CHAPTER 13

Treatment of Psychological Disorders

CHAPTER OUTLINE

Psychotherapy is the treatment of psychological disorders through psychological methods, such as talking about problems and exploring new ways of thinking and acting.

I. BASIC FEATURES OF TREATMENT

What features do all treatment techniques have in common?

A. The basic features of treatment for disorders include a client, or patient; a therapist, or helper; a special relationship between the two; a theory about the causes of the client’s problems; and a set of treatment procedures to address the client’s problems.

1. Inpatients receive treatment while staying in a hospital or other residential institution. They have impairments severe enough to create a threat to their own well-being or that of others. Their treatment almost always includes psychoactive drugs. Outpatients receive treatment while living in the community.

2. There are many providers of psychological treatment.
   a) Psychiatrists are medical doctors specially trained to treat mental disorders. They are authorized to prescribe drugs.
   b) Psychologists who do psychotherapy have usually completed a doctoral program in clinical or counseling psychology, sometimes with additional specialized training. Except for New Mexico and Louisiana, psychologists in the United States may not prescribe drugs. However, many other states are currently considering granting prescription privileges to specially trained psychologists.
   c) Clinical social workers, marriage and family therapists, and licensed professional counselors usually hold a master’s degree in their field and provide therapy in hospitals, clinics, or private practice.
   d) Psychiatric nurses, substance abuse counselors, pastoral counselors, and paraprofessional providers provide therapy, usually as part of a treatment team.

3. The basic goal in psychotherapy is to help troubled people change their thinking, feelings, and behavior to relieve discomfort, and to promote happiness and better functioning in their life roles.

4. The majority of mental health professionals see themselves as eclectic therapists, borrowing effective methods from many types of therapy.

II. PSYCHODYNAMIC PSYCHOTHERAPY

How did Freud get started as a therapist?

Psychoanalysis, Sigmund Freud’s treatment method, was aimed at understanding unconscious conflicts and how they affect clients. Almost all forms of psychotherapy reflect some of Freud’s ideas, including his one-to-one method of treating people; his systematic search for relationships between an individual’s life history and current problems; his emphasis on thoughts, emotions, and motivations in treatment; and his focus on the client-therapist relationship.

A. Classical Psychoanalysis
1. Originally, Freud had hypnotized patients recall events that might have caused their problems. Later, he merely had patients lie on a couch, relax, and report whatever came to mind, free association.
   a) Many patients taking Freud’s “talking cure” reported memories of childhood sexual abuse. Freud decided that these reflected childhood fantasies and unconscious conflicts, a judgment that has since been criticized.

2. Classic psychoanalysis uses free association, dream analysis, and analysis of the way the client reacts to the therapist (transference) to help a client gain insight into problems. Clients first recognize unconscious thoughts and emotions, then work through the many ways in which those unconscious elements affect their everyday life.

3. This treatment may require as many as three to five sessions per week for several years.

B. Contemporary Variations on Psychoanalysis
Classical psychoanalysis is not as prevalent as it was. Currently, there is more focus on social relationships in clients’ problems and how the ego can be used to solve them.

1. In short-term psychodynamic psychotherapy the aim is to provide benefits in far less time than is required in classical psychoanalysis.
   a) In object relations therapy, the powerful need for human contact and support is important. Object relations therapists work to develop a nurturing relationship with their clients, providing a “second chance” for these clients to receive the support that might have been absent in infancy and to counteract some of the consequences of maladaptive early attachment patterns.

2. Interpersonal therapy focuses on helping clients overcome problems with relationships that occur after childhood.

III. HUMANISTIC PSYCHOTHERAPY
Why won't some therapists give advice?

Humanistic therapists, sometimes called phenomenologists, view people as capable of consciously controlling their own actions and taking responsibility for their decisions. Human behavior is innately driven toward growth and is guided by the way people perceive their world. When there are distorted perceptions or lack of awareness about feelings, growth is blocked.

