? What people do you know who do not cling to this belief?
- How does holding this belief affect your life, both negatively and positively?
- How would your life be different if you stopped holding this belief? What would you do differently?

LINK IT!

rebt.org/index.html
Albert Ellis Institute

Beck's Cognitive Therapy: Overcoming "the Power of Negative Thinking"

How does Beck's cognitive therapy help people overcome depression and anxiety disorders?

"To be happy, I have to be successful in whatever I undertake."

"To be happy, I must be accepted (liked, admired) by all people at all times."

"If people disagree with me, it means they don't like me."

If you agree with all of these statements, you probably spend a good part of your time upset and unhappy. Psychiatrist Aaron T. Beck (1976) maintains that much of the misery of depressed and anxious people can be traced to **automatic thoughts**—unreasonable but unquestioned ideas that rule the person's life. Beck believes that depressed individuals hold "a negative view of the present, past, and future experiences" (1991, p. 369). They tend to view themselves as "deficient, defective, and/or undeserving"; their environment as "unduly demanding, depriving, and/or rejecting"; and their future as "without promise, value, or meaning" (Karasu, 1990a, p. 138). These people notice only negative, unpleasant things and

Aaron T. Beck

Remember It! Cognitive Therapies

1. Cognitive therapists believe that, for the most part, emotional disorders
   a. have physical causes.
   b. result from unconscious conflicts and motives.
   c. result from faulty and irrational thinking.
   d. result from environmental stimuli.
2. Rational-emotive therapy is a non-directive therapy that requires a warm, accepting therapist. (true/false)
3. The goal of Beck's cognitive therapy is best described as helping people
   a. develop effective coping strategies.
   b. replace automatic thoughts with more objective thoughts.
   c. develop an external locus of control.
   d. develop realistic goals and aspirations.
4. Beck's cognitive therapy has proved very successful in the treatment of
   a. depression and mania.
   b. schizophrenia.
   c. fears and phobias.
   d. anxiety disorders and depression.

Answers: 1. c 2. false 3. b 4. d

jump to upsetting conclusions. Anxious people expect the worst; they "catastrophize" and at the same time underestimate their ability to cope with situations.

The goal of **Beck's cognitive therapy** is to help patients stop their negative thoughts as they occur and replace them with more objective thoughts. The focus is on the present, not the past. No attempt is made to uncover hidden meanings in the patients' thoughts and responses. After challenging patients' irrational thoughts, the therapist sets up a plan and guides patients so that their own experience in the real world provides evidence to refute their false beliefs. Patients are given homework assignments, such as keeping track of automatic thoughts and the feelings evoked by them, and substituting more rational thoughts.

Beck's cognitive therapy is brief—usually only 10 to 20 sessions—and is therefore less expensive than many other types of therapy (Beck 1976). This therapy has been researched extensively and is reported to be highly successful in the treatment of mildly to moderately depressed patients (Antonuccio et al., 1995). There is some evidence that depressed people who have received Beck's cognitive therapy are less likely to relapse than those who have been treated with antidepressants (Scott, 1996).

Beck's cognitive therapy is also effective for generalized anxiety disorder (Beck, 1993), bulimia, and panic disorder (Barlow, 1997). An alternative to Beck's cognitive therapy was developed by University of Waterloo psychologist Donald Meichenbaum (1985). He proposed that individuals can be "inoculated" against negative events by being taught in advance to make positive and optimistic self-evaluations. In this way, the positive evaluations act as a buffer against negative experiences.

The Biological Therapies

What are the three main biological therapies?

Professionals who favour the biological perspective—the view that psychological disorders are symptoms of underlying physical disorders—usually favour a **biological therapy**. The three treatment categories in biological therapy are drug therapy, electroconvulsive therapy (ECT), and psychosurgery.

automatic thoughts: Unreasonable and unquestioned ideas that rule a person's life and lead to depression and anxiety.

Beck's cognitive therapy: A brief cognitive therapy for depression and anxiety, designed to help people recognize their automatic thoughts and replace them with more objective thoughts.

biological therapy: A therapy that is based on the assumption that most mental disorders have physical causes and that attempts to change or influence the biological mechanism involved (e.g., through drug therapy, ECT, or psychosurgery).

IT HAPPENED IN CANADA

Deinstitutionalization

In the 1960s, most psychiatric patients were placed in a hospital—usually a large psychiatric institution where they often resided for many years. Nowadays, however, many people who suffer from psychiatric problems are placed, as outpatients, in a group home, which is a semi-independent living arrangement; sometimes they may even be allowed to live completely on their own. This change is largely the result of *deinstitutionalization,* the effort by governments and health authorities to find alternatives to placing people in psychiatric institutions for long periods.

