

Chapter 12: Approaches to Treatment and Therapy

Chapter Overview

Learning Objectives

Chapter Outline

Additional Lecture Ideas

Prefrontal Lobotomies

The Role of Critical Thinking in Preventing Emotional Problems

Measuring the Effectiveness of Therapy

Ch-Ch-Ch-Changes

A Brief History of Convulsive Therapies

Additional Readings

In-Class Activities and Demonstrations Taking a Critical Look at Therapy

Comparing Treatment Approaches

Therapy Similarities and Differences

What Type of Psychotherapy?

Interviewing Mental Health Professionals

Handout Masters

Multimedia

World Wide Web

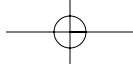
Films and Videos

Transparencies

LEARNING OBJECTIVES

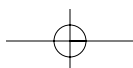
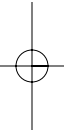
After studying this chapter, students should be able to answer the following questions:

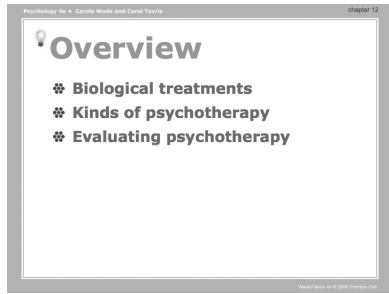
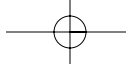
- 1) What are four general classes of drugs used to treat psychological disorders?
- 2) What are four cautions regarding drug treatments for psychological disorders?
- 3) What are the main differences between psychosurgery and electroconvulsive therapy?
- 4) What are the basic principles of psychodynamic therapy?
- 5) What are four main techniques of behavioral therapy?
- 6) What do behavioral and cognitive therapies generally focus on in the treatment of psychological disorders?
- 7) What are the basic principles of rational-emotive behavior therapy?
- 8) Why are client-centered therapy and existentialist therapy both representatives of the humanist approach to treatment?
- 9) How does the therapeutic alliance predict the successfulness of therapy outcomes?
- 10) What is the scientist-practitioner gap?
- 11) What evidence is there that therapy helps alleviate psychological disorders?
- 12) What are four ethical risks to clients in therapy?



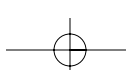
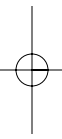
I. **BIOLOGICAL TREATMENTS**

- A. Biological (organic) approach regards mental disorders as diseases that can be treated medically



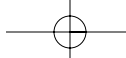


PPT 12-2



B. The question of drugs

1. Main classes of drugs used for treatment of mental and emotional disorders
 - a. Antipsychotic drugs or neuroleptics have transformed the treatment of schizophrenia and other psychoses
 - (1) Although they may lessen the most dramatic symptoms, they usually cannot restore normal thought patterns or relationships
 - (2) Allow people to be released from hospitals, but individuals may be unable to care for themselves or may stop taking medication
 - (3) Overall success is modest
 - b. Antidepressant drugs—used primarily to treat depression, anxiety, phobias, and obsessive-compulsive disorder—come in three classes:
 - (1) Monoamine oxidase (MAO) inhibitors—elevate levels of norepinephrine and serotonin by blocking or inhibiting the enzyme that deactivates these neurotransmitters



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Antipsychotic drugs

Many block or reduce sensitivity of dopamine receptors.

Some increase levels of serotonin, a neurotransmitter that inhibits dopamine activity

Can relieve positive symptoms of schizophrenia, but ineffective—or even worsen—negative symptoms

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Antidepressant drugs

Monoamine oxidase inhibitors (MAOI's)
Elevate norepinephrine and serotonin in brain by blocking an enzyme that deactivates these neurotransmitters

Tricyclic antidepressants
Boost norepinephrine and serotonin by preventing reuptake

Selective serotonin reuptake inhibitors (SSRI's)
Boost serotonin by preventing reuptake

Herbs such as St. John's Wort have also been used.

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Tranquilizers

Increase the activity of GABA

Developed for treatment of mild anxiety

Often prescribed inappropriately by general practitioners for any patient with mood complaints

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Lithium carbonate

Used to treat bipolar disorder

Moderates levels of norepinephrine by protecting cells from being overstimulated by neurotransmitter glutamate

Must be given in right dose, bloodstream levels monitored

Newer treatments include Tegetrol and Depakote.

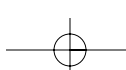
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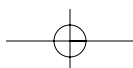
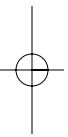
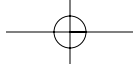
T92:
Drugs Used in the Treatment of Psychological Disorders

Learning Objective 12.1

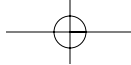
T89:
How SSRIs Work



- (2) Tricyclic antidepressants—also elevate levels of norepinephrine and serotonin, but by blocking reabsorption or “reuptake” of these neurotransmitters
 - (3) Selective serotonin reuptake inhibitors (SSRIs)—e.g., Prozac, specifically elevate levels of serotonin by preventing its reuptake
- c. Tranquilizers are often incorrectly prescribed for panic, anxiety, and unhappiness
- (1) These are the least effective drugs for above symptoms
 - (2) Many people develop problems with tolerance and withdrawal—in particular, cessation of Xanax can result in rebound panic attacks
- d. Lithium carbonate—prescribed for bipolar disorder; must be administered in the correct dose or can be dangerous



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2. Psychologists cannot currently prescribe drugs, but are lobbying for prescription privileges



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Your turn

Your friend has largely withdrawn from social activities, and has stopped maintaining her appearance or apartment. If she goes to see a doctor, what do you expect her doctor to prescribe?

1. An MAOI
2. An SSRI (e.g., Prozac)
3. A tranquilizer (e.g., Valium)
4. Lithium carbonate

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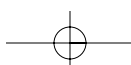
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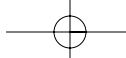
1. An MAOI
2. **An SSRI (e.g., Prozac)**
3. A tranquilizer (e.g., Valium)
4. Lithium carbonate

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3. Cautions about drugs
 - a. Placebo effects may account for much of the apparent effectiveness of drugs; recent evidence suggests that drugs are not very effective
 - b. High drop-out rates from side effects of drugs
 - c. People who take antidepressant drugs without learning how to cope with their problems are highly likely to relapse on discontinuing medication
 - d. Dosage problems—challenge is to find the therapeutic window (the amount that is enough, but not too much); race, gender, and age all influence dosage
 - e. Long-term risks
 - (1) Some drugs have known risks when taken long-term
 - (2) Long-term risks of taking other drugs, such as antidepressants, are not known
4. Because a disorder may have biological origins does not mean the only appropriate treatment is medical
5. There is considerable pressure for physicians to prescribe drugs as a result of pressure from drug companies and managed-care organizations



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Placebo effect

The apparent success of a treatment due to patient's expectation rather than the treatment itself

Meta-analysis indicates that clinicians consider medication helpful, yet patient ratings in treatment groups were no greater than those in placebo groups.

