01 - 16 Treatment of Mental Health Problems

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S teve M. has paranoid schizophrenia. He frequently hears voices berating him and accusing him of having done something wrong. He was convinced that a transmitter had been implanted in his head, through which he was receiving these messages. When he takes his medications, the voices are quieted and the paranoid beliefs begin to recede. Over the past 5 years, Steve has been hospitalized three times. Each time he had stopped his medication, twice believing himself well, and once, just tired of the whole thing. In between hospitalizations, he has spent some time in an outpatient program and some time taking classes at university. He still struggles with determining what is real and what is not, but he has learned through therapy that he can check this out with the people he trusts, principally his stepmother, brother, and father. Steve has developed a long-term relationship with a psychologist from the clinic whom he sees once a week (in addition to his medication checks with the psychiatrist). Together they confront the very real challenges that his illness and the stigma attached to it poses. His parents, through the parent-support group they have joined, are learning to do the same. (Adapted from Bernheim, 1997, pp. 126–130). Steve and his family are making use of a variety of types of treatment to control his paranoid schizophrenia. The medications he is taking are one form of biological treatment for psychological problems. He is also seeing a psychotherapist to learn new ways of coping with his problems. His parents are making use of community-based resources to understand Steve’s problems. In this chapter we look at methods for treating abnormal behavior. The most frequently used methods are listed in the Concept Review Table. Each of these treatments is linked to a particular theory of the causes of mental health problems. The types of health systems through which these treatments are delivered will vary from one country to another, but we will focus on the common characteristics of each type of treatment. As we discuss in the next section, our theories of mental health problems, and therefore our treatment of these problems, have changed a great deal over history. For more Cengage Learning textbooks, visit www.cengagebrain.co.uk CHAPTER OUTLINE HISTORICAL BACKGROUND Early asylums Modern treatment facilities Professionals who provide psychotherapy

TECHNIQUES OF PSYCHOTHERAPY Behavior therapies Systematic desensitization and in vivo exposure Cognitive-behavior therapies Psychodynamic therapies Humanistic therapies Sociocultural approaches to therapy Special issues in treating children The effectiveness of psychotherapy Common factors in psychotherapies CUTTING EDGE RESEARCH: INNOVATIVE NEUROSTIMULATION TREATMENTS BIOLOGICAL THERAPIES Psychotherapeutic drugs Electroconvulsive therapy Combining biological and psychological therapies ENHANCING MENTAL HEALTH SEEING BOTH SIDES: IS ALCOHOLICS ANONYMOUS (AA) AN EFFECTIVE INTERVENTION FOR ALCOHOL MISUSE? 579

HISTORICAL BACKGROUND Among the earliest beliefs about mental health problems, dating back to the Stone Age, was that a person who behaved in unusual ways was possessed by evil spirits. These demons were removed or exorcised through such techniques as prayer, incantation, and magic. If these techniques were unsuccessful, more extreme measures were taken to ensure that the body would be an unpleasant dwelling place for the evil spirit. Flogging, starving, burning, and causing the person to bleed profusely were frequent forms of ‘treatment’. Some of the earliest written texts on mental health problems are from the Chinese, who viewed the human body as containing both a positive and negative force. If the two forces were not in balance, illness, including insanity, could result. The ancient Chinese also believed that emotions could be caused when ‘vital air’ flows on specific internal organs. For example, sorrow was caused when air flowed on the lungs, anger was caused when air flowed on the liver, and worry was caused when air flowed on the spleen. In the Western world, the Greek physician Hippocrates (circa 460–377 B.C.) is credited with bringing a medical perspective to the study of mental health problems. He believed that unusual behaviors were the result of a disturbance in the balance of bodily fluids. Hippocrates, and the Greek and Roman physicians who followed him, argued for more humane treatment of the mentally ill. They stressed the importance of pleasant surroundings, exercise, proper diet, massage, and soothing baths, as well as some less desirable treatments, such as purging and mechanical restraints. Although there were no institutions for the mentally ill, CONCEPT REVIEW TABLE Methods of therapy Type of therapy Example Description Behavior therapies Systematic desensitization The client is trained to relax and then presented with a hierarchy of anxiety-producing situations and asked to relax while imagining each one. In vivo exposure Similar to systematic desensitization except that the client actually experiences each situation. Flooding A form of in vivo exposure in which a phobic individual is exposed to the most feared object or situation for an extended period without an opportunity to escape. Selective reinforcement Reinforcement of specific behaviors, often through the use of tokens that can be exchanged for rewards. Modeling A process in which the client learns behaviors by observing and imitating others; often combined with behavioral rehearsal (e.g., in assertiveness training). Cognitive-behavior therapies Treatment methods that use behavior modification techniques but also incorporate procedures designed to change maladaptive beliefs. Psychodynamic therapies Traditional psychoanalysis Through free association, dream analysis, and transference, attempts to discover the unconscious basis of the client’s current problems so as to deal with them in a more rational way. Contemporary psychodynamic therapies (e.g., interpersonal therapy) More structured and short-term than traditional psychoanalysis; emphasize the way the client is currently interacting with others. Humanistic therapies (e.g., client-centered therapy) In an atmosphere of empathy, warmth, and genuineness, the therapist attempts to facilitate the process through which the client works out solutions to his or her own problems. Biological therapies Psychotherapeutic drugs Use of drugs to modify mood and behavior. Electroconvulsive therapy (ECT) A mild electric current is

applied to the brain to produce a seizure. CHAPTER 16 TREATMENT OF MENTAL HEALTH PROBLEMS For more Cengage Learning textbooks, visit www.cengagebrain.co.uk