Thirty years ago there were almost 48 000 beds in Canadian psychiatric hospitals, whereas today there are fewer than 15 000. The move toward deinstitutionalization of psychiatric patients has, to a large extent, been made possible by our increased understanding of psychobiology, which has fundamentally changed the treatment of people diagnosed with psychiatric disorders. As we describe in this chapter, some psychiatric disorders can be regulated reasonably well with antipsychotic medications.

Many unresolved issues still remain regarding deinstitutionalization and the use of antipsychotic medications. For instance, antipsychotic drugs can have many side effects. In addition, psychiatric patients often feel they are "cured" and stop taking their medication. And too often, psychiatric patients find themselves without resources, out of work, and wandering the streets.

Clearly then, other forms of treatment, such as the many types of therapeutic interventions described in this chapter, can help psychiatric patients deal with the day-to-day pressures of their lives.

Drug Therapy: Pills for Psychological Ills

The favourite and by far the most frequently used biological treatment is drug therapy. A major breakthrough in drug therapy came in the mid-1950s, when antipsychotic drugs—sometimes called the major tranquilizers—began to be used to treat schizophrenia. In the late 1950s, antidepressants were discovered. Finally, in 1970, lithium, the miracle drug for bipolar disorder, was introduced into psychiatry (Snyder, 1984). Modern drug therapy is now capable of relieving the debilitating symptoms of schizophrenia, depression, bipolar disorder, and some anxiety disorders. This has had a tremendous impact on the treatment of psychological disorders.

Antipsychotic Drugs

How do antipsychotic drugs help schizophrenic patients?

Antipsychotic drugs, or *neuroleptics,* are prescribed mainly for schizophrenia to control severe psychotic symptoms, such as hallucinations, delusions, and other disorders in thinking. They are also effective in reducing restlessness, agitation, and excitement. You may have heard of these drugs under some of their brand names—Thorazine, Stelazine, Compazine, and Mellaril. These drugs apparently work by inhibiting the activity of the neurotransmitter dopamine. About 50 percent of patients have a good response to these drugs (Kane, 1996). However, even those patients who are helped by antipsychotics often stop taking them because of their very unpleasant side effects: causing restless pacing and fidgeting, muscle spasms and cramps, and a shuffling gait. Long-term use of antipsychotic drugs carries a high risk of the most severe side effect, *tardive dyskinesia.* Tardive dyskinesia involves almost continual twitching and jerking movements of the face and tongue, and squirming movements of the hands and trunk (Glazer et al., 1993).

Several newer "atypical" neuroleptics, such as asclozapine, help patients who have not benefitted from standard neuroleptics (Rosenheck et al., 1997). These drugs affect certain dopamine receptors differently than the standard neuroleptics, and they block serotonin receptors. Although it has fewer side effects it can cause a fatal blood defect for 1 to 2 percent of patients.

New drugs risperidone and olanzapine produce no fatalities and have fewer side effects than the standard antipsychotics (Casey, 1996). Risperidone is much more effective than the other antipsychotics in treating the negative symptoms of schizophrenia—apathy, emotional unresponsiveness, and social withdrawal (Marder, 1996).

While antipsychotic drugs help two-thirds of patients, they do not cure schizophrenia (Wolkin et al., 1989). Rather, they reduce and control many of the major symptoms so that patients can function. Most patients must continue to take them to keep the symptoms under control (Schooler et al., 1997).

Antidepressant Drugs

For what conditions are antidepressants prescribed?

Antidepressants work well as mood elevators for people who are severely depressed. They have also been helpful in the treatment of certain anxiety disorders.

Imbalances in the neurotransmitters serotonin and norepinephrine often accompany symptoms of depression. The *tricyclic antidepressants* (e.g., amitriptyline and imiprine, known as Elavil and Tofranil) are the drug treatment of first choice for major depression (Perry, 1996); they are effective for more than 60 percent of depressed patients (Karasu, 1990b). Tricyclics, however, can have some unpleasant side effects—sedation, dizziness, nervousness, fatigue, dry mouth, forgetfulness, and weight gain (Frazer, 1997). According to Noyes and colleagues, progressive weight gain—an average of more than 8.5 kilograms—is the main reason people stop taking tricyclics, in spite of the relief from distressing psychological symptoms (Noyes et al., 1989).

SEROTONIN-SELECTIVE REUPTAKE INHIBITORS (SSRIS)

Some more recently developed antidepressants, including Prozac, Zoloft, Paxil, and Anafranil, block the reuptake of serotonin, increasing its effect at the synapses (Goodwin, 1996). Prozac is one of the most widely used and is effective for less severe depression, (Avenoso, 1997; Nelson, 1991). It is also effective in the treatment of obsessive-compulsive disorder, which has been associated with a serotonin imbalance (Rapoport, 1989). Similar outcomes have been obtained with Zoloft and Paxil. In general, SSRIs have fewer side effects (Nelson, 1997) and are safer in overdose than tricyclics (Thase & Kupfer, 1996).