Humanistic therapy operates on four assumptions:

- Treatment is seen as a human encounter between equals, not a cure from an expert.
- Clients will improve on their own, given the right conditions.
- Ideal conditions in therapy can best be established through a therapeutic relationship in which clients are made to feel accepted and supported as human beings. It is the client’s experience of this relationship that brings beneficial changes.
- Clients must remain responsible for choosing how they will think and behave.

A. Client-Centered Therapy
1. Carl Rogers’s client-centered therapy or person-centered therapy relies on the creation of a relationship that reflects three intertwined therapist attitudes:
   a) Unconditional Positive Regard
      Therapists show unconditional positive regard, always treating the client as a valued person, no matter what. The therapist listens without interrupting, or giving advice, accepting and trusting the client’s insights without judgment.
   b) Empathy
Therapists try to see the world as the client sees it. They try to develop **empathy**, an emotional understanding of what the client might be thinking and feeling. Empathy is shown by active listening and **reflection**, paraphrasing back to the client what he or she seems to be saying and feeling.

c) **Congruence**

**Congruence**, or **genuineness**, refers to consistency between what the therapist feels and the way she or he acts toward the client. The therapist must not just *say* the client is accepted and valued—the therapist must *feel* it.

B. **Gestalt Therapy**

1. Frederick S. (Fritz) Perls and his wife Laura were founders of **Gestalt therapy**. They believed that people create their own versions of reality and that people’s natural psychological growth continues only as long as they perceive, remain aware of, and act on their true feelings.

   a) Gestalt therapists use more direct and dramatic methods. They may prod clients to become aware of feelings they have disowned and to discard ideas and values that are not really their own. They may point out inconsistencies between what clients say and how they behave.

   b) Clients may engage in imaginary dialogues with people and even inanimate objects or parts of their own personality to get in touch with themselves.

IV. **BEHAVIOR THERAPY AND COGNITIVE-BEHAVIOR THERAPY**

*Can we learn to conquer fears?*

**Behavior therapies** view psychological problems as **learned behaviors** that can be changed without searching for hidden or unconscious causes. Therapists help clients to understand the learning principles that maintain their problems and then teach them to learn more adaptive behaviors.

Features of this therapy include a good therapist-client relationship, a careful listing of behaviors and thoughts to be changed, a therapist who acts as a kind of teacher by providing learning-based treatments, and constant evaluation of therapy’s effects.

Methods that rely mainly on classical conditioning are called **behavior therapy**; those that rely mainly on operant conditioning are called **behavior modification**; and those that focus on altering both thoughts and behavior are called **cognitive-behavior therapy**.

A. **Techniques for Modifying Behavior**

1. **Systematic Desensitization**

   During **systematic desensitization**, a client practices **progressive relaxation** while imagining fear-provoking situations from a **desensitization hierarchy**, a list of fear-provoking situations. The process of remaining calm while thinking about something feared weakens the learned association between anxiety and the feared object or situation.

   a) **In vivo**, or “real-life,” desensitizations appear to be especially effective but were difficult to arrange or control. A new technique, **virtual reality graded exposure**, makes it possible for clients to “experience” precisely graduated versions of the feared situations without actually being exposed to them.

2. **Modeling**

   In **modeling**, a client learns skills by watching other people perform desired behaviors. In **participant modeling** the therapist demonstrates desirable behaviors, and the client practices them. The clients can learn to be more appropriately self-expressive and comfortable in social situations through **assertiveness** and social skills training.
3. Positive Reinforcement
A therapist systematically uses positive reinforcement to alter problematic behaviors. They set up contingencies, or rules, that specify the behaviors to be strengthened through reinforcement. The receipt of rewards or tokens is dependent on a client’s display of desirable behaviors. In institutions, behavior therapists sometimes establish a token economy, a system for rewarding desirable behaviors.