ª STOCK MONTAGE Philippe Pinel in the courtyard of the hospital of Salpetriere. many individuals were cared for with great kindness in temples dedicated to the gods of healing. This progressive view of mental illness did not continue, however. Primitive superstitions and belief in demon possession were revived during the Middle Ages. The mentally ill were considered to be in league with Satan and to possess supernatural powers with which they could cause floods, pestilence, and injuries to others. Seriously disturbed individuals were treated cruelly: It was believed that beating, starving, and torturing the mentally ill served to punish the devil. This type of cruelty culminated in the witchcraft trials of the fifteenth, sixteenth, and seventeenth centuries, in which thousands of people, many of whom may have been mentally ill, were sentenced to death. Early asylums In the late Middle Ages, cities created asylums to cope with the mentally ill. These asylums were simply prisons; the inmates were chained in dark, filthy cells and treated more as animals than as human beings. It was not until 1792, when Philippe Pinel was placed in charge of an asylum in Paris, that some improvements were made. As an experiment, Pinel removed the chains that restrained the inmates. Much to the amazement of skeptics who thought Pinel was mad to unchain such ‘animals’, the experiment was a success. When released from their restraints, placed in clean, sunny rooms, and treated kindly, many people who for years had been considered hopelessly insane improved enough to leave the asylum. By the beginning of the twentieth century, the fields of medicine and psychology were making great advances. In 1905, a mental disorder known as general paresis was shown to have a physical cause: a syphilis infection acquired many years For more Cengage Learning textbooks, visit www.cengagebrain.co.uk HISTORICAL BACKGROUND before the symptoms of the disorder appeared. The syphilis spirochete remains in the body after the initial genital infection disappears, and it gradually destroys the nervous system. The results include the syndrome known as general paresis – a gradual decline in mental and physical functioning, marked changes in personality, and delusions and hallucinations. If the disorder is not treated, death occurs within a few years. At one time, general paresis accounted for more than 10 percent of all admissions to mental hospitals, but today few cases are reported, owing to the effectiveness of penicillin in treating syphilis. The discovery that general paresis was the result of a disease encouraged those who believed that mental illness has biological causes. Nevertheless, in the early 1900s the public still did not understand mental illness and viewed mental hospitals and their inmates with fear and horror. Modern treatment facilities Psychiatric hospitals have been upgraded markedly in the last century, but there is still much room for improvement. The best psychiatric hospitals are comfortable and wellkept places that provide therapeutic activities: individual and group psychotherapy, recreation, occupational therapy (designed to teach skills as well as provide relaxation), and educational courses to help patients prepare for jobs upon release from the hospital. The worst are primarily custodial institutions where patients lead a boring existence in rundown, overcrowded wards and receive little treatment beyond medication. Most psychiatric hospitals fall somewhere between these extremes. Beginning in the early 1960s, emphasis shifted from treating individuals with mental health problems in hospitals to treating them in their own communities. This movement toward community treatment was motivated partly by the recognition that hospitalization has some inherent disadvantages, regardless of how good the facilities may be. Hospitals remove people from the social support of family and friends and the familiar patterns of daily life, and they encourage dependence. They are also very expensive. ª CORBIS/BETTMANN The crib, a restraining device used in a New York mental institution in 1882.

During the 1950s, psychotherapeutic drugs (discussed later in the chapter) were discovered that could relieve depression and anxiety and reduce psychotic behavior. When these drugs became widely available in the 1960s, many hospitalized patients could be discharged and returned home to be treated as outpatients. By the 1970s, specialized psychiatric hospitals across Europe were closed or reduced in size, with the expectation that patients would be treated in community treatment centers designed to provide outpatient treatment and other services, including short-term and partial hospitalization. In partial hospitalization, individuals may receive treatment at the center during the day and return home in the evening, or they can work during the day and spend nights at the center. The movement toward discharge of institutionalized patients to community-based services became known as deinstitutionalization. As Figures 16.1 and 16.2 show, the number of patients treated in specialized psychiatric hospitals has decreased dramatically in many European countries, but only slightly in some countries recently admitted to the European Union. In Sweden, for example, there are now no Number of psychiatric beds per 100,000 1985 1995 United Kingdom 50 150 200 300 450 Switzerland Sweden Spain Portugal Norway Netherlands Luxembourg Italy Ireland Iceland Greece Germany France Finland Denmark Belgium Austria Figure 16.1 Trends in the numbers of psychiatric beds in western Europe 1978-2002. Reductions in the number of patients treated in specialized psychiatric facilities have occurred in many European nations. European health for all database, WHO Regional Office for Europe, 2004. 1990 1994 1998 2002 Cyprus Estonia Hungary Latvia Lithuania Malta Poland Slovakia Slovenia Czech Republic 50 150 250 Psychiatric beds per 100,000 population Figure 16.2 Trends in the numbers of psychiatric beds in the new EU Member States, 1988-2002. New EU member states show less reduction in psychiatric hospitalization. European health for all database, WHO Regional Office for Europe, 2004. CHAPTER 16 TREATMENT OF MENTAL HEALTH PROBLEMS For more Cengage Learning textbooks, visit www.cengagebrain.co.uk

psychiatric hospitals and patients who need hospitalization are expected to be treated in general hospitals. Slovakia and Slovenia show little change in the use of psychiatric hospitals for patients, however, and the Russian Federation has the highest number of inpatient psychiatric beds of the countries studied (see Figure 16.2). For some patients, deinstitutionalization has been successful. The services of mental health centers and private clinicians, along with help from their families and the use of psychotherapeutic drugs, have enabled them to resume satisfactory lives. This is particularly true in countries with good economic resources. For example, one study of 751 patients discharged from two psychiatric hospitals in England found that five years later, 90 percent were living in the community, and very few had come in contact with the criminal justice system or had become homeless (Trieman et al., 1999). For others, however, deinstitutionalization has had unfortunate consequences, largely because the facilities in their communities are far from adequate. Currently, 28 percent of European countries have little or no communitybased services for people with serious mental health problems (WHO, 2004). Many individuals who improve with hospitalization and could manage on their own with assistance do not receive adequate follow-up care in terms of outpatient therapy, monitoring of medication, or help in finding friends, housing, and jobs. As a consequence, they lead a ‘revolving-door’ existence, going in and out of institutions between unsuccessful attempts to cope on their own. Some discharged patients are too incapacitated to even attempt to support themselves or function without custodial care. They often live in dirty, overcrowded housing or on the streets. The disheveled man standing on the corner talking to himself and shouting gibberish may be one victim of deinstitutionalization. The woman with all her possessions in a shopping bag who spends one night in the doorway of an office