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High relapse and dropout rate

There may be short-term success, but 50-66% of patients stop taking medication due to side effects.

Individuals who take antidepressants without learning to cope with problems are more likely to relapse.

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Dosage problems

Finding the therapeutic window, the dosage that is enough but not too much

Drugs may be metabolized differently in Men and women
Old and young
Different ethnic groups

Appropriate dosage also affected by metabolic rates, amount of body fat, number and type of drug receptors in the brain, smoking, and eating habits.

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Long-term risks

Antipsychotic drugs can be dangerous, even fatal if taken for many years.
Tardive dyskinesia

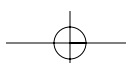
Antidepressants are assumed to be safe, but no long-term studies have been conducted.

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**Lecture Launchers:
Deinstitutionalization**

Learning Objective 12.2



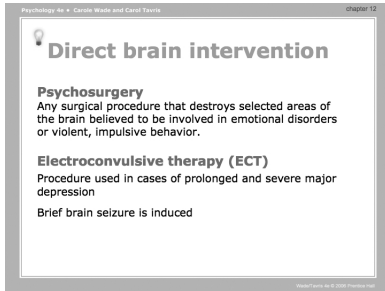
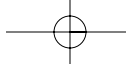
6. Many psychotherapies work as well or better and teach people how to cope

C. Direct brain intervention

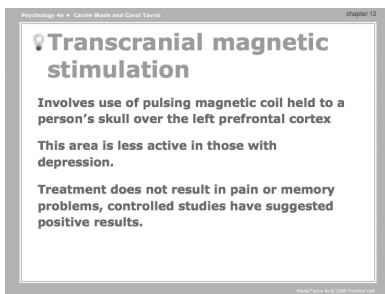
1. Psychosurgery—surgery to destroy selected areas of the brain thought to be responsible for emotional disorders
 - a. Most famous form of psychosurgery is the prefrontal lobotomy
 - (1) Never assessed scientifically
 - (2) Left patients with personality changes and/or unable to function
 - b. Rarely used today
2. Electroconvulsive therapy (ECT) or “shock therapy”
 - a. Used for treatment of the suicidally depressed, who cannot wait for antidepressants to take effect; not effective with other disorders
 - b. Critics claim that it is often used improperly and can cause brain damage

II. KINDS OF PSYCHOTHERAPY

- A. Common goal of psychotherapies—to help clients think about their lives in new ways and find solutions for problems that plague them



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PPT 12-14

Prefrontal Lobotomies

Learning Objective 12.3

A Brief History of Convulsive Therapies

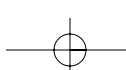
T86:
Major Schools of Therapy

Therapy Similarities and Differences

T87:
Orientations of Psychotherapists

T88:
Where People Turn for Help

What Type of Psychotherapy?

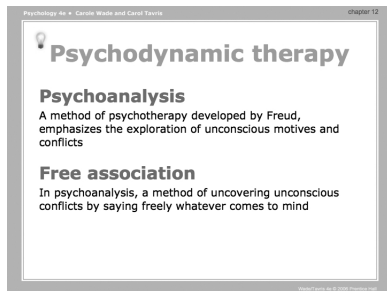
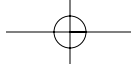


B. Psychodynamic therapy

1. Probes the past and the mind to produce insight and emotional release which eliminates symptoms
2. Freud's original method was called psychoanalysis—has evolved into psychodynamic therapies
3. Psychodynamic therapies considered “depth” therapies because they explore the unconscious by using techniques such as free association and transference
4. Does not aim to solve an individual's immediate problem
5. Many psychodynamic therapists use Freudian principles, but not methods
6. Brief psychodynamic therapy does not go into whole history, but focuses on main issue, as well as self-defeating habits and recurring problems

C. Behavior and cognitive therapy

1. Behavioral and cognitive therapies focus on changing current behavior and attitudes rather than striving for insight

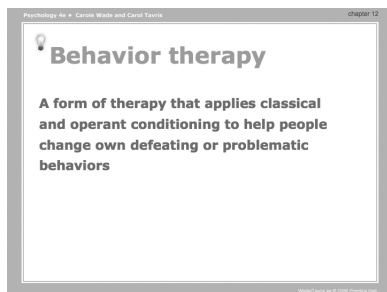


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PPT 12-16

Learning Objective 12.4

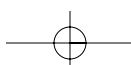


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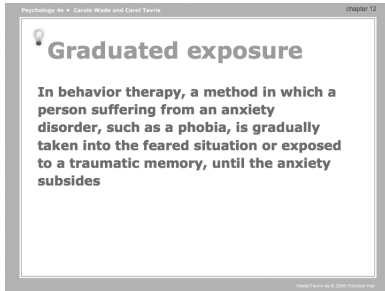
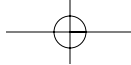
T91:
Behavior Therapy Techniques

PH Teaching Film:
Cognitive-Behavioral Therapy

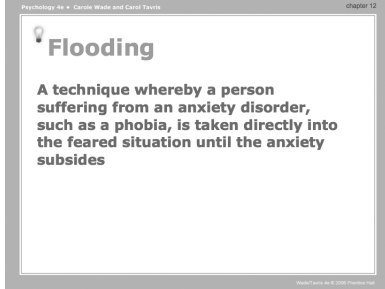
Learning Objective 12.5



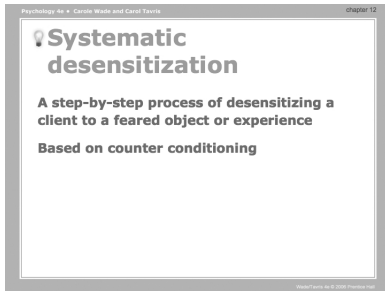
2. Behavioral techniques—derived from behavioral principles
 - a. Systematic desensitization—a step-by-step process of “desensitizing” a client to a feared object or experience; based on counterconditioning
 - b. Aversive conditioning—substitutes punishment for the reinforcement that has perpetuated a bad habit
 - c. Flooding or exposure treatments—therapist accompanies client into the feared situation
 - d. Behavioral records and contracts identify current unwanted behaviors and their reinforcers
 - e. Skills training—practice in specific acts needed to achieve goals