MONOAMINE OXIDASE INHIBITORS (MAO INHIBITORS)

Another line of treatment for depression is the monoamine oxidase inhibitors. By blocking the action of an enzyme that breaks down norepinephrine and serotonin in the synapses, MAO inhibitors increase the availability of norepinephrine and serotonin.

These drugs (e.g., Nardil and Marplan) are usually prescribed for depressed patients who do not respond to other antidepressants (Thase et al., 1992). They are also effective in treating panic disorder (Sheehan & Raj, 1988) and social phobia (Marshall et al., 1994). But MAO inhibitors have many of the same unpleasant side effects as tricyclic antidepressants, and patients taking MAO inhibitors must avoid certain foods or run the risk of stroke.

Lithium: A Natural Salt That Evens Moods

How does lithium help patients with bipolar disorder?

Lithium, a naturally occurring salt, is considered a wonder drug for 40 to 50 percent of patients with bipolar disorder (Thase & Kupfer, 1996). It is said to begin to calm the manic state within five to ten days. This is a noteworthy accomplishment, in that the average episode, if untreated, lasts between three and four months. The proper maintenance dose of lithium will usually even out the moods of the patient and reduce the number and severity of episodes of both mania and depression (Prien et al., 1984; Teuting et al., 1981). Patients who discontinue lithium are 6.3 times more likely to have a recurrence (Suppes et al., 1991). Careful and continuous monitoring of lithium levels in the patient's system is absolutely necessary to guard against lithium poisoning and permanent damage to the nervous system (Schou, 1989).

The Minor Tranquilizers

The minor tranquilizers known as *benzodiazepines* include Valium, Librium, and Xanax. Used primarily to treat anxiety, "benzodiazepines are the most widely prescribed class of psychoactive drugs in current therapeutic use" (Medina et al., 1993, p. 1; see also Famighetti, 1997).

Xanax is effective in treating panic disorder and works faster and has fewer side effects than antidepressants (Noyes et al., 1996). But there is a downside to Xanax: many patients, after they are panic-free, experience moderate to severe withdrawal symptoms, including severe anxiety, if they stop taking the drug (Otto et al., 1993).

Some Problems with Drug Therapy

What are some of the problems with drug therapy?

So far, one might conclude that drug therapy is the simplest and possibly the most effective way of treating schizophrenia, depression, panic disorder, and obsessive-compulsive disorder. There are, how-

antipsychotic drugs: Drugs used to control severe psychotic symptoms, such as the delusions and hallucinations of schizophrenics; also known as neuroleptics or major tranquilizers.

antidepressants: Drugs that are prescribed to treat depression and some anxiety disorders.

ever, a number of potential problems with the use of drugs. Antipsychotics and antidepressants have side effects that can be so unpleasant that many patients stop treatment before they have a reduction in symptoms.

Antipsychotics, antidepressants, and lithium do not cure psychological disorders, so patients usually experience a relapse if they stop taking the drugs when their symptoms lift. Maintenance doses of antidepressants following a major depression reduce the probability of recurrences (Prien & Kocsis, 1995). Maintenance doses are usually required with anxiety disorders as well, otherwise symptoms are likely to return (Ramussen et al., 1993).

The main problem with antidepressants is that they are relatively slow-acting. In addition, more often than not, depressed patients have to try several different antidepressants before finding one that is effective. A severely depressed patient needs at least two to six weeks to obtain relief, and 30 percent don't respond at all. This poses a risk for suicidal patients. If suicide is a danger, antidepressant drugs are not the treatment of choice.

Electroconvulsive Therapy: The Controversy Continues

For what purpose is electroconvulsive therapy (ECT) used, and what is its major side effect?

Electroconvulsive therapy (ECT), or electric shock, was widely used as a treatment for several mental disorders until the introduction of the antipsychotic and antidepressant drugs in the 1950s. ECT developed a bad reputation, partly because it was misused and overused in this country in the 1940s and 1950s. Often it was misused simply to make troublesome patients easier to handle. Some patients received hundreds of shock treatments. Today, electroconvulsive therapy is used mainly as a treatment for severe depression (Coryell, 1998). ECT has been found to result in marked improvement or remission in 80 percent of manic patients who have not been helped by lithium (Fink, 1997).

If you were to have electroconvulsive therapy, what could you expect? One or two electrodes would be placed on your head, and a mild electric current would be passed through your brain for one or two seconds. Immediately after the shock was administered, you would lose consciousness and experience a seizure lasting between 30 and 60 seconds. Apparently the seizure is necessary if ECT is to have any effect. The complete ECT procedure takes about five minutes. Medical complications following the procedure are said to be rare (Abrams, 1988). Usually there is no pain associated with the treatment, and patients have no memory of the experience when they wake up.