building and the next in a subway station may be another. In some European cities, up to 50 percent of homeless people have a severe mental health problem (WHO, 2003). The increasing visibility of homeless mentally ill individuals, particularly in large cities, has aroused public concern and prompted a move toward reinstitutionalization. However, this raises an important ethical issue. If such people are not readjusting to society, should they be involuntarily committed to a mental hospital? One of the most cherished civil rights in a democratic society is the right to liberty. Some experts believe that legal action is warranted only if a person is potentially dangerous to others. The rare, but highly publicized, occasions when a person experiencing a psychotic episode attacks an innocent bystander have generated fears for public safety. But dangerousness is difficult to predict (Monahan, 2001). Studies suggest that people who have both serious mental health problems and a substance misuse problem (such as alcoholism) do appear to commit violent crimes more often than healthy people (Steadman et al., 1998). Figure 16.3 provides data For more Cengage Learning textbooks, visit www.cengagebrain.co.uk HISTORICAL BACKGROUND Patients with SA Patients without SA Comparisons without SA Comparisons with SA 20 10 0 10 weeks 20 weeks 30 weeks 40 weeks 50 weeks Figure 16.3 Likelihood of Violence. The percent of patients with or without a substance abuse problem, and community comparisons with or without a substance abuse problem, who committed a violent act in the previous 10 weeks. Note that the community comparison group was assessed only at one time – at the end of the study. SA refers to substance abuse. (H. J. Steadman, E. P. Mulvey, J. Monahan, P. C. Robbins, P. S. Applebaum, T. Grisso, L. Roth, & E. Silver (1998). Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. Archives of General Psychiatry, 55, 393 – 401. © 1998 American Medical Association.) from a large study in which patients with diagnosed mental health problems were compared with mentally healthy people in the community. Those with mental health problems and a substance misuse problem were more likely to commit a serious violent act than the community comparison group or than the patients with mental health problems but no substance misuse problem. In addition, patients with mental health problems but no substance misuse problem were slightly more likely to commit violent acts than healthy people with no substance misuse problem. Note, however, that the presence of a substance misuse problem was as strong a predictor of violence as the presence of a diagnosed mental health problem in this study. In general, experts' opinions regarding whether a given individual will commit violent crimes are often incorrect, particularly for the long term (Gardner, Lidz, Mulvey, & Shaw, 1996). Professionals who provide psychotherapy There is substantial variety in the kinds of professionals involved in the delivery of mental health treatment from one country to another. In general, a psychiatrist has an M.D. degree and has completed advanced training in a mental health facility, during which he or she received supervision in the diagnosis of abnormal behavior, drug therapy, and psychotherapy. As a physician, the psychiatrist can prescribe medication and, in most states, hospitalization.

584 CHAPTER 16 TREATMENT OF MENTAL HEALTH PROBLEMS Psychologists who work as therapists have obtained graduate training in clinical or counseling psychology. Usually, they hold a Ph.D. (Doctor of Philosophy) degree that requires four to five years of postgraduate study, plus a year or more of internship. The term psychoanalyst is reserved for individuals who have received specialized training at a psychoanalytic institute learning the methods and theories derived from Freud. The program usually takes several years, during which the trainees must undergo their own psychoanalyses as well as treat several clients psychoanalytically while under supervision. Depending on the nation, other mental health professionals may be involved in treatment.

Sometimes these professionals work as a team. The psychiatrist prescribes psychotherapeutic medications and monitors their effectiveness; the psychologist sees the same client in individual or group psychotherapy. In our discussion of psychotherapeutic techniques, we will not specify the profession of the psychotherapists. Instead, we will assume that they are trained and competent members of any one of these professions. INTERIM SUMMARY l Treatment of the mentally ill has progressed from the ancient notion that abnormal behavior resulted from possession by evil spirits that needed to be punished, to custodial care in asylums, to modern mental hospitals and community mental health centers. l The policy of deinstitutionalization was intended to move hospitalized mental patients into the community, where they would receive outpatient services. l The deinstitutionalization movement was never adequately funded and, despite its good intentions, has added to the number of homeless mentally ill individuals, causing concern about civil rights and adequate care. l Several different mental health professionals provide service to people with mental health problems, including psychiatrists and psychologists. CRITICAL THINKING QUESTIONS 1 What do you think society's obligations are to people with serious mental health problems? What laws should be enacted to protect the rights of these people? 2 Does society have any right or obligation to see to it that children with serious mental health problems receive treatment, even if their parents do not agree to the treatment? For more Cengage Learning textbooks, visit www.cengagebrain.co.uk TECHNIQUES OF PSYCHOTHERAPY Psychotherapy refers to the variety of psychological interventions that share the goal of alleviating human problems and facilitating effective functioning in society. Some psychotherapists (such as behavior therapists and cognitivebehavior therapists) focus on changing habitual patterns of thinking and behavior. Others (such as psychoanalysts) believe that modification of behavior is dependent on the individual'sunderstandingofhisorherunconsciousmotives and conflicts. Despite differences in techniques, most methodsofpsychotherapyhavecertainbasicfeaturesincommon. They involve a helping relationship between two people: the client (patient) and the therapist. The client is encouraged to discuss intimate concerns, emotions, and experiences freely without fear of being judged by the therapist or having confidences betrayed. The therapist, in turn, offers empathy and understanding, engenders trust, and tries to help the client develop more effective ways of handling problems. Behavior therapies The term behavior therapy includes a number of therapeutic methods based on the principles of learning and conditioning (see Chapter 7). Behavior therapists assume that maladaptive behaviors are learned ways of coping with stress and that some of the techniques developed in experimental research on learning can be used to substitute more appropriate responses for maladaptive ones. Don't people need to gain insight into their behaviors in order to change them? Behavior therapists point out that although the achievement of insight is a worthwhile goal, it does not ensure behavioral change. Often we understand why we behave the way we do in a certain situation but are unable to change our behavior. If you are unusually timid about speaking in class, you may be able to trace this fear ª MICHAEL NEWMAN/PHOTO RESEARCHERS Behavioral treatments for phobias require people to actually confront the object of their phobia.

to past events (your father criticized your opinions whenever you expressed them, your mother made a point of correcting your grammar, you had little experience in public speaking during school because you were afraid to compete with your older brother, who was captain of the debate team). Understanding the reasons behind your fear does not necessarily make it easier for you to contribute to class discussions. Behavior therapies attempt to modify behaviors that are maladaptive in specific situations. In the initial session, the therapist listens carefully to the client's