PPT 12-18



PPT 12-19

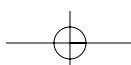


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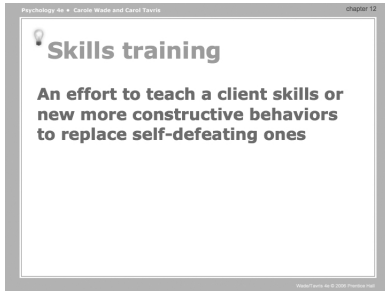
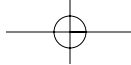


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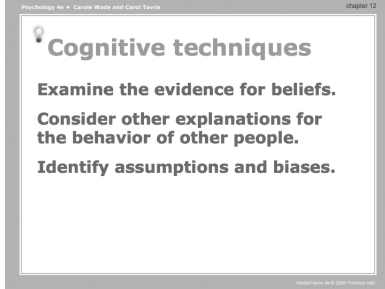
T90:
Aversion Therapy in the Treatment of Alcoholism



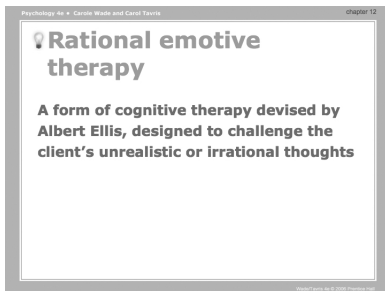
3. Cognitive techniques
 - a. Aim is to identify thoughts, beliefs, and expectations that might be prolonging a person's problems
 - b. Albert Ellis and Rational Emotive Behavior Therapy—therapist challenges illogical beliefs directly with rational arguments
 - c. Aaron Beck's approach encourages clients to test their beliefs against the evidence
4. Cognitive-behavior therapy—combines the above two approaches; most common treatment



PPT 12-22



PPT 12-23

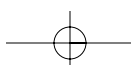
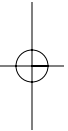


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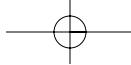
The Role of Critical Thinking in Preventing Emotional Problems

Learning Objective 12.6

Learning Objective 12.7



- D. Humanist and existential therapy**
1. Humanistic therapies—assume that people seek self-actualization and self-fulfillment
 2. Do not delve into the past; help people to feel better about themselves “here and now”
 3. Client-centered or nondirective therapy by Carl Rogers
 - a. Therapist offers unconditional positive regard to build self-esteem
 - b. No specific techniques, but therapists must be warm, genuine, and empathic; client adopts these views and becomes self-accepting
 4. Existential therapies—help clients explore the meaning of existence and utilize the power to choose a destiny and accept responsibility for their life predicament



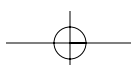
PPT 12–25



PPT 12–27

Video Classics: Carl Rogers on Therapy

Learning Objective 12.8

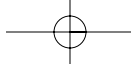


E. Family and couples therapy

1. Problems develop in a social context; therefore, the entire context (usually the family) is treated
2. Observing the family together reveals family tensions and imbalances in power and communication
3. Some use genograms—family tree of psychologically significant events—identifies repetitive patterns across generations
4. Family systems approach—recognizes that if one member in the family changes, the others must change too

F. Psychotherapy in practice

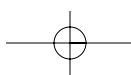
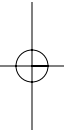
1. Most psychotherapists use techniques from different approaches
2. Group therapy
 - a. Clients learn that their problems are not unique
 - b. Often used in institutional settings, but also in other settings
 - c. Different from self-help or personal growth groups
3. A common process in all therapies is to replace self-defeating narratives or life stories with ones that are more hopeful and attainable

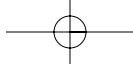


PPT 12-27



PPT 12-28

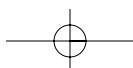
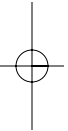


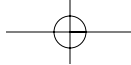


III. EVALUATING PSYCHOTHERAPY

A. The therapeutic alliance

1. Successful therapy depends on the bond between client and practitioner
 - a. Personality traits of the client contribute to this relationship
 - b. Cultural context contributes to this relationship





PPT 12–29

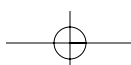


PPT 12–30

T93:
Duration of Therapy and Improvement

Interviewing Mental Health Professionals

Learning Objective 12.9

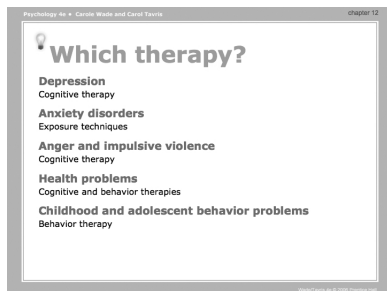


- B. The scientist-practitioner gap
 - 1. Conflict between scientists and practitioners about the relevance of research findings to clinical practice
 - a. Practitioners believe it is very difficult to study psychotherapy empirically
 - b. Scientists want the effectiveness of psychotherapy scientifically demonstrated
 - 2. Short-term treatment is usually sufficient
- C. Which therapy for which problem?
 - 1. Problems of assessing therapy
 - a. Placebo effect
 - b. Justification of effort principle
 - 2. Empirically validated treatments must meet stringent criteria
 - 3. For many specific problems and emotional disorders, behavioral and cognitive therapies are the method of choice—particularly effective for anxiety disorders, depression, health problems, and anger and impulsive violence
 - 4. “Depth therapies” may be more appropriate for less clearly defined therapeutic issues