Although ECT can cut depression short, it is not a cure. Experts think that the seizure temporarily changes the biochemical balance in the brain, which in turn results in a lifting of depression.

The Side Effects of ECT

Some psychiatrists and neurologists have spoken out and written books and articles against the use of ECT, arguing that the procedure causes pervasive brain damage and memory loss (Breggin, 1979; Friedberg, 1976, 1977; Grimm, 1976). But advocates of ECT say that claims of brain damage are based on animal studies in which dosages of ECT were much higher than those now used in human patients (Devanand et al., 1994). No structural brain damage as a result of ECT has been revealed in studies in which MRI or CT scans were compared before and after a series of treatments (Devanand et al. 1994).

Even advocates of ECT acknowledge that there are side effects, the most disturbing of which is memory loss. The memory loss appears to result from a temporary disruption of memory consolidation that, in most cases, lasts for only a few weeks. Some patients have a spotty memory loss of events that happened before ECT (Sackeim et al., 1993; Squire, 1986). In a few patients the memory loss may last longer than six months (Sackeim, 1992).

A survey by the U.S. National Institute of Mental Health (1985) found that most psychiatrists believe that a legitimate place exists for ECT in the treatment of severely depressed patients who are suicidal or who have not been helped by any other therapy. In Canada, several position papers have been presented to the Canadian Psychiatric Association supporting the selective use of ECT. Psychologists Murray Enns and Jeffrey Reiss (1992) at the University of Manitoba reviewed the pros and cons of the procedure and also concluded that when used properly, ECT is a safe and effective treatment.

Remember It! Biological Therapies

1. For the most part, advocates of biological therapies assume that psychological disorders have a physical cause. (true/false)
2. Match the disorder with the drug most often used for its treatment.

____ 1)	panic disorder and agoraphobia	a.	lithium
____ 2)	schizophrenia	b.	antipsychotic
____ 3)	bipolar disorder	c.	antidepressant
____ 4)	depression		
____ 5)	obsessive-compulsive disorder		

3. Medication that relieves the symptoms of schizophrenia is thought to work by blocking the action of
   a. serotonin.
   b. dopamine.
   c. norepinephrine.
   d. epinephrine.
4. Which of the following statements concerning drug therapy for psychological disorders is false?
   a. It is often difficult to determine the proper dose.
   b. Drugs often have unpleasant side effects.
   c. Patients often relapse if they stop taking the drugs.
   d. Drugs are usually not very effective.
5. For which disorder is ECT typically used?
   a. severe depression
   b. schizophrenia
   c. anxiety disorders
   d. panic disorder
6. The major side effect of ECT is tardive dyskinesia. (true/false)
7. Psychosurgery techniques are now so precise that the exact effects of the surgery can be predicted in advance. (true/false)

Answers: 1. true 2. 1) c 2) b 3) a 4) c 5) c 3. b 4. d 5. a 6. false 7. false

Psychosurgery: Cutting to Cure

What is psychosurgery, and for what problems is it used?

An even more drastic procedure than ECT is **psychosurgery**—brain surgery performed strictly to alleviate serious psychological disorders, such as severe depression, severe anxiety, or obsessions, or to provide relief in some cases of unbearable chronic pain. Psychosurgery is not the same as brain surgery performed to correct a physical problem, such as a tumour or blood clot.

The first such surgical procedure for human patients was developed by Portuguese neurologist Egas Moniz in 1935 to treat severe phobias, anxiety, and obsessions. In his technique, the **lobotomy**, surgeons severed the frontal lobes and the deeper brain centres involved in emotion. No brain tissue was removed. At first the procedure was considered a tremendous contribution, and it won for Moniz the Nobel Prize in Medicine in 1949. Not everyone considered it a contribution, however: one of Moniz's lobotomized patients curtailed the surgeon's activities by shooting him in the spine, leaving him paralyzed on one side.

Neurosurgeons performed tens of thousands of frontal lobotomies throughout the world from 1935 until 1955. Although the surgery was effective in calming many patients, it often left them in a severely deteriorated condition. Apathy, impaired intellect, loss of motivation, and a change in personality kept many from resuming a normal life.