statement of the problem. What exactly does the client want to change? Is it a fear of flying or of speaking in public? Difficulty in controlling eating or drinking? Feelings of inadequacy and helplessness? Inability to concentrate and get work done? The first step is to define the problem clearly and break it down into a set of specific therapeutic goals. If, for example, the client complains of general feelings of inadequacy, the therapist will try to get the client to describe these feelings more specifically: to pinpoint the kinds of situations in which they occur and the kinds of behaviors associated with them. Inadequate to do what? To speak up in class or in social situations? To get assignments completed on time? To control eating? Once the behaviors that need to be changed have been specified, the therapist and client work out a treatment program, choosing the treatment method that is most appropriate for the particular problem. Systematic desensitization and in vivo exposure Systematic desensitization is method of gradually reducing fearful responses to stimuli and overcoming the maladaptive behaviors that often accompany fear, such as avoidance of feared situations. The client is first trained to relax deeply so that he or she can use relaxation techniques to reduce fearful responses. One way to relax is to progressively tense then relax various muscles, starting, for example, with the feet and ankles and proceeding up the body to the neck and face. The person learns what muscles feel like when they are truly relaxed and how to discriminate among various degrees of tension. Sometimes drugs and hypnosis are used to help people who cannot relax otherwise. The next step is to create a hierarchy of the anxietyproducing situations. The situations are ranked in order from the one that produces the least anxiety to the one that produces the most. In systematic desensitization, the client is then asked to relax and imagine each situation in the hierarchy, starting with the one that is least anxietyproducing. In vivo exposure is a method highly similar to systematic desensitization that requires the client to actually experience the anxiety-producing situations. In vivo exposure is more effective than simply imagining anxiety-producing situations, but some clients need to begin with imagination and eventually move to actually experiencing feared situations. For more Cengage Learning textbooks, visit www.cengagebrain.co.uk TECHNIQUES OF PSYCHOTHERAPY An example will make these procedures clearer. Suppose that the client is a woman who suffers from a phobia of spiders. The phobia is so strong that she is afraid to walk in her own back yard, let alone go for a walk in the countryside or on a holiday in a wooded area. Her anxiety hierarchy might begin with a picture of a spider in a book. Somewhere around the middle of the hierarchy might be viewing a spider in a glass cage at the zoo. At the top of the hierarchy would be actually handling a spider. After this woman has learned to relax and has constructed the hierarchy, the therapist begins taking her through her list. In systematic desensitization, she sits with her eyes closed in a comfortable chair while the therapist describes the least anxiety-provoking situation. If she can imagine herself in the situation without any increase in muscle tension, the therapist proceeds to the next item on the list. If the woman reports any anxiety while visualizing a scene, she concentrates on relaxing, and the same scene is visualized until all anxiety has been neutralized. This process continues through a series of sessions until the situation that originally provoked the most anxiety now elicits only relaxation. During in vivo exposure, the woman would actually experience each of the situations on her list, beginning with the least feared one, with the coaching of the therapist. Before she actually handled a spider herself, the therapist might model handling the spider without being fearful – the therapist would hold the spider in the client’s presence, displaying confidence and no anxiety. Eventually the client would handle the spider herself, allowing it to crawl on her while using relaxation to control her anxiety. In vivo exposure therapy of this sort has proven extremely effective in the treatment of phobias (Bandura, Blanchard, & Ritter, 1969). The specific learning process operating in in vivo exposure may be extinction. Exposing

oneself to a feararousing stimulus and discovering that nothing bad happens extinguishes the conditioned fear response. Relaxation may be merely a useful way to encourage a person to confront the feared object or situation. Indeed, if phobic individuals can force themselves to stay in the feared situation for a long period (for example, a claustrophobic person sits in a closet for hours or someone who fears contamination goes for days without washing), the initial terror gradually subsides. The term flooding is used to refer to this procedure, a type of in vivo therapy in which a phobic individual is exposed to the most feared object or situation for an extended period without an opportunity to escape. This approach has proved to be particularly effective in the treatment of agoraphobia and obsessive-compulsive disorders (Foa & Franklin, 2001). Selective reinforcement Systematic desensitization and in vivo exposure help reduce unwanted behaviors. Selective reinforcement is a technique designed to strengthen or increase specific desired behaviors.

586 CHAPTER 16 TREATMENT OF MENTAL HEALTH PROBLEMS Imagine a 9-year-old girl who is inattentive in school, refuses to complete assignments or participate in class, and spends most of her time daydreaming. In addition, her social skills are poor and she has few friends. A teacher may wish to reinforce ‘on-task’ behavior, such as paying attention to schoolwork or instructions from the teacher, completing reading assignments, and taking part in class discussions. The teacher may give the girl a token (such as a poker chip) whenever she observes the girl performing on-task behaviors. The little girl then could exchange these tokens for special privileges that she values, such as standing first in line (worth three tokens) or being allowed to stay after school to help the teacher with special projects (worth nine tokens). Reinforcement of desirable responses can be accompanied by extinction of undesirable ones. For example, a boy who habitually shouts to get his mother’s attention could be ignored whenever he does so and reinforced by her attention only when he comes to her and speaks in a conversational tone. Operant conditioning procedures involving rewards for desirable responses and no rewards for undesirable ones have been used successfully in dealing with a broad range of childhood problems, including bed-wetting, aggression, tantrums, disruptive classroom behavior, poor school performance, and social withdrawal. Similar procedures have been used in treating autism, for example, by reinforcing socially appropriate behaviors such as looking other people in the eyes, or reducing inappropriate behavior, such as temper tantrums. Modeling Another effective means of changing behavior is modeling. Modeling is the process by which a person learns behaviors by observing and imitating others. Because observing others is a major way in which humans learn, watching people who are displaying adaptive behavior should teach people with maladaptive responses better strategies. Observing the behavior of a model (either live or videotaped) has proved effective in reducing fears and teaching new skills. For example, observing a therapist handle a spider can reduce the fears of a person with a spider phobia, making it possible for him or her to eventually handle the spider also. Modeling is effective in overcoming fears and anxieties because it provides an opportunity to observe someone else go through the anxiety-provoking situation without getting hurt. Watching videotapes of models enjoying a visit to the dentist or going through various hospital procedures has proved successful in helping both children and adults overcome their fears of such experiences (Thorpe & Olson, 1997). Behavioral rehearsal In a therapy session, modeling is often combined with behavioral rehearsal, or role playing. The therapist helps For more Cengage Learning textbooks, visit www.cengagebrain.co.uk the client rehearse or practice more adaptive behaviors. In the following excerpt, a therapist helps a young man overcome his anxieties about talking with women. The young man has been pretending to talk to a woman over the phone and finishes by asking her if she would like to go to the cinema with him. Client: Um, I was wondering, you wouldn’t want to

go to the cinema with me, or anything, would you? Therapist: Okay, that's a start. Can you think of another way of asking her out that sounds a bit more positive and confident? For example, 'There's a great new movie showing at the cinema and I'd like very much to take you, if you are free.' Client: That's great! Therapist: Okay, you try it. Client: Um, I've got two free tickets to the movie. If you don't have anything to do, you might want to come along. Therapist: That's better. Try it one more time, but this time try to convey to her that you'd really like her to go. Client: I've got two tickets for a great new movie. It would be great if you'd go with me, if you're not busy. Therapist: Great! Just practice it a couple of more times, and you're ready to pick up the phone. This example illustrates the use of behavioral rehearsal in a type of behavior therapy known as assertiveness training. Like the young man in the example, many people have trouble asking for what they want or refusing to allow others to take advantage of them. By practicing assertive responses (first in role-playing with the therapist and then in real-life situations), the individual not only reduces anxiety but also develops more effective coping techniques. The therapist determines the kinds of situations in which the person is passive and then helps him or her think of and practice some assertive responses that might be effective. The following are examples of situations that might be worked through during a sequence of therapy sessions: Someone steps in front of you in line. A friend asks you to do something that you do not want to do. Your boss criticizes you unjustly. You return defective merchandise to a store. You are annoyed by the conversation of people behind you in a cinema. The mechanic did an unsatisfactory job of repairing your car.