PPT 12–31

Learning Objective 12.10



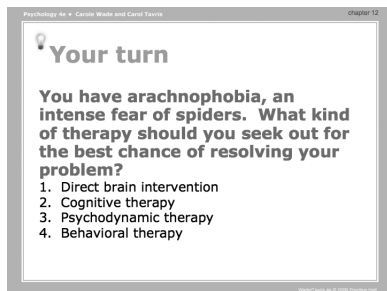
PPT 12–32

Measuring the Effectiveness of Therapy

Taking a Critical Look at Therapy

PH Teaching Film:
Obsessive-Compulsive Disorder

Learning Objective 12.11

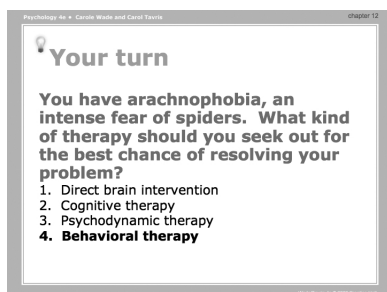


PPT 12–33

Comparing Treatment Approaches

PH Teaching Film:
9-11 PTSD Therapy

Ch-Ch-Ch-Changes



PPT 12–34

5. Cognitive-behavior therapies do not succeed well with personality disorders and psychoses, or people who are not motivated to carry out a cognitive and behavioral program
 6. Combined approaches
 - a. For certain problems, combinations of medication and psychotherapy work best
 - b. Other types of problems require use of a combination of psychotherapeutic approaches
- D. When therapy harms**
1. Coercion by the therapist to accept the therapist's advice, sexual intimacies, or other unethical behavior
 2. Bias on the part of a therapist who does not understand some aspect of the client
 3. Therapist-induced disorders—unconsciously inducing the client to produce the symptoms they are looking for

Taking Psychology with You: How to Evaluate Self-Help Groups and Books

Some primary benefits of self-help groups are the awareness that members are not alone, encouragement, and help in feeling better about themselves. Support groups offer understanding, empathy, and advice. They are different from psychotherapy in that they are not for those with serious psychological difficulties, are not regulated by law or professional standards, and vary widely in philosophies and methods. Some self-help books can be as effective as treatment administered by a therapist. Good self-help books: should be written by an author whose qualifications extend beyond personal experience; should provide advice based on sound scientific theories; should provide evidence of the program's effectiveness; should not promise the impossible; and should be organized in a systematic program.



PPT 12–35

PH Teaching Film:
Lost Daughter

Learning Objective 12.12

PH Teaching Film:
Psychotherapy Under Scrutiny

LECTURE SUGGESTIONS

Prefrontal Lobotomies

The doctor who developed the prefrontal lobotomy was given the Nobel Prize in Medicine. Yet, most students who have seen movies such as *One Flew Over the Cuckoo's Nest* consider the procedure to be absolutely barbaric and without any possible redeeming value. Use the above question to stimulate a class discussion on this topic. Since many students would answer "Yes" to this question, you can play the devil's advocate by presenting the following scenario:

Imagine that you are a doctor in a mental hospital in the late 1940s. Your mental hospital that was constructed to hold 700 patients now has over 1300 patients. Many of these are violent and need to be tied to their beds or kept in locked cells. The antipsychotic drugs will not be invented for another 5 or 10 years. Patients regularly attack one another and attack the attendants. Others run through the hallways screaming and yelling. You have one patient who has been in the hospital for 25 years and has been kept essentially in confinement. You hold no hope of recovery. However, you know that there is a therapeutic technique that will take only a half-hour, and if successful, will result in a large decrease of episodes of violent behavior in this patient. Again, if successful, the patient will appear to be much happier and more content with life. You also know that, for most patients receiving this procedure, there will be little difference in measurable IQ, and in fact, you know of no behavioral test that routinely shows any mental deficit from the procedure. Would you, as this patient's doctor, use this procedure or not?

When put into this context, most students begin to understand why prefrontal lobotomies were used as frequently as they were in the 1940s and 1950s. Most college students find it difficult to imagine a world in which there were no drugs that could be effectively used in place of procedures such as prefrontal lobotomy. Visiting a mental hospital today, it is difficult for most of us to imagine the general level of uproar and violence in the hospitals as recently as the 1940s.



The Role of Critical Thinking in Preventing Emotional Problems

Cognitive therapists feel that certain emotional disorders, like anxiety and depression, can be traced to irrational and illogical ways of thinking. Let's look at some of the fallacies that cognitive psychologists have noted in the thinking of people with emotional disorders.

1. **Faulty generalization.** This is the tendency to use a particular event or item of information as the basis for a general conclusion. The man whose wife leaves him concludes that no one could ever love him. The student who fails a test concludes that she is a failure. The woman who gets an occasional headache concludes that she is an unhealthy person.
2. **Polarized thinking.** This is the tendency to classify people, events, behavior, thoughts, and so forth into rigid categories, such as either right or wrong, or good or bad. It is also called dualistic thinking, black-and-white thinking, and bifurcation. It is an oversimplification of reality. A woman feels that if another person does not give clear evidence of liking her, then the other person must dislike her. An adolescent feels that thinking about anything related to sex is bad, and tries unsuccessfully to have only pure thoughts.
3. **Incorrect assumptions about what is safe and what is threatening.** The maladjusted person may feel that it is threatening to express his views or to show her anger. Taking the initiative to talk with a person of the opposite sex may be perceived as threatening; the person could just walk away, or could say something hurtful.
4. **Maladaptive attitudes toward pleasure and pain.** This is the attitude that if an activity is pleasant, it must be sinful, and if it is unpleasant, it means you have done the right thing. It is like thinking that a medicine is no good unless it stings or tastes bad. This type of thinking may result from selectively remembering pleasurable behaviors that were punished and unpleasant activities that were rewarded. Erikson, who was a psychodynamic psychologist, suggested that the superego, or conscience, can be very powerful and that it also tends to be juvenile as a result of being established in childhood. He thought that some people can suffer terrible guilt as a result of this juvenile superego's conviction that pleasurable things are "bad."

5. Tyranny of “shoulds.” This is the tendency to dedicate one’s life to self-imposed obligations and responsibilities, and to feel anxious, depressed, or guilty if a “should” is left undone. “I should go to that meeting,” “I should write to Aunt Hattie,” “I should change the sheets on my bed.” It is conceivable that a person could have more “shoulds” than there are hours in the day to execute them. This is another situation that psychodynamic psychologists would attribute to a domineering superego.
6. Biased attributions. Attributions are an attempt to understand events by proposing a cause for them. In the case of the maladjusted person, the primary problem is the causes proposed to explain personal behavior, or events that involve the self. The bias may be in the direction of protecting the self, in which case the maladjusted person attributes successes and positive events to his own efforts or abilities, and failures and negative events to other people or environmental circumstances. A psychodynamic psychologist might describe this as overuse of defense mechanisms, like rationalization and projection. The maladjusted person may also go to the opposite extreme and attribute successes and positive events to others or environmental factors and attribute failure and negative events to his own lack of initiative or ability. In one case, the maladjusted person is protecting a fragile self-esteem, and in the other, the person is confirming low self-esteem.
7. Personalization of events. This is a mild form of delusions of reference in which there is a tendency to see personal significance in the behavior of others. A person goes to a party at which the host serves Mexican food. The person does not like Mexican food and thinks that the host served it to spite her. The professor scolds the class for poor performance on a test. A student feels that the message is intended for her personally.