In the mid-1950s, when antipsychotic drugs came into use, psychosurgery virtually stopped. Since that time there has been a "second wave" of psychosurgical procedures; these are far less drastic than the lobotomies of decades past. In some of the most modern procedures, electric currents are delivered through

electroconvulsive therapy (ECT): A treatment in which an electric current is passed though the brain, causing a seizure; usually reserved for the severely depressed who are either suicidal or unresponsive to other treatment.

psychosurgery: Brain surgery to treat some severe, persistent, and debilitating psychological disorder or severe chronic pain.

lobotomy: A psychosurgery technique in which the nerve fibres connecting the frontal lobes to the deeper brain centres are severed.

electrodes to destroy a much smaller, more localized area of brain tissue. This results in less intellectual impairment than in conventional surgery. In one procedure, called a *cingulotomy*, electrodes are used to destroy the cingulum, a small bundle of nerves connecting the cortex to the emotion centres of the brain. The cingulotomy has been helpful in some extreme cases of obsessive-compulsive disorder (Greist, 1992; Jenike et al., 1991). For recent Canadian work in this area, read about Paul Derry in *On the Cutting Edge in Canada* in Chapter 2.

Even today, the results of psychosurgery are still not predictable and, for better or for worse, the consequences are irreversible. For this reason, psychosurgery is considered a treatment of absolutely last resort.

Therapies and Therapists: Many Choices

Evaluating the Therapies: Do They Work?

How effective is psychotherapy? Several researchers have attempted to determine whether therapy helps and which therapies are most effective. Most studies suggest that the average person who receives therapy is better off than those who do not (Lipsey & Wilson, 1993; Smith et al., 1980).

It also appears that the different types of therapy—behavioural, psychodynamic, and cognitive—are more or less equally effective. Moreover, neither the length of treatment nor the therapist's years of

REVIEW & REFLECT 13.1
Summary and Comparison of Major Approaches to Therapy

Type of Therapy	Perceived Cause of Disorder	Goals of Therapy	Methods Used	Primary Disorders Treated
Psychoanalysis	Unconscious sexual and aggressive urges or conflicts; fixations; weak ego.	Help patient bring disturbing, repressed material to consciousness and work through unconscious conflicts; strengthen ego functions.	Psychoanalyst analyzes and interprets dreams, free associations, resistances, and transference.	General feelings of unhappiness; unresolved problems from childhood.
Person-centred	Blocking of normal tendency toward self-actualization; incongruence between real and desired self; overdependence on positive regard of others.	Increase self-acceptance and self-understanding; help patient become more inner-directed; increase congruence between real and desired self; enhance personal growth.	Therapist shows empathy, unconditional positive regard, and reflects client's expressed feelings back to client.	General feelings of unhappiness; interpersonal genuineness, and problems.
Behaviour	Learning of maladaptive behaviours or failure to learn appropriate behaviours.	Extinguish maladaptive behaviours and replace with more adaptive ones; help patient acquire needed social skills.	Therapist uses methods based on classical and operant conditioning and modelling, which include systematic desensitization, flooding, exposure and response prevention, aversion therapy, and reinforcement.	Fears, phobias, panic disorder, obsessive-compulsive disorder, bad habits.
Cognitive	Irrational and negative assumptions and ideas about self and others.	Change faulty, irrational, and/or negative thinking.	Therapist helps client identify irrational and negative thinking and substitute rational thinking.	Depression, anxiety, panic disorder; general feelings of unhappiness.
Biological	Underlying physical disorder caused by structural or biochemical abnormality in the brain; genetic inheritance.	Eliminate or control biological cause of abnormal behaviour; restore balance of neurotransmitters.	Physician prescribes drugs such as antipsychotics, antidepressants, lithium, or tranquilizers; ECT, psychosurgery.	Schizophrenia, depression, bipolar disorder, anxiety disorders.

experience appeared to be related to the effectiveness of treatment (Smith et al., 1980).

These findings have led some researchers to suggest that it may be the strength of the relationship between the therapist and the patient that accounts for the effectiveness of treatment, rather than the specific techniques of the various therapies (Blatt et al., 1996; Krupnick et al., 1996). Perhaps the elements that are *common* to virtually all therapies (the patient–therapist relationship, "acceptance and support of the patient," "the opportunity to express emotions," and so on), rather than the ones that are different, account for success (Altshuler 1989, p. 311).

Read Review & Reflect 13.1, which summarizes the five major approaches to therapy.

Mental Health Professionals: How Do They Differ?

What different types of mental health professionals conduct psychotherapy?

Who are mental health professionals, and for what problems are their services most appropriate?

For serious psychological disorders, a clinical psychologist or psychiatrist is the best source of help. A **clinical psychologist**, who usually has a Ph.D. in clinical psychology, specializes in assessing, treating, and/or researching psychological problems and behavioural disturbances. Clinical psychologists use various types of psychotherapy to treat a variety of psychological disorders and adjustment problems.

A **psychiatrist** is a medical doctor with a specialty in the diagnosis and treatment of mental disorders. Psychiatrists can prescribe drugs and other biological treatments; many also provide psychotherapy. A **psychoanalyst** is usually (not always) a psychiatrist with specialized training in psychoanalysis from a psychoanalytic institute.