Table 16.1 Some elements of an assertive response Decide what you want to say and stick with it rather than giving in to others the minute they disagree with you. For example, when a clerk says you cannot return a defective product, say, 'This is defective and I want to return it' repeatedly until the clerk allows you to return it or at least calls the manager, whom you tell, 'This is defective and I want to return it' until you get your money back. Ask for small, specific changes in a situation or another person's behavior rather than requesting global changes. For example, rather than saying, 'I want you to be more loving', say, 'I want you to listen to me when I talk.' Use 'I' phrases instead of accusatory phrases when discussing a difficult situation with another person. Four pieces to an 'I' statement are: I feel . . . when you . . . because . . . what I want . . . For example, 'I feel angry when you don't show up for an appointment because it wastes my time. What I want is for you to call me and cancel our appointment when you think you won't be able to make it'. Most people do not enjoy dealing with such situations, but some are so fearful of asserting themselves that they say nothing and instead build up feelings of resentment and inadequacy. In assertiveness training, the client rehearses with the therapist effective responses that could be made in such situations and then gradually tries them out in real life. The therapist tries to teach the client to express his or her needs in a way that is straightforward and forceful but is not seen by others as hostile or threatening (see Table 16.1). Self-regulation Because the client and therapist seldom meet more than once per week, the client must learn to control or regulate his or her own behavior so that progress can be made outside the therapy hour. Moreover, if people feel that they are responsible for their own improvement, they are more likely to maintain whatever gains they make. Self-regulation involves monitoring, or observing, one's own behavior and using various techniques, including self-reinforcement, and exposure to feared situations while practicing relaxation strategies, to change maladaptive behavior. An individual monitors his or her behavior by keeping a careful record of the kinds of situations that elicit the maladaptive behavior and the kinds of responses that are For more Cengage Learning textbooks, visit www.cengagebrain.co.uk incompatible with it. For example, a person who is concerned

with alcohol abuse would note the kinds of situations in which he or she is most tempted to drink and would try to control such situations or devise a response that is incompatible with drinking (see Marlatt's Seeing Both Sides essay for an application of these techniques). A man who finds it hard not to join his coworkers in a beer at the pub after work might substitute a game of tennis or a jog around the block as a means of relieving tension. This activity would be incompatible with drinking. Self-reinforcement is rewarding yourself immediately for achieving a specific goal. The reward could be praising yourself, watching a favorite television program, telephoning a friend, or eating a favorite food. Self-punishment is arranging for an aversive consequence for failing to achieve a goal, such as depriving yourself of something you enjoy (not watching a favorite television program, for instance) or making yourself do an unpleasant task (such as cleaning your room). Depending on the kind of behavior you want to change, various combinations of self-reinforcement, self-punishment, or control of stimuli and responses may be used. Table 16.2 outlines a program for self-regulation of eating. Often, many of the techniques of behavior therapy are used in combination to treat people with serious mental health problems. Behavior therapy has proven effective for several of the anxiety disorders, including panic disorder, phobias, and obsessive-compulsive disorders (Rothbaum & Osalov, 2006; Turner, 2006), for depression (Dimidjian et al., 2006), for problems in sexual functioning (Gambescia & Weeks, 2007), and for several childhood disorders (Kazdin & Weisz, 2003). Cognitive-behavior therapies The behavior therapy procedures discussed so far have focused on modifying behavior directly. They devote little attention to the individual's thinking and reasoning processes. Initially, behavior therapists discounted the importance of cognition, preferring a strict stimulus – response approach. However, in response to evidence that cognitive factors – thoughts, expectations, and interpretations of events – are important determinants of behavior, cognitive approaches are now regularly combined with behavioral approaches in what is known as cognitive-behavior therapy (A. T. Beck, Rush, Shaw, & Emery, 1979; J. S. Beck, 1995). The cognitive component of cognitive-behavior therapy involves helping the client control disturbing emotional reactions, such as anxiety and depression, by teaching more effective ways of interpreting and thinking about experiences. For example, as we noted in discussing Beck's cognitive theory of depression (see Chapter 15), depressed individuals tend to appraise events from a

negative and self-critical viewpoint. They expect to fail rather than succeed, and they tend to magnify failures and minimize successes in evaluating their performance. In treating depression, cognitive-behavior therapists help clients recognize the distortions in their thinking and make changes that are more in line with reality. The following dialogue illustrates how a therapist, through carefully directed questioning, makes a client who is Table 16.2 Self-Regulation of Eating This program illustrates the use of learning principles to help control food intake. (After Fairburn 1995) Self-Monitoring Daily Log Keep a detailed record of everything you eat. Note the amount eaten, the type of food and its caloric value, the time of day, and the circumstances of eating. This record will establish the caloric intake that is maintaining your present weight. It will also help identify the stimuli that elicit and reinforce your eating behavior. Weight Chart Decide how much weight you want to lose, and set a weekly weight loss goal. Your weekly goal should be realistic (between 1 and 2 pounds). Record your weight each day on graph paper. In addition to showing how your weight varies with food intake, this visual record will reinforce your dieting efforts as you observe progress toward your goal. Controlling Stimulus Conditions Use these procedures to narrow the range of stimuli associated with eating:

1. Eat only at predetermined times, at a specific table, using a special place mat, napkin, dishes, and so forth. Do not eat at other times or in other places (for example, while standing in the kitchen).
2. Do not combine eating with other activities, such as reading or watching television.
3. Keep in the house only the foods that are permitted on your diet.
4. Shop for food only after having had a full meal; buy only items that are on a previously prepared list. Modifying Actual Eating Behavior Use these procedures to break the chain of responses that makes eating automatic.
5. Eat very slowly, paying close attention to the food.
6. Finish chewing and swallowing before putting more food on the fork.
7. Put your utensils down for periodic short breaks before continuing to eat. Developing Incompatible Responses When tempted to eat at times other than those specified, find a substitute activity that is incompatible with eating. For example, exercise to music, go for a walk, talk with a friend (preferably one who knows that you are dieting), or study your diet plan and weight graph, noting how much weight you have lost. Self-Reinforcement Arrange to reward yourself with an activity that you enjoy (watching television, reading, planning a new wardrobe, visiting a friend) when you have maintained appropriate eating behavior for a day. Plan larger rewards (for example, buying something you want) for a specified amount of weight loss. Self-punishment (other than forgoing a reward) is probably less effective because dieting is a fairly depressing business anyway. CHAPTER 16 TREATMENT OF MENTAL HEALTH PROBLEMS For more Cengage Learning textbooks, visit www.cengagebrain.co.uk