You may have noticed that the types of faulty thinking described by cognitive psychologists as roots of emotional disorders are very similar to uncritical, rigid thinking in general. Faulty thinking can distort our interpretation of events, and it can cause us to make unfortunate decisions.

Measuring the Effectiveness of Therapy

By this point in the course, students should be well aware of the importance of empirical measurement in the evaluation of theories and practices in psychology. The following list of the problems encountered in the attempt to measure the effectiveness of therapy serves as an excellent review of the challenges met in many areas of psychological research.

Complexity of elements. A central problem in measuring the effectiveness of therapy is the sheer number of elements involved: qualities of the therapist and client, the kind of therapy, the nature of the problem, and the duration of the therapy. People may be depressed or anxious for a variety of reasons, and some may respond better to one kind of therapy than another (Whisman, 1993).

The justification of effort problem. People usually become attached to their therapists or groups, especially if they have invested money or time in them. (Remember “the justification of effort” research.) The minute researchers say that some therapy does not “work,” they hear a chorus of howls: “But psychotherapy worked for me! I would never have (taken that job/moved to Cincinnati/left home) if it hadn’t been for Dr. Blitznik!”

The illusion of improvement. Most people who go through any therapy or self-improvement program will tell you they are the better for it. “I went through _____ and now I am a new person!” “I took a course in _____ and it changed my life!” Every program claims enthusiastic graduates, even when studies find that the program or therapy was objectively ineffective (Hinrichsen, Revenson, & Shinn, 1985). One reason seems to be that people edit their memories of what they were like before. When they want to believe they have changed, they revise their memories of how bad off they once were (Conway & Ross, 1984).

Defining “success.” Whether therapy is “successful” depends on how “success” is defined. Years ago, in a follow-up study of 16 men with erection problems, Stephen Levine and David Agle (1978) learned how complicated it is to define success in sex therapy. Is a man “cured” if he can achieve erections, but is so worried about failing that he disregards his wife’s sexual satisfaction? Is he “cured” if he can achieve erections but does not much want to? What if he can have erections half the time? When the researchers defined “cure” as reduced frequency of erection failure, sex therapy was successful in ten cases. When they defined “cure” as complete elimination of sexual problems in both husband and wife, sex therapy was successful in only one case. With some couples, solving the sexual problem upset a delicate marital balance of power, creating new problems.

Conway, M., & Ross, M. (1984). Getting what you want by revising what you had. *Journal of Personality and Social Psychology, 47*, 738–748.

Hinrichsen, G. A., Revenson, T. A., & Shinn, M. (1985). Does self-help help? An empirical investigation of scoliosis peer support groups. *Journal of Social Issues, 41*(1), 65–88.

Levine, S. B., & Agle, D. (1978). The effectiveness of sex therapy for chronic secondary psychological impotence. *Journal of Sex & Marital Therapy, 4*, 235–258.

Whisman, M. A. (1993). Mediators and moderators of change in cognitive therapy of depression. *Psychological Bulletin, 102*, 204–218.

Ch-Ch-Ch-Changes

“The more that things change, the more they stay the same.” This pithy observation may serve to make us look erudite after a few beers at the bar, but for many people it doesn’t ring true. From plastic surgery to career changes to relocating hearth and home, people seek change because it *isn’t* the same old thing. What can and cannot change, however, is another matter. Looking over the research, psychologist Martin Seligman sketches traits, disorders, and behavior patterns that seem more or less resistant to change.

Panic.....	Curable
Specific Phobias.....	Almost Curable
Sexual Dysfunctions.....	Marked Relief
Social Phobia.....	Moderate Relief
Agoraphobia.....	Moderate Relief
Depression.....	Moderate Relief
Sex Role Change.....	Moderate Relief
Obsessive-Compulsive Disorder.....	Moderate Mild Relief
Sexual Preferences.....	Moderate Mild Change
Anger.....	Mild Moderate Relief
Everyday Anxiety.....	Mild Moderate Relief
Alcoholism.....	Mild Relief
Overweight.....	Temporary Change
Post-traumatic Stress Disorder.....	Marginal Relief
Sexual Orientation.....	Probably Unchangeable
Sexual Identity.....	Probably Unchangeable

Seligman, M. E. P. (1994, May/June). What you can change and what you cannot change. *Psychology Today*, pp. 35-41, 70, 72–74, 84.

A Brief History of Convulsive Therapies

Electroconvulsive therapy (ECT) is a topic that guarantees lively classroom debate. Some background on the development of convulsive techniques will enrich your discussion.

- Julius Wagner-Jauregg (1857–1940) noticed that improvements in mental illness often followed a severe fever. Beginning in 1886 he induced fevers in the mentally ill, using at turns tuberculin, typhus vaccine, and tertian malaria. In 1917 nine patients with general paresis were treated by injecting blood from patients experiencing active malaria; three recovered, three showed temporary relief, and three showed no improvement. In 1927 Wagner-Jauregg won the Nobel Prize for Medicine based on this type of work.
- Manfred Sakel (1900–1957) in 1933 reported success using insulin coma and insulin subcoma therapy to treat schizophrenia. Sakel concluded that the repeated induction of hypoglycemia, typically accompanied by coma and convulsions, produced beneficial effects. With the advent of chlorpromazine in the early 1950s and subsequent clinical comparisons, insulin coma therapy quickly fell from favor.
- Laszlo Meduna (1896–1964), a Hungarian psychiatrist, is credited as the founder of modern convulsive therapy. A somewhat popular notion in Meduna’s time was that schizophrenic processes were helpful in treating epilepsy, leading some researchers to unsuccessfully transfuse the blood of schizophrenics to treat those with epilepsy. Meduna sought to demonstrate the reverse, believing that there was a funda-

mental antagonism between epileptic processes and schizophrenic processes. Accordingly, he tried camphor, pentylenetetrazol, and carbon dioxide to induce seizures in his patients.