4. Extinction
To lessen a behavior extinction is used. Reinforcers that normally follow a particular response are removed. An exposure technique called flooding, which extinguishes a conditioned fear response, keeps a patient in a feared but harmless situation. As a result, the client who is deprived of the normally rewarding escape pattern learns that there is no reason for continued anxiety and the fear response gradually weakens.

5. Aversion Therapy
Aversion conditioning uses classical conditioning to reduce undesirable behavior by associating it with some psychological or physical discomfort. Aversion conditioning is unpleasant, it does not work for everyone and its effects are often temporary. Therefore it is not used often and only long enough to allow the client to learn alternative behaviors.

6. Punishment
To eliminate a dangerous or disruptive behavior, punishment may be used. An unpleasant stimulus is presented after the behavior, which reduces its occurrence.

B. Cognitive-Behavior Therapy
Therapy relies on learning principles to help clients change the way they think as well as how they behave.

1. Rational-Emotive Therapy
Rational-emotive behavior therapy (REBT) was developed by Albert Ellis. REBT aims at identifying and replacing unrealistic, self-defeating, problem-causing thoughts.
   a) In cognitive restructuring, one replaces upsetting, irrational thoughts with alternative, adaptive thoughts.
   b) Stress inoculation training involves clients imagining being in a stressful situation, then practice newly learned cognitive skills to remain calm.

2. Beck’s Cognitive Therapy
Aaron Beck’s cognitive therapy is based on the idea that certain mental disorders can often be traced to errors in logic and false beliefs—cognitive distortions. The therapist first helps clients learn to identify the cognitive distortions that precede anxiety, depression, and other psychological problems. Then they subject these thoughts to critical thinking and hypothesis testing, providing concrete evidence that challenges and ultimately destroys erroneous beliefs.

V. GROUP, FAMILY, AND COUPLES THERAPY
How does group therapy differ from individual therapy?

A. Group Therapy
In group therapy, several clients interact under the guidance of a therapist. Clients often feel less alone in their problems and can boost one another’s self-confidence and self-acceptance. Clients share and learn from one another and can try out new skills in a supportive situation.

B. Family and Couples Therapy
1. **Family therapy** treats two or more people from the same family system. The problems of one family member make her or him the initially identified client. However, the family becomes the client, and the goal is to create harmony and balance within the family by helping each member understand family interaction patterns and the problems they create.

2. In **couples therapy**, improving communication between partners is the focus of the treatment.

VI. EVALUATING PSYCHOTHERAPY

*How effective is psychotherapy?*

Many therapists use integrated psychotherapy approaches which combine methods from various approaches. Confirming the effectiveness of therapeutic methods is difficult and controversial.

In 1952 Hans Eysenck reviewed studies evaluating psychotherapy. Though others disagreed, he concluded that recovery occurred no more often in those receiving therapy than in those who did not. Several more recent research reviews have found that, in general, psychotherapy does work. However, it is extraordinarily problematic to try to measure improvement in psychotherapy in a way that applies to all therapies for all disorders.

A. Thinking Critically: Are All Forms of Psychotherapy Equally Effective?

1. **What am I being asked to believe or accept?**
   Theories of behavior disorder and the specific treatment methods are irrelevant to psychotherapy success. All approaches are equally effective. This assumption has been called the Dodo Bird Verdict.

2. **Is there evidence available to support the claim?**
   Meta-analytic studies that average the results of many studies do not show significant differences in the overall effectiveness of the psychodynamic, humanistic, and behavioral approaches to therapy.

3. **Can that evidence be interpreted another way?**
   Research methods used may fail to detect real differences among methods. It may be that some specific techniques, rather than an entire approach, are more successful than others. Also, the different effects of specific procedures could be masked by the beneficial effects of any type of therapy—the support received from a therapist, the hope and expectancy that problems will be addressed, and so on. Possibly a therapist whose personal characteristics motivate a client to change might promote that change regardless of the therapeutic methods being used.