suicidal because her marriage is failing aware of the unrealistic nature of her beliefs. Therapist: Why do you want to end your life? Client: Without Raymond, I am nothing. . . . I can't be happy without Raymond. . . . But I can't save our marriage. Therapist: What has your marriage been like? Client: It has been miserable from the very beginning. . . . Raymond has always been unfaithful. . . . I have hardly seen him in the past five years. Therapist: You say that you can't be happy without Raymond. . . . Have you found yourself happy when you are with Raymond? Client: No, we fight all the time and I feel worse. Therapist: You say you are nothing without Raymond. Before you met Raymond, did you feel you were nothing? Client: No, I felt I was somebody. Therapist: If you were somebody before you knew Raymond, why do you need him [in order] to be somebody now? Client: (puzzled) Hmmm. . . . Therapist: If you were free of the marriage, do you think that men might be interested in you – knowing that you were available? Client: I guess that maybe they would be. Therapist: Is it possible that you might find a man who would be more constant than Raymond? Client: I don't know. . . . I guess it's possible. . . . Therapist: Then what have you actually lost if you break up the marriage? Client: I don't know. Therapist: Is it possible that you'll get along better if you end the marriage? Client: There is no guarantee of that. Therapist: Do you have a real marriage? Client: I guess not. Therapist: If you don't have a real marriage, what do you actually lose if you decide to end the marriage? Client: (long pause) Nothing, I guess. (Beck, 1976, pp. 280 – 291) The behavioral component of the treatment comes into play when the therapist encourages the client to formulate alternative ways of viewing her situation and then test the implications of those alternatives. For example, the woman client in the preceding dialogue might be asked to For more Cengage Learning textbooks, visit www.cengagebrain.co.uk TECHNIQUES OF PSYCHOTHERAPY record her moods at regular intervals and then note how her depression and feelings of self-esteem fluctuate as a function of what she is doing. If she finds that she feels worse

after interacting with her husband than when she is alone or is interacting with someone else, this information could serve to challenge her belief that she ‘can’t be happy without Raymond’. A cognitive-behavioral program to help someone overcome agoraphobia might include training in more adaptive thinking, along with in vivo exposure (accompanied excursions that take the individual progressively farther from home). The therapist teaches the client to replace self-defeating internal dialogues (‘I’m so nervous, I know I’ll faint as soon as I leave the house’) with positive self-instructions (‘Be calm; I’m not alone; even if I have a panic attack, I can cope’). Table 16.3 describes a program for the treatment of depression that includes techniques for modifying behavior and changing attitudes. Cognitive-behavior therapists agree that it is important to alter a person’s beliefs in order to bring about an enduring change in behavior. Most maintain that behavioral procedures are more powerful than strictly verbal ones in affecting cognitive processes. For example, to overcome anxiety about giving a speech in class, it is helpful to think positively: ‘I know the material well, and I’m sure I can present my ideas effectively’ and ‘The topic is interesting, and the other students will enjoy what I have to say.’ But first presenting the speech to a roommate and again before a group of friends will probably do more to reduce anxiety. Successful performance increases our feeling of mastery. In fact, it has been suggested that all therapeutic procedures that are effective give the client a sense of mastery or self-efficacy. Observing others cope and succeed, being verbally persuaded that we can handle a difficult situation, and judging from internal cues that we are relaxed and in control contribute to feelings of self-efficacy. But the greatest sense of efficacy comes from actual performance, from the experience of mastery. In essence, nothing succeeds like success (Bandura, 2006). Cognitive-behavior therapies have proven highly effective in treating an array of nonpsychotic conditions, including depression (Shapiro, Barkham et al., 1994), anxiety disorders (Figure 16.4) (Clark, Ehlers, et al. 2006; Van Boeijn, van Oppen et al., 2005), eating disorders (Cooper, Fairburn, & Hawker, 2004), drug and alcohol dependence (Koumimtsidis, Reynolds, Drummond, Davis, Sell, & Tarrier, 2007), and sexual dysfunctions (Leiblum & Rosen, 2000). These therapies help people overcome troubling thoughts, feelings, and behaviors and also to prevent relapses after therapy has ended. In addition, cognitive-behavior therapies can help people with psychotic symptoms learn how to manage their symptoms (Chadwick, Birchwood, & Trower, 1996; Haddock & Slade, 1995; Morrison, Rengon, Dunn, Williams, & Bentall, 2003).

590 CHAPTER 16 TREATMENT OF MENTAL HEALTH PROBLEMS Table 16.3 Coping With Depression This is a condensed description of a 12-session course used to treat depressed individuals in small groups. (Reprinted with permission from The Coping With Depression Course: Psychoeducational Intervention for Unipolar Depression, by P. M. Lewnsohn, D. O. Antonucio, J. L. Skinmetz, & L. Teri. Copyright © 1984 by Castalia Publishing Company. All rights reserved.) Instruction in Self-Change Skills Pinpointing the target behavior and recording its baseline rate of occurrence; discovering the events or situations that precede the target behavior and the consequences (either positive or negative) that follow it; setting goals for change and choosing reinforcers. Relaxation Training Learning progressive muscle relaxation to handle the anxiety that often accompanies depression; monitoring tension in daily situations; and applying relaxation techniques. Increasing Pleasant Activities Monitoring the frequency of enjoyable activities and planning weekly schedules so that each day contains a balance between negative/neutral activities and pleasant ones. Cognitive Strategies Learning methods for increasing positive thoughts and decreasing negative ones; for identifying irrational thoughts and challenging them; and for using self-instructions to help handle problem situations. Assertiveness Training Identifying situations in which being nonassertive adds

to feelings of depression; learning to handle social interactions more assertively via modeling and role playing. Increasing Social Interaction Identifying the factors that are contributing to low social interaction (such as getting into the habit of doing things alone, feeling uncomfortable due to few social skills); deciding on activities that need to be increased (such as calling friends to suggest getting together) or decreased (such as watching television) in order to increase the level of pleasant social interaction. Psychodynamic therapies A key assumption of psychodynamic therapies is that people's current problems cannot be resolved successfully without a thorough understanding of their unconscious basis in early relationships with parents and siblings. The For more Cengage Learning textbooks, visit www.cengagebrain.co.uk Percent of panic patients remaining symptom-free after 15 months 60 20 Cognitivebehavioral Drug Relaxation Type of therapy Figure 16.4 Percentage of Panic Patients Remaining Symptom-Free After 15 Months. People receiving cognitivebehavioral therapy for panic disorder were more likely to remain symptom-free over 15 months than people receiving only drug therapy or relaxation training. (After Clark et al., 1994) goal of these therapies is to bring conflicts (repressed emotions and motives) into awareness so that they can be dealt with in a more rational and realistic way. The psychodynamic therapies include traditional Freudian psychoanalysis and more recent therapies based on it (see Vakoch & Strupp, 2000). One of the main techniques that psychodynamic therapists use to recover unconscious conflicts is free association, in which the client is encouraged to give free rein to thoughts and feelings and to say whatever comes to mind without editing or censoring it. This is not easy to do, however. In conversation, we usually try to keep a connecting thread running through our remarks and exclude irrelevant ideas. With practice, free association ª SIDNEY HARRIS, COURTESY SCIENCECARTOONPLUS.COM