- Ugo Cerletti's (1877–1963) contribution to this sequence of events was to advocate the use of electroshock. In 1938, after a series of studies using nonhuman animals, Cerletti applied electroshock to a 19-year-old man found wandering the streets of Rome in a psychotic state. The patient received 11 electroshock applications, and was reported to be “cured” after one year and able to return to his former job. Electroshock methods were introduced to the United States in 1939, although the Journal of the American Medical Association published editorials warning of the possibility of electrocution.
- After World War II interest in convulsive therapies increased, although concern was growing over complications associated with the techniques. For example, both pentylenetetrazol and electrical inductions produced death, panic, fear, fractures, memory loss, postseizure delirium, spontaneous seizures, and cardiovascular disorders. By 1950, muscle paralysis and anesthesia were commonly used when inducing seizures. More recent developments include localizing the placement of electrodes to one side of the head, and modifying the amount of electricity or frequency of treatments.

Fink, M. (1979). *Convulsive therapy: Theory and practice* (pp. 5–17). New York: Raven Press.

ADDITIONAL READINGS

Bateman, A., Brown, D., & Pedder, J. (2000). *Introduction to psychotherapy: An outline of psychodynamic principles and practice* (3rd ed.). London, England: Routledge/Taylor & Francis Group.

Brown, L. (1994). *Subversive dialogues: Theory in feminist therapy*. New York: Basic Books.

de Schill, S. (2000). *Crucial choices—crucial changes: The resurrection of psychotherapy*. Amherst, NY: Prometheus Books.

Eysenck, H. J. (1952). The effects of psychotherapy: An evaluation. *Journal of Consulting Psychology, 16*, 319–324.

Rogers, C. (1951). *Client-centered therapy*. Boston: Houghton. Contains many examples of therapist-client interaction for use in class.

Sadock, B., & Sadock, V. (2001). *Kaplan & Sadock's pocket handbook of psychiatric drug treatment* (3rd ed.). Philadelphia, PA: Lippincott Williams & Wilkins Publishers.

Smith, M. L., Glass, G. V., & Miller, R. L. (1980). *The benefits of psychotherapy*. Baltimore, MD: Johns Hopkins University Press.

Valenstein, E. S. (1986). *Great and desperate cures: The rise and decline of psychosurgery and other radical treatments for mental illness*. New York: Basic Books.

Wedding, D., & Corsini, R. J. (Eds.). (1979). *Great cases in psychotherapy*. Itasca, IL: Peacock.

ACTIVITIES AND DEMONSTRATIONS



Taking a Critical Look at Therapy

Students use critical thinking skills to evaluate different approaches to mental health. The student handout for this exercise is included as **Handout Master 12.1**. Suggested answers are given below.

Suggested answers:

1. Points students might make include:
Human beings are social animals with a strong need for affiliation. Pets may not replace human companions, but for many people, they can serve as a friend and can provide affection.

Psychological well-being requires having a sense of purpose. Pets require care, and thus help human beings fulfill their “need to be needed.”

All primates, including people, need contact comfort. Pets can be extremely comforting to hold and fondle.

Humor can be an antidote to stress or depression. Pets are often fun for people to watch; they do things that amuse us and make us laugh.

A social life contributes to a sense of well-being, and sometimes pets can bring people together.

Physical exercise also contributes to psychological well-being, and some pets can provide a motive for exercise (e.g., walking the dog).

2. Some points students may make in their answers:

The fact that help from a relative has been requested suggests that the depressed person is having so much trouble functioning that he or she cannot find a therapist on his/her own. However, research suggests that loss of control over major decisions can itself be a source of depression. Therefore, it would be important to involve the depressed person as much as possible in decisions about treatment.

Good decision-making depends on having good information. Therefore, it would be important to find out as much as possible about treatment options by consulting with a local mental health clinic, the local psychological society or mental health association, the student counseling center, friends who have been in therapy, etc. You would also want to find out about fees for various types of treatment and whether insurance would cover the costs.

Some cases of depression may have biological causes. A complete medical examination would therefore be in order.

Warmth, empathy, and genuineness are important in a therapist. You would want to look for these qualities in an initial interview.

A strong therapeutic alliance between the client and the therapist also contributes to success. Therefore, you would want to be sure that your relative regards the therapist as trustworthy and effective. The therapist need not necessarily be of the same gender, race, ethnicity, or sexual orientation, but obviously one should not go to a therapist whose biases prevent him or her from practicing good therapy.

If a therapist recommends antidepressant drugs, you should ask many questions about their appropriateness. Drugs can help many depressed people, but individuals respond differently to drugs. For many people with mood disorders that are not extremely severe, psychotherapy works as well as, or better than, drugs. If drugs are used, they should not take the place of psychotherapy, because drugs do not teach people how to cope with their problems.

You would want to keep in mind that psychodynamic and behavioral therapies tend to be ineffective in cases of major depression, but a person with a mood disorder may respond to a combination of drug treatments, cognitive-behavioral methods, and group support.

Sometimes, a problem that seems to be affecting only one individual actually involves the whole family, or stems from family dynamics. You would want, therefore, to consider whether a family-systems approach might be useful.

3. The following suggested answers elaborate on the suggestions offered by the American Psychological Association Task Force on Self-Help Therapies:

What kind of expertise does the author have that qualifies him or her to write about this problem?

Is the advice in the book based on sound empirical evidence and well-reasoned arguments rather than merely on hunches, personal opinion, or the experiences of a few interviewees? Glowing testimonials from “graduates” of the program or a few case reports are not reliable evidence. How many people drop out of the program? How many people fail to benefit from it? Are any harmed by it? Can we tell by reading this book?

Does the author make assumptions that are unsupported by evidence, for example, that 90% of all people are “codependent” or that the children of alcoholics invariably become alcoholic themselves?

Does the author oversimplify and overgeneralize by attributing all problems to a single cause or claiming that a program can help everyone? Some diet books suggest weight-loss programs that could be dangerous for some people, such as borderline diabetics. Pop-psychological books could be bad medicine for chronically depressed readers.

Are the claims made by the author realistic? It is unlikely that a book can cure a serious mental disorder, or transform all of a person’s social relationships.

Is the advice given specific or vague? Are terms carefully defined, or does the message of the book boil down to vague advice and an inspirational pep talk?
Does the book tell readers how to evaluate their progress?