For clients with other psychological problems (such as substance abuse, marital or family problems, and adjustment disorders), the choice of mental health professionals widens. A *counselling psychologist* usually has a doctorate in clinical or counselling psychology, or a doctor of education degree with a major in counselling. A *counsellor* typically has a master's degree in psychology or counsellor education. Often employed by colleges and universities, counselling psychologists and counsellors help students with personal problems and/or test or counsel them in academic or vocational areas. A *psychiatric social worker* usually has a master's degree in social work with specialized training in psychiatric problems, and may practise psychotherapy. Read *Apply It!* to learn how to go about selecting a therapist.

Therapy and Race, Ethnicity, and Gender

Why is it important to consider multicultural variables in the therapeutic setting?

There is a growing awareness that psychotherapists need to consider multicultural variables such as race, ethnicity, and gender in diagnosing and treating psychological disorders (Bernal & Castro, 1994; Heilbron & Guttman, 2000; Hogan & Barlow, 2000). According to Kleinman and Cohen (1997), people experience and suffer from biological and psychological disorders within a cultural context in which the meaning of symptoms, outcomes, and responses to therapy may differ dramatically. When the cultures of the therapist and patient differ markedly, behaviour that is normal for the patient can be misinterpreted as abnormal by the therapist (Lewis-Fernandez & Kleinman, 1994). Cultural values, social class, and non-verbal communication (gestures, facial expressions) that differ across cultures can all hinder effective counselling (Sue, 1994). Race has also been associated with differential treatment, as has gender (Strakowski et al., 1995; Yonkers & Hamilton, 1995). Canadian awareness of these issues can be seen through the integration of culturally familiar forms of therapy. For an example, see the work on healing circles in *On The Cutting Edge in Canada*.

clinical psychologist: A psychologist, usually with a Ph.D., whose training is in the diagnosis, treatment, or research of psychological and behavioural disorders.

psychiatrist: A medical doctor with a specialty in the diagnosis and treatment of mental disorders.

psychoanalyst (SY-ko-AN-ul-ist): A professional, usually a psychiatrist, with special training in psychoanalysis.

on the cutting edge in canada

"Culture is Healing"

In most cases, alcohol and substance abuse can be "cured" with the right kind of support. For aboriginal people, the success rate with typical approaches has been very low. Rod McCormick, at the University of British Columbia, has conducted ongoing research with aboriginal populations that suggests that aboriginal people feel reluctant to acknowledge the need for therapy and, if they become involved in therapy, they often drop out early because typical Euro-Western treatments are not sensitive to their cultural values.

Although there are considerable differences among aboriginal groups, they share some similar beliefs about health and illness. These beliefs integrate the individual within the broader, family, community, and spiritual network. Within the aboriginal worldview, healing and spirituality are integrated, not separated. Mainstream approaches focus primarily on the individual, without addressing the broader context. McCormick, among others, has recently advocated for the re-introduction of traditional healing practices to facilitate reconnection to cultural values and traditions and to treat aboriginal clients within familiar contexts (McCormick, 2000). Review of outcomes where traditional healing practices have been introduced suggests that traditional healing circles and healing practices are desired (Wyrostock & Paulston, 2000) and successful (McCormick, 1997, 2000). As McCormick points out, for aboriginal people, connection to "culture is treatment" (2000, p. 30).

Remember It!

Selecting Therapies and Therapists

1. What is true regarding the effectiveness of therapies?
   a. All are equally effective for any disorder.
   b. Specific therapies have proved effective in treating particular disorders.
   c. Insight therapies are consistently best.
   d. Therapy is no more effective than no treatment for emotional and behavioural disorders.
2. One must have a medical degree to become a
   a. clinical psychologist.
   b. psychoanalyst.
   c. psychiatrist.
   d. clinical psychologist, psychiatrist, or psychoanalyst.
3. Match the problem with the most appropriate therapy.

   ____ 1) eliminating fears, bad habits
   ____ 2) schizophrenia
   ____ 3) general unhappiness, interpersonal problems
   ____ 4) severe depression

   a. behaviour therapy
   b. insight therapy
   c. drug therapy

Answers: 1. b 2. c 3. 1) a 2) c 3) b 4) c

Finding a Therapist

Apply It!

People are often embarrassed to seek professional help or are afraid that friends and relatives will think less of them if they do. Sometimes they are afraid of the therapy itself, or afraid that seeking help means there is something fundamentally wrong with them. There is no reason for such feelings. Going to a psychotherapist when you are feeling anxious or depressed is no different from going to a doctor when you are feeling sick. If you have a problem that has made you unhappy for a significant length of time, you should seek help—especially if you feel overwhelmed by your problem and your friends or relatives have suggested that you seek help.

There are times when you need the help of a trained professional. That person may be a psychiatrist, psychologist, social worker, or mental health counsellor.