becomes easier. But even individuals who conscientiously try to give free rein to their thoughts will occasionally find themselves blocked, unable to recall the details of an event or finish a thought. Freud believed that blocking, or resistance, results from the individual's unconscious control over sensitive areas and that these are precisely the areas that need to be explored. Another technique often used in traditional psychoanalytic therapy is dream analysis, which consists of talking about the content of one's dreams and then free associating to that content. Freud believed that dreams are 'the royal road to the unconscious'; they represent an unconscious wish or fear in disguised form. He distinguished between dreams' manifest content (the obvious, conscious content) and their latent content (the hidden, unconscious content). By talking about the manifest content of a dream and then free associating to that content, the analyst and client attempt to discover the dream's unconscious meaning. As the therapist and client interact during therapy, the client will often react to the therapist in ways that seem exaggerated or inappropriate. The client may become enraged when the therapist must reschedule an appointment, or may be excessively deferential to the therapist. The term transference refers to the tendency for the client to make the therapist the object of thoughts and emotions: The client expresses attitudes toward the analyst that are actually felt toward other people who are, or were, important in his or her life. By pointing out how their clients are reacting to them, therapists help their clients achieve a better understanding of how they react to others. The following passage illustrates an analyst's use of transference, followed by the use of free association: Client: I don't understand why you're holding back on telling me if this step is the right one for me at this time in my life. Therapist: This has come up before. You want my approval before taking some action. What seems to be happening here is that one of the conflicts you have with your wife is trying to get her approval of what you have decided you want to do, and that conflict is occurring now between us. Client: I suppose so.

Other people’s approval has always been very important to me. Therapist: Let’s stay with that for a few minutes. Would you free associate to that idea of getting approval from others. Just let the associations come spontaneously – don’t force them. (Adapted from Woody & Robertson, 1988, p. 129) Traditional psychoanalysis is a lengthy, intensive, and expensive process. Client and analyst usually meet for For more Cengage Learning textbooks, visit www.cengagebrain.co.uk TECHNIQUES OF PSYCHOTHERAPY 50-minute sessions several times a week for at least a year and often for several years. Many people find selfexploration under traditional psychoanalysis to be of value; however, for some people it is unaffordable. In addition, people suffering from acute depression, anxiety, or psychosis typically cannot tolerate the lack of structure in traditional psychoanalysis and need more immediate relief from their symptoms. In response to these needs, as well as to changes in psychoanalytic theory since Freud’s time, newer therapies that draw upon psychoanalytic theory and practices, but are more structured and short-term than traditional psychoanalysis, have been developed. One such therapy is called interpersonal therapy (Weissman & Markowitz, 2002). Sessions are scheduled less frequently, usually once a week. There is less emphasis on complete reconstruction of childhood experiences and more attention to problems arising from the way the individual is currently interacting with others. Free association is often replaced with direct discussion of critical issues, and the therapist may be more direct, raising pertinent topics when appropriate rather than waiting for the client to bring them up. Although transference is still considered an important part of the therapeutic process, the therapist may try to limit the intensity of the transference process. Research has found interpersonal therapy to be helpful in the treatment of depression, anxiety, drug addiction, and eating disorders (Weissman & Markowitz, 2002). Humanistic therapies Humanistic therapies are based on the humanistic approach to personality discussed in Chapter 13. They emphasize the individual’s natural tendency toward growth and selfactualization. Psychological disorders are assumed to arise when circumstances or other people (parents, teachers, spouses) prevent the individual from achieving his or her potential. When this occurs, people begin to deny their true desires, and their potential for growth is reduced. Humanistic therapies seek to help people get in touch with their real selves and make deliberate choices regarding their lives and behavior rather than being controlled by external events. Like the psychoanalyst, the humanistic therapist attempts to increase the client’s awareness of underlying emotions and motives. But the emphasis is on what the individual is experiencing in the here and now, rather than in the past. The humanistic therapist does not interpret the client’s behavior (as a psychoanalyst might) or try to modify it (as a behavior therapist would), because this would amount to imposing the therapist’s views on the patient. The goal of the humanistic therapist is to facilitate exploration of the individual’s own thoughts and feelings and to assist the individual in arriving at his or her own solutions. This approach will become clearer as we look at client-centered therapy (also called nondirective therapy), one of the first humanistic therapies.

592 CHAPTER 16 TREATMENT OF MENTAL HEALTH PROBLEMS Client-centered therapy, developed in the 1940s by the late Carl Rogers, is based on the assumption that each individual is the best expert on himself or herself and that people are capable of working out solutions to their own problems. The task of the therapist is to facilitate this process – not to ask probing questions, make interpretations, or suggest courses of action. In fact, Rogers preferred the term facilitator to therapist, and he called the people he worked with clients rather than patients because he did not view emotional difficulties as indications of an illness to be cured. The therapist facilitates the client’s progress toward self-insight by restating what the client says about his or her needs and