Comparing Treatment Approaches

Present students with the following scenarios, and ask them to consider how a psychodynamic, cognitive-behavioral, and humanistic psychologist would analyze the situation. What questions would each ask? What would each be interested in observing? What type of “treatment” would each be likely to suggest?

This exercise can work in many different formats. For example, you could present the scenarios to students during a lecture and ask for volunteers to outline each theorist’s views. A somewhat more engaging approach would be to assign individual students to play the roles of each type of psychologist—you can do this with or without advance warning—and ask each role player to tell the class his or her views on each scenario. Another way would be simply to break the class into small groups and have each group consider each of the three scenarios from the various theoretical perspectives.

When you have finished going over each of the scenarios, you might ask students to consider whether each approach seems equally appropriate and beneficial. Are some approaches better suited to certain situations than others?

SCENARIO #1: A mother brings her young son (eight years old) to the therapist because he is “acting up” in school and at home. He is extremely hostile and belligerent toward both his teacher and his mother and refuses to cooperate even under threat of punishment.

SCENARIO #2: A man in his mid-thirties finds that he is having difficulty establishing an intimate relationship with the woman he is dating. He cares for her and would someday like to get married, but he is reluctant to make a commitment.

SCENARIO #3: A twenty-five-year-old woman, a high-powered stock broker, is frustrated by her inability to quit smoking. She has tried several times and has been successful for brief periods, but she always starts smoking again when her life becomes stressful.

Therapy Similarities and Differences

As a take-home or in-class assignment, ask students to complete the Schools of Therapy handout (Handout Master 12.2). Then use their completed tables as a basis for discussion, comparing the similarities and differences among these major schools of thought. Suggested answers are listed below.

	Psychoanalysis	Cognitive-Behavioral	Humanistic	Family
View of human nature	pessimistic	neutral	positive	neutral
Is change possible?	difficult	yes	yes	yes
If so, what is the origin of such changes?	overcoming unconscious resistance	correcting irrational thought patterns	free will; effort	changing family
Nature of the “self”	determined by unconscious dynamics; balance of id, ego, and superego	determined by environmental events and cognitive processes	part of human nature	reflects family dynamics

What Type of Psychotherapy?

Students identify the types of psychotherapy represented by quotations representing various therapeutic perspectives. The student handout for this exercise is included as Handout Master 12.3. Answers are given below.

Answers:

- | | | |
|------------------|------------------|---------------|
| 1. psychodynamic | 5. psychodynamic | 9. family |
| 2. family | 6. cognitive | 10. cognitive |
| 3. behavioral | 7. humanistic | |
| 4. humanistic | 8. behavioral | |

Interviewing Mental Health Professionals

This assignment gives your students first-hand knowledge about careers in therapeutic settings. Have your students interview a mental health professional and either write a brief report about their conversation or present the information in class for discussion. The interviewee could be a member of your school's counseling center, a psychiatric case worker, a clinician, a psychiatrist, a clinical psychologist in private practice, a social worker, a staff member at the local Veteran's Administration hospital, a director of a halfway house, or a doctor at a state or private hospital. The structure of the interview should include (a) information about the professional's education and training, (b) years of experience on the job, (c) memorable or difficult cases and the solutions used to work with that person, (d) day-to-day responsibilities, (e) pay range, (f) job satisfaction, (g) information about how and why the professional chose this career path. If your students are able to interview a range of professionals, you could devote class time to comparing the responses given by different workers to the same questions. Many undergraduates are attracted to psychology because they want to be involved in administering therapy; this exercise may prove enlightening to them as a glimpse into the real world of mental health professionals.

MULTIMEDIA

World Wide Web

Albert Ellis Institute

<http://www.rebt.org/>

Your starting point for information about rational emotive therapy. You only think you don't want to visit this site, but you really do, you know.

American Academy of Psychoanalysis

<http://www.aapsa.org/>

AAPSA provides information about this approach to treating mental illness.

Association for Child Psychoanalysis

<http://www.westnet.com/acp/>

Psychoanalysis specifically for children and their disorders.

Association for Humanistic Psychology

<http://ahpweb.org/index2.html>

A clearinghouse of information about this organization and its goals.

Cognitive-Behavioral Therapy

<http://www.nacbt.org/>

National Association of Cognitive-Behavioral Therapy. A source of information about this technique.

ECT Galore

<http://www.psycom.net/depression.central.ect.html>

More than you'd ever want to know about electroconvulsive therapy can be found here.

History of the Lobotomy

<http://www.epub.org.br/cm/n02/historia/lobotomy.htm>

A concise history of the development of this psychosurgical technique.

Lobotomy's Hall of Fame

<http://www.cerebromente.org.br/n02/historia/important.htm>

Lobotomies of the rich and famous are summarized here, as is psychosurgery featured in popular films and writings.

NIMH

<http://www.nimh.nih.gov/>

National Institute of Mental Health. A good place to start for information on therapy and treatment of mental disorders.

Teenage Lobotomy

<http://www.geocities.com/SunsetStrip/Palms/6100/rocket1.htm>

FILMS AND VIDEOS

Prentice Hall Lecture Launchers

Deinstitutionalization

This clip presents archival footage of life in a mental institution. Sordid conditions, warehousing of patients, and a general lack of effective therapy characterize this era. The strategy of deinstitutionalization, or returning patients to the community, is discussed, as are the pitfalls and promises of this approach. This segment shows daily activities in a mental institution “20 years ago” (actually, in the 1960s). Many students may believe that mental institutions still look like this, and that patients are locked away in “asylums.” Use this clip to challenge those notions and to highlight how advances in therapy and institutional care have taken place over the last several decades. Also use this clip to discuss the concept of deinstitutionalization: how it arose, what its intent was, and how it has fared as a treatment strategy.

Prentice Hall Video Classics

Carl Rogers on Therapy

Kindly Carl Rogers discusses three attributes a therapist should exhibit for successful work with a client: genuineness, unconditional acceptance of the client, and empathy. This interview segment does a good job of summarizing Rogers' basic position on client-centered therapy.

Prentice Hall Introductory Psychology Teaching Films

Lost Daughter

This segment introduces therapeutic involvement in “recovered memories” and explores the impact of false memories on a family.

Obsessive Compulsive Disorder

This segment describes a form of Obsessive Compulsive Disorder called “harming obsession.” It illustrates the disruptive nature of OCD and some possible treatments.