Just as you wouldn't select a doctor or lawyer at random, you shouldn't just go to any therapist who happens to be nearby. Professional training and academic credentials are important, but they do not guarantee that you will receive high-quality treatment. A good place to start your search for a therapist is to ask family members, friends, your doctor, or your psychology professor for recommendations. Another place to look is the psychology department or counselling centre at your school or the psychiatry department of a local hospital or medical school. Also, many cities have community mental health centres and human service agencies that can provide recommendations. In addition, some companies have employee-assistance programs that offer counselling to employees or will refer them to an appropriate therapist.

In considering a particular therapist, you should ask about his or her educational background, supervised experience, types of therapy practised, length of treatment, and fees. The therapist must be professionally trained to listen in a supportive fashion and help you understand and interpret your thoughts and feelings. Bear in mind that in Canada there are no restrictions on the use of the title "therapist." People who call themselves therapists may not actually be qualified to provide the kind of therapy you need. You can usually find out about a therapist's credentials simply by asking. If you want to check further, you can contact the local branch of the Mental Health Association, which will be listed in the white pages of the phone book.

Take your time when choosing a therapist. A "good" therapist is one who is able to create an atmosphere of acceptance and empathy. Because the relationship between client and therapist is an extremely important ingredient of successful therapy, it is essential to have a therapist whom you trust. The first step is to arrange for a brief consultation. If, during that initial interview, you find that you do not feel comfortable with the therapist, you should say so. Usually the therapist will be willing to recommend someone else.

Private therapists receive fees for their services that are comparable to those received by doctors, dentists, and other professionals. Some health insurance plans cover those fees; others do not. If you have insurance that covers psychotherapy, check to make sure your policy covers the type of therapy you will be receiving. Also note any restrictions contained in the policy, such as limits on the number of sessions allowed.

Group therapy tends to be less expensive than individual therapy because the cost is shared among several people. You can also receive free or less expensive therapy at public facilities such as community mental health centres. These are usually supported by tax revenues. The services of a student counselling centre are usually provided free or at a low cost.

You may be concerned about confidentiality, but you need not be. Confidentiality is fundamental to the client–therapist relationship. However, there are some limits that should be explained to you in your first interview with the therapist.

Of course, what we said earlier about taking your time when choosing a therapist doesn't apply in a crisis. In such situations it is essential to get help immediately. In most communities you can call a hotline and receive counselling at any time, day or night. If the crisis is non-violent in nature, you can call a mental health centre or go to a hospital emergency room. If the crisis is more urgent—for example, if a friend is threatening to commit suicide—call the police.

KEY TERMS

antidepressants, p. 431
antipsychotic drugs, p. 430
automatic thoughts, p. 428
aversion therapy, p. 425
Beck's cognitive therapy, p. 429
behaviour modification, p. 421
behaviour therapy, p. 421
biological therapy, p. 429
clinical psychologist, p. 435
cognitive therapy, p. 426
directive therapy, p. 417
electroconvulsive therapy (ECT), p. 432
encounter group, p. 420
existential therapy, p. 417
exposure and response prevention, p. 424
family therapy, p. 419
flooding, p. 424
free association, p. 415
Gestalt therapy, p. 417
group therapy, p. 420
insight therapy, p. 414
interpersonal therapy (IPT), p. 418
lobotomy, p. 433
non-directive therapy, p. 417
participant modelling, p. 425
person-centred therapy, p. 416
psychiatrist, p. 435
psychoanalysis, p. 415
psychoanalyst, p. 435
psychodrama, p. 420
psychosurgery, p. 433
psychotherapy, p. 414
rational-emotive therapy, p. 427
resistance, p. 415
self-actualization, p. 416
stimulus satiation, p. 422
systematic desensitization, p. 423
time out, p. 422
token economy, p. 422
transference, p. 416
unconditional positive regard, p. 417

THINKING CRITICALLY

Evaluation

In your opinion, what are the major strengths and weaknesses of the following approaches to therapy: psychoanalysis, person-centred therapy, behaviour therapy, cognitive therapy, and drug therapy?

Point/Counterpoint

From what you have learned in this chapter, prepare a strong argument to support each of these positions:

a. Psychotherapy is generally superior to drug therapy in the treatment of psychological disorders.
b. Drug therapy is generally superior to psychotherapy in the treatment of psychological disorders.

Psychology in Your Life

What questions would you ask a therapist before beginning treatment?

SUMMARY & REVIEW

Insight Therapies

What are the four basic techniques of psychoanalysis, and how are they used to help disturbed patients?

The four basic techniques of psychoanalysis—free association, analysis of resistance, dream analysis, and analysis of transference—are used to uncover the repressed memories, impulses, and conflicts presumed to cause the patient's problems.

What is the role of the therapist in person-centred therapy?