4. **What evidence would help to evaluate the alternatives?**
   The debate is likely to continue, but many researchers believe that it focuses on the wrong question. It is more important to address the “ultimate question”: What treatment, by whom, is most effective for this individual with that specific problem, under what set of circumstances?

5. **What conclusions are most reasonable?**
   Statistical analyses show that various treatment approaches are about equally effective overall. But potential clients must realize that the success of their treatment can still be affected by how severe their problems are, by the quality of the relationship they form with a therapist, by their motivation to change, and by the appropriateness of the therapy methods chosen for their problems.

Many clinical psychologists want scientific evidence that the benefits of the treatment itself are clinically significant, meaning that they are large enough to make an important difference in the lives of their individual clients.
B. Focus on Research: Which Therapies Work Best for Which Problems?

1. *What was the researchers’ question?*
   What therapies have proven themselves most effective in treating various kinds of psychological disorders?

2. *How did the researchers answer the question?*
   An American Psychological Association task force examined the outcomes of thousands of well-controlled experiments that evaluated psychotherapy methods.

3. *What did the researchers find?*
   A number of treatments known as *empirically supported therapies*, or ESTs, have been validated by controlled experimental research. The therapies identified as effective for particular problems in adult clients are mainly behavioral, cognitive, and cognitive-behavioral methods, along with interpersonal and brief dynamic therapy.

4. *What do the results mean?*
   Some believe that the experimental research has allowed a scientific evaluation of various therapies and generated a list of methods from which clinicians and consumers can choose with confidence when facing specific disorders. Critics argue that the list of empirically supported therapies is based on research that may not be relevant to clinicians practicing in the real world.

5. *What do we still need to know?*
   Empirical research shows that, for some disorders, certain treatments are more effective than others. In comparative studies of adult psychotherapy, they tend to reveal a small to moderate advantage for behavioral and cognitive-behavioral methods, especially in the treatment of phobias and certain other anxiety disorders, and bulimia nervosa. This tends to be true for child and adolescent clients as well. Also, the client-therapist relationship seems to play a significant role in the success of many forms of treatment. The challenge is to combine research on ESTs with research on their common factors to gain a broader understanding of psychotherapy effectiveness.

   Based on what is known so far, potential clients must consider what treatment approach, methods, and goals he/she finds comfortable and appealing; information about the potential therapist’s “track record” with a particular method for treating problems similar to those the person faces; and the likelihood of forming a productive relationship with the therapist.

C. Sociocultural Factors in Therapy

1. Differences in religious faith, gender, age, ethnicity, sexual orientation, socioeconomic background, and so forth can create miscommunication or mistrust. Recent immigrants and other members of minority populations underuse or withdraw from mental health services.

2. Virtually all mental health training programs in North America seek students from traditionally underserved minority groups to provide a better client-therapist match of cultural backgrounds.

3. Some states in the United States require psychologists to complete courses in the role of cultural factors in therapy before being licensed. Such cultural sensitivity training offers a way for therapists to improve their *cultural competence*—to be able to appreciate different client’s world views.

D. Rules and Rights in the Therapeutic Relationship

1. Psychotherapists are bound by common sense and professional ethics to obey certain guidelines of conduct so their relationship does not harm the client.
2. Confidentiality is critical to a therapeutic relationship. The APA’s code of ethics now includes standards for protecting confidentiality for the growing number of clients who seek psychological services via telehealth or e-health channels (phone, e-mail, Internet). Most state laws in the United States regard information revealed in therapy to be privileged communication.
   a) Only under certain conditions is a therapist required to violate confidentiality. These conditions include:
      (1) A client is so severely disturbed or suicidal as to require hospitalization.
      (2) A client uses a mental illness and therapy history to defend a civil or criminal charge.
      (3) The therapist must defend against the client’s charge of malpractice.
      (4) The client reveals information about sexual or physical child abuse.
      (5) The therapist believes the client may commit a violent act against a specific person.

VII. BIOLOGICAL TREATMENTS

Is electric shock still used to treat disorders?