Psychotherapy Under Scrutiny

This segment suggests that a therapist violated a professional code of ethics during the treatment of a vulnerable patient. It also discusses the damage the media can do to a professional's reputation, regardless of guilt or innocence.

9–11 PTSD Therapy

This video clip looks at the impact of post-traumatic stress disorder on those individuals who were part of the World Trade Center catastrophe. It explains how this disorder has changed their day-to-day lives since the terror attack.

Cognitive Behavioral Therapy

Explores the benefit of combining medication with therapy in the treatment of schizophrenia. This new alternative was tested to determine its overall effectiveness.

Other Sources

APA Psychotherapy Series (1995, 12 parts, APA). This series of training tapes is designed for therapists seeking insight into other methods and techniques, and students new to psychotherapy seeking basic training. However, individual tapes might be useful in a classroom context to illustrate typical therapy sessions. Individual tapes focus on multimodal, feminist, ethnocultural, client-centered, cognitive-behavior, cognitive-affective, and short-term dynamic therapies, as well as psychoanalytic therapy with schizophrenics and individual therapy using a family systems approach.

Antidepressant Agents (1999, 23 min, IM) This video examines tricyclic agents, SSRIs, and monoamine oxidase inhibitors, and how they influence brain activity.

Approaches to Therapy (1990, 30 min, IM). A single client is seen engaged in psychodynamic, humanistic, and cognitive-behavioral therapies. Differences among the sessions are discussed by experts, who also offer tips for choosing a therapist.

Committed in Error: The Mental Health System Gone Mad (52 min, FHS). Sixty-six years is a long time to be incarcerated in a mental health institution, especially if there's nothing wrong with you. Find out the details of this real-life case in this video.

Dealing With Addictions (1994, 55 min, IM). Albert Ellis helps a client overcome addictions to food, alcohol, and other substances. He also tells him to sit up straight.

Therapy Choices (1990, 30 min, IM). Family-systems therapy, group psychotherapy, and self-help are examined. Clients and experts share their views.

Titticut Follies (85 min, zipporah.com). A chilling look at life in a prison for the criminally insane, circa early 1960s. Some of it is depressing, some of it is quite graphic, all of it is worth seeing. This film was heavily censored in the greater Boston area for quite some time.

TRANSPARENCIES

T86. Major Schools of Therapy

Psychodynamic, cognitive-behavioral, humanistic, and family therapies are compared.

T87. Orientations of Psychotherapists

The relative frequency of therapists who adopt different approaches to therapy is shown.

T88. Where People Turn for Help

Sources of psychological help are shown.

T89. How SSRIs Work

The operation of Selective Serotonin Reuptake Inhibitors is illustrated.

T90. Aversion Therapy in the Treatment of Alcoholism

One approach to treating alcoholism trades on the concepts of classical conditioning.

T91. Behavior Therapy Techniques

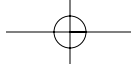
Different strategies for therapy, all based on a behavioral approach, are summarized.

T92. Drugs Used in the Treatment of Psychological Disorders

Common antipsychotics, antidepressants, and tranquilizers are described.

T93. Duration of Therapy and Improvement

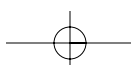
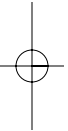
The transparency indicates that staying in therapy for a longer time is associated with increased improvement in mental health.

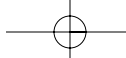


Handout Master 12.1

Taking a Critical Look at Therapy

1. Pets can have a therapeutic effect on people; they seem to have the power to calm the anxious and cheer the depressed. Give three reasons why this might be so, based on what you have learned in this course.
2. Suppose a member of your family has become increasingly depressed in recent months and it is apparent that the person needs treatment. You are chosen to look into the options and to make decisions about the treatment. Based on information in Chapter 11, how might you proceed?
3. Nowadays, many people get “therapy” for their problems from self-help books. These books give advice on everything from conquering depression to breaking bad habits to improving your love life. Unfortunately, some books may do more harm than good. If the reader does not get “better,” his or her self-esteem, which may already be low, may suffer even further. Give at least three questions you should ask about any self-help book, based on the critical thinking guidelines in your textbook.

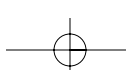
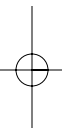




Handout Master 12.2
Schools of Therapy

Complete the following handout, which compares various schools of therapy.

	Psychoanalysis	Cognitive- Behavioral	Humanistic	Family
View of human nature				
Is change possible?				
If so, what is the origin of such changes?				
Nature of the "self"				



Handout Master 12.3

What Type of Psychotherapy?

Identify the type of psychotherapy represented by each statement below, choosing from:

Cognitive
Psychodynamic
Behavioral

Humanistic
Family therapy

1. When she started relating to me in the way she related to her mother, it became clear that she perceived her mother as a rival for her father's affection.
2. That child was a bad actor; he had a serious behavior disorder. It wasn't difficult to understand how he got that way after I had a few sessions with his parents and siblings.
3. She has the worst case of agoraphobia I've ever seen. A peer counselor is stopping by every day to work with her. It took a week to get her out the front door, and more than a week to get her off the porch. They're working on walking out to the mailbox now. We're making progress, but it's slow.
4. I had to refer a patient to another therapist last week. I just couldn't seem to identify with the guy, and couldn't accept the way he acted. Feeling as I did about him, I didn't think I could help him.
5. The theme of hostility toward authority figures occurs over and over again in his dreams and free associations, yet he claims that he and his father had a close and affectionate relationship.
6. I asked her to list the reasons why she thinks she is unable to get through a job interview. She gave me three typewritten pages enumerating more fears, apprehensions, self-criticisms, and negative self-evaluations than I would have believed possible for one person to have. Her thinking about herself has really gotten off the track.
7. He needs to convince himself that his past failures are not elements of a pattern that will govern his future. And he needs to convince himself that he is in charge of his life, and that he can choose the paths that will lead to accomplishment and satisfaction.
8. We have this voluntary program at the state penitentiary for men who have been convicted of child molestation. We are currently trying a method in which we pair electric shock with pictures of attractive children.
9. People do not develop in isolation. They are part of an interacting system. To effect a change in an individual, it is necessary to change the social context in which the individual operates.
10. We think that depression is frequently the result of misinterpretation of environmental events, a tendency to attribute failures to the self and accomplishments to things like luck, fate, or the help of other people. Most of us have a self-serving bias in our attributions; people who are depressed have a self-defeating bias in their attributions.