Person-centred therapy is a non-directive therapy in which the therapist provides an atmosphere of unconditional positive regard. Clients are free to be themselves so that their natural tendency toward positive growth will be released.

What is the major emphasis in Gestalt therapy?

Gestalt therapy emphasizes the importance of clients' fully experiencing, in the present moment, their feelings, thoughts, and actions, and taking personal responsibility for their behaviour.

What four problems commonly associated with major depression is interpersonal therapy designed to treat?

Interpersonal therapy (IPT) is designed to help depressed patients cope with severe responses to the death of a loved one, interpersonal role disputes, difficulties in adjusting to role transitions, and deficits in interpersonal skills.

What are some advantages of group therapy?

Group therapy is less expensive than individual therapy and gives people an opportunity to express feelings and get feedback from other members, and to give and receive help and emotional support.

Behaviour Therapy: Unlearning the Old, Learning the New

What is behaviour therapy?

Behaviour therapy is a treatment approach that employs the principles of operant conditioning, classical conditioning, and/or observational learning theory to replace inappropriate or maladaptive behaviours with more adaptive responses.

How do behaviour therapists modify behaviour using operant conditioning techniques?

Operant conditioning techniques involve the withholding of reinforcement to eliminate undesirable behaviours, as in time out, or the use of reinforcement to shape or increase the frequency of desirable behaviours, as in token economies.

What behaviour therapies are based on classical conditioning?

Behaviour therapies based on classical conditioning are systematic desensitization, flooding, exposure and response prevention, and aversion therapy.

How do therapists use systematic desensitization to rid people of fears?

Therapists using systematic desensitization train clients in deep muscle relaxation and then have them confront a series of graduated anxiety-producing situations, either real or imagined, until they can remain relaxed in the presence of even the most feared situation.

What is flooding?

With flooding, clients are exposed to the feared object or event or asked to imagine it vividly for an extended period until their anxiety decreases and they realize that none of the dreaded consequences come to pass.

How is exposure and response prevention used to treat people with obsessive-compulsive disorder?

In exposure and response prevention, people with obsessive-compulsive disorder are exposed to the anxiety-generating stimuli but gradually increase the time before they begin their compulsive rituals. Thus, they learn to tolerate their anxiety.

How does aversion therapy rid people of a harmful or undesirable behaviour?

Aversion therapy pairs the unwanted behaviour with an aversive stimulus until the bad habit becomes associated with pain or discomfort.

How does participant modelling help people overcome fears?

In participant modelling, an appropriate response is modelled in graduated steps and the client is asked to imitate each step with the encouragement and support of the therapist.

Cognitive Therapies: It's the Thought That Counts

What is the aim of rational-emotive therapy?

Rational-emotive therapy is a directive form of therapy designed to challenge and modify the client's irrational beliefs, which are believed to cause personal distress.

How does Beck's cognitive therapy help people overcome depression and anxiety disorders?

Beck's cognitive therapy helps people overcome depression and anxiety disorders by pointing out irrational thoughts that are causing them misery and by helping them learn other, more realistic ways of looking at themselves and their experience.

The Biological Therapies

What are the three main biological therapies?

The three main biological therapies are drug therapy, ECT, and psychosurgery.

How do antipsychotic drugs help schizophrenic patients?

Antipsychotic drugs control the major symptoms of schizophrenia by inhibiting the activity of dopamine.

For what conditions are antidepressants prescribed?

Antidepressants are prescribed for depression, generalized anxiety disorder, panic disorder, agoraphobia, and obsessive-compulsive disorder.

How does lithium help patients with bipolar disorder?

Lithium is used to control the symptoms in a manic episode and to even out the mood swings in bipolar disorder.

What are some of the problems with drug therapy?

Some problems are the sometimes unpleasant or dangerous side effects, the difficulty in establishing the proper dosages, and the fact that a relapse is likely if the drug therapy is discontinued.

For what purpose is electroconvulsive therapy (ECT) used, and what is its major side effect?

ECT is a treatment of last resort for people with severe depression; it is most often reserved for those who are in imminent danger of committing suicide. Its major side effect is some memory loss.

What is psychosurgery, and for what problems is it used?

Psychosurgery is brain surgery performed strictly to relieve some severe, persistent, and debilitating psychological disorder; it is considered experimental and highly controversial.

Therapies and Therapists: Many Choices

What different types of mental health professionals conduct psychotherapy?

Professionals trained to conduct psychotherapy fall into the following categories: clinical psychologists, counselling psychologists, counsellors, psychiatrists, psychoanalysts, and psychiatric social workers.

Why is it important to consider multicultural variables in the therapeutic setting?

Multicultural variables such as race, ethnicity, and gender have a profound influence on patients' responses to the therapy and the therapist and on therapists' responses to patients.