A. Electroconvulsive Therapy

In electroconvulsive therapy (ECT), an electric current passed through a person’s brain causes seizures. Initially it was used to treat schizophrenia, depression, and sometimes mania. Though many patients improved, there were side effects, such as memory loss, confusion, speech disorders, and, in some cases, death due to cardiac arrest.

1. ECT is now safer and is used only on people with severe depression (and, at times, mania) who are not helped by other treatments. Patients are given an anesthetic so they are unconscious before the shock, along with a muscle relaxant to prevent bone fractures during convulsions. The shock only lasts about half a second and is delivered to one side of the brain, and number of treatments is limited.

2. Magnetic seizure therapy (MST) which creates seizures with pulses of magnetic energy and less intense repetitive transcranial magnetic stimulation (rTMS) are being tested for possible use.

B. Psychoactive Drugs

1. Neuroleptics
   
   Neuroleptics or antipsychotics reduce psychotic symptoms, such as hallucinations, delusions, and disordered thinking, especially in schizophrenics.

   a) Phenothiazines, such as chlorpromazine (Thorazine) and haloperidol (Haldol), help 60 to 70 percent of patients to some extent. But these older neuroleptics cause many side effects, including dry mouth, dizziness, and motor problems. A permanent side effect in some long-term users is tardive dyskinesia (TD), a syndrome of uncontrollable, repetitive movements of the body and face.

   b) Newer drugs, called atypical neuroleptics, have fewer side effects. Clozapine (Clozaril) does not cause movement disorders and is a very effective schizophrenia treatment. Unfortunately, in a small number of patients, it causes a potentially fatal blood disease, agranulocytosis.

   c) Other atypical neuroleptics have even fewer side effects, do not cause agranulocytosis, and also appear to reduce negative symptoms. These include risperidone (Risperdal), olanzapine (Zyprexa), quetiapine (Seroquel), ziprasidone (Geodon), and aripiprazole (Abilify). However, a number of people may still stop taking these drugs because of bothersome side effects.
2. Antidepressants

Antidepressants help relieve the symptoms of depression in 50 to 60 percent of patients. However, some recent research has shown that the drugs’ effects were only slightly better than those of placebos.

   a) Monoamine oxidase inhibitors (MAOIs) effectively treat depression, especially when it is coupled with anxiety and panic. They have serious side effects.
   b) Tricyclic antidepressants (TCAs) have milder side effects and may be somewhat more effective. However, overdoses of TCAs, and combining alcohol and TCAs, can be fatal.
   c) Newer antidepressants that have even fewer side effects include fluoxetine (Prozac), now the most prescribed antidepressant in the United States. A newer version R-fluoxetine is under development. Other new antidepressants include bupropion (Wellbutrin), venlafaxine (Effexor), nefazodone (Serzone), escitalopram (Lexapro), and duloxetine (Cymbalta).

3. Lithium and Anticonvulsants

   a) The mineral salt lithium carbonate, when taken regularly, prevents both the manic and depressive phases in some bipolar patients. The dosage must be exact and carefully controlled because taking too much can lead to severe and sometimes fatal effects.
   b) Anticonvulsant drugs (divalproex [Epival/Depakote] and lamotrigine [Lamictal]) have been used as an alternative to lithium in treating mania because they have fewer side effects and are easier to regulate.

4. Anxiolytics

Anxiolytics, or tranquilizers, are used to combat symptoms of anxiety.

   a) Overdoses of barbiturate-like tranquilizers, such as meprobamate (Miltown, Equanil), are potentially fatal.
   b) Benzodiazepines are now the most widely prescribed and used of all legal drugs. They include chlordiazepoxide (Librium), diazepam (Valium), and alprazolam (Xanax).

      (1) Benzodiazepines can have bothersome to severe side effects and are addictive.
   c) Buspirone (BuSpar) avoids some side effects of the other anxiolytics, including the potential for dependence, but requires days to weeks of use prior to symptom relief.
   d) Many antidepressant drugs are now being used to treat anxiety disorders. These include fluoxetine (Prozac), paroxetine (Paxil), clomipramine (Anafranil), fluvoxamine (Luvox) and sertraline (Zoloft).

C. Human Diversity and Drug Treatment

The same psychoactive drug can have significantly different effects in people from different ethnic groups and in men versus women.

   a) Some of the ethnic differences may be related to genetically regulated differences in drug metabolism, whereas others may be due to dietary practices.
   b) Gender differences in drug response appear related to hormonal or body composition differences.

D. Drugs and Psychotherapy

1. Drug treatments can have serious unpredictable side effects, including dependence and irreversible movement problems. Recently there have been warnings about the danger of suicidal behavior in children and adolescents who are given certain antidepressants,
and about elevated risk of death in elderly patients who are taking antipsychotics. There is also concern about the validity of psychoactive drugs.

2. Neither drugs nor psychotherapy is clearly more effective overall in treating psychological disorders. Dropout rates may be lower in psychotherapy, and its effects may last longer than those of drug therapies.
   a) Cognitive-behavior therapy and interpersonal therapy have been found to be as effective as antidepressants for treating severe depression.
   b) Cognitive-behavior therapy is as effective as drugs for treatment of phobias, panic disorder, generalized anxiety disorder, and obsessive-compulsive disorder.

3. Some recent research has shown that combining drugs and psychotherapy can be more effective than either one alone in some cases. The combination has been successful in treating bipolar disorder, long-term severe depression, ADHD, OCD, alcoholism, panic disorder, stammering, and compulsive sexual behavior.
   a) A new approach uses psychotherapy to prevent relapse and make further progress as initial drug treatment is discontinued.

4. However, many other studies have found little advantage in combining drugs and psychotherapy. It has been suggested that, where indicated, treatment begin with cognitive or interpersonal psychotherapy and that drug treatments be added only if psychotherapy is ineffective.

E. Linkages: Biology, Behavior, and the Treatment of Psychological Disorders

All mental processes and behavior are the result of biological processes, especially those involving neurotransmitters and their receptors. Therapeutic psychoactive drugs affect neurotransmitters and their receptors.

1. The benzodiazepines (Valium and Xanax) exert their anti-anxiety effects by helping the inhibitory neurotransmitter GABA bind to receptors and suppress neuron firing.
2. The phenothiazines and haloperidol act as antagonists and block receptors for dopamine.
3. Prozac, Anafrani, and some other antidepressants are selective serotonin reuptake inhibitors (SSRIs), because they slow the reuptake or return of serotonin to the brain cell which released it. Effexor slows the reuptake of both serotonin and norepinephrine.

VIII. COMMUNITY PSYCHOLOGY

How can we prevent psychological disorders?

Community psychology’s goals are to treat people in their home communities and to work for social changes that can prevent psychological disorders.

A. The community mental health movement arose in the 1960s as an attempt to make treatment accessible to people in their communities.
   1. The availability of psychoactive drugs and increased concern for patient welfare spurred deinstitutionalization, the release of many inpatients from mental hospitals.
   2. The mental health services available in the community to care for the released mental patients never effectively matched the need for them.
   3. Some former hospital patients and those who formerly would have been sent to a hospital live in halfway houses and other community-based facilities where they receive psychosocial rehabilitation, help to cope with their problems and to develop social and occupational skills. However, many remain among the homeless or in jail.

B. Community psychology also tries to prevent psychopathology by addressing social problems that may underlie some disorders.
1. Efforts to detect psychological problems in their earliest stages and keep them from becoming worse include early intervention programs, such as Head Start, suicide hotlines, and child abuse prevention programs.

2. Community psychology also supports the notion that nonprofessionals—including relatives and friends of troubled clients can help combat psychological disorders. This has encouraged the development of self-help or mutual-help groups like Alcoholics Anonymous (AA).