emotions. Rogers believed that the most important qualities for a therapist are empathy, warmth, and genuineness. Empathy refers to the ability to understand the feelings the client is trying to express and the ability to communicate this understanding to the client. The therapist must adopt the client's frame of reference and strive to see the problems as the client sees them. By warmth, Rogers meant acceptance of individuals the way they are, including the conviction that they have the capacity to deal constructively with their problems. A therapist who is genuine is open and honest and does not play a role or operate behind a professional façade. People are reluctant to reveal themselves to those whom they perceive as phony. Rogers believed that a therapist who possesses these three attributes will facilitate the client's growth and self-exploration (Rogers, 1970). Rogers was the first therapist to make tape recordings of therapy sessions and permit them to be studied and analyzed. He and his colleagues have contributed much to psychotherapy research. Client-centered therapy has some limitations, however. Like psychoanalysis, it appears to be successful only with individuals who are fairly verbal and are motivated to discuss their problems. For people who do not voluntarily seek help or are seriously disturbed and unable to discuss their feelings, more directive methods are usually necessary. In addition, by using the client's self-reports as the only measure of psychotherapeutic effectiveness, the client-centered therapist ignores behavior outside the therapy session. Individuals who feel insecure and ineffective in their interpersonal relationships often need more structured help in modifying their behavior. Sociocultural approaches to therapy Sociocultural approaches to treatment view the individual as part of a larger system of relationships, influenced by social forces and culture, and believe that this larger system must be addressed in therapy. Group therapy Many emotional problems involve difficulties in relating to others, including feelings of isolation, rejection, and For more Cengage Learning textbooks, visit www.cengagebrain.co.uk loneliness and an inability to form meaningful relationships. Although the therapist can help the client work out some of these problems, the final test lies in how well the person can apply the attitudes and responses learned in therapy to relationships in everyday life. Group therapy permits clients to work out their problems in the presence of others, observe how other people react to their behavior, and try out new ways of responding when old ones prove unsatisfactory (Forsyth & Corazzini, 2000). It is often used as a supplement to individual psychotherapy. Psychoanalytic, humanistic, and cognitive-behaviorist therapists have modified their techniques so that they can be used with groups. Group therapy has been used in a variety of settings: in hospital wards and outpatient psychiatric clinics, with parents of disturbed children, and with teenagers in correctional institutions, to name a few. Typically, a group consists of a small number of individuals (six to eight is considered optimal) who have similar problems. The therapist usually remains in the background, allowing group members to exchange experiences, comment on one another's behavior, and discuss their own problems as well as those of the other members. However, in some groups the therapist is quite active. For example, in a group desensitization session, people who share the same phobias (such as fear of flying or anxiety about tests) may be led through a systematic ª BILL BACHMANN / ALAMY Group therapy brings together individuals with similar problems.

desensitization hierarchy. Or in a session for training social skills, a group of shy and unassertive individuals may be coached in a series of role-playing scenes. Group therapy has several advantages over individual therapy. It uses the therapist's resources more efficiently because one therapist can help several people at once. An individual can derive comfort and support from observing that others have similar, perhaps more severe problems. A person can learn vicariously by watching how others behave and can explore attitudes and reactions by interacting with a

variety of people, not just with the therapist. Groups are particularly effective when they give participants opportunities to acquire new social skills through modeling and to practice these skills in the group. Most groups are led by a trained therapist. However, the number and variety of self-help groups – groups that are conducted without a professional therapist – are increasing. Self-help groups are voluntary organizations of people who meet regularly to exchange information and support one another's efforts to overcome a common problem. Alcoholics Anonymous is the best known of these groups (see Humphreys' Seeing Both Sides essay for a discussion of AA). Other groups help people cope with specific stressful situations, such as bereavement, divorce, and single parenthood. Marital and family therapy Problems in communicating feelings, satisfying one's needs, and responding appropriately to the needs and demands of others become intensified in the intimate context of marriage and family life. To the extent that they involve more than one client and focus on interpersonal relationships, marital therapy – in which a married or partnered couple undergoes therapy – and family therapy – in which the entire family undergoes therapy together – can be considered specialized forms of group therapy. The high divorce rate and the number of couples seeking help for difficulties in their relationships have made marital or couples therapy a growing field. Studies show that joint therapy for both partners is more effective in solving marital problems than individual therapy for only one partner (Baucom, Epstein, & Gordon, 2000). Marital therapy can also be very helpful when one partner has a psychological disorder whose symptoms or consequences are disrupting the marriage. There are many approaches to marital therapy, but most focus on helping the partners communicate their feelings, develop greater understanding and sensitivity to each other's needs, and work on more effective ways of handling their conflicts. Some couples enter marriage with very different and often unrealistic expectations about the roles of husband and wife. The therapist can help them clarify their expectations and work out a mutually agreeable compromise. Sometimes the couple negotiates behavioral contracts, agreeing on the behavior changes For more Cengage Learning textbooks, visit www.cengagebrain.co.uk each person is willing to make in order to create a more satisfying relationship, and specifying rewards and penalties for making, or not making, the desired changes. Family therapy overlaps with marital therapy but has a somewhat different origin. It developed in response to the discovery that many people who improved in individual therapy away from their families – often in institutional settings – relapsed when they returned home. It became apparent that many of these people came from disturbed family settings that must be modified if the individual's gains were to be maintained. In the case of children with psychological problems, it is particularly important that the family be treated. The basic premise of family therapy is that the problem shown by the identified patient is a sign that something is wrong with the entire family; the family system is not operating properly. The difficulty may lie in poor communication among family members or in an alliance between some family members that excludes others. For example, a mother whose relationship with her husband is unsatisfactory may focus all her attention on her son. As a result, the husband and daughter feel neglected, and the son, upset by his mother's excessive attention and the resentment directed toward him by his father and sister, develops problems in school. Although the boy's school difficulties may be the reason for seeking treatment, it is clear that they are only a symptom of a more basic family problem. In family therapy, the family meets regularly with one or two therapists (usually a male and a female). The therapist observes the interactions among family members and tries to help each member become aware of the way he or she relates to the others and how his or her actions may be contributing to the family's problems. Sometimes videotape recordings are played back to make the family members aware of how they interact. At other times, the therapist may visit the family at home to

observe conflicts and verbal exchanges as they occur in their natural setting. It often becomes apparent that problem behaviors are being reinforced by the responses of family members. ª FRANK PEDRICK/THE IMAGE WORKS Family therapies seek to treat the family as a whole.

594 CHAPTER 16 TREATMENT OF MENTAL HEALTH PROBLEMS For example, a child's temper tantrums or a teenager's eating problems may be inadvertently reinforced by the attention they elicit from the parents. The therapist can teach the parents to monitor their own and their children's behavior, determine how their reactions may be reinforcing the problem behavior, and then alter the reinforcement contingencies. An important application of family therapy is in teaching families of people with schizophrenia to communicate more positively and clearly (Goldstein, 1987). People with schizophrenia in families in which conflict and hostility are expressed in hurtful ways and in which family members are overinvolved in each other's lives tend to have more frequent relapses than those in families in which conflict and hostility are expressed more calmly and family members respect each other's independence. Training programs that enhance family members' skills in expressing negative emotion and interacting in positive ways can reduce relapse rates for people with schizophrenia. Special issues in treating children Every therapy we have described has been used at one time or another to treat children and adolescents with psychological health problems. Studies of the effectiveness of psychological therapies generally show that children and adolescents who receive therapy have better outcomes than those who receive no therapy (Kazdin & Weisz, 2003). The effectiveness of any specific type of therapy may depend largely on the type of disorder the child or adolescent has. Designing and applying effective therapies for children and adolescents is made difficult by a number of factors. First, the therapy must be matched to the child's developmental level. Children must be able to understand what the therapist is saying and participate in the therapy to benefit from it. Therapies that are over their heads do them little good. Second, children are embedded in families, and often the family as well as the child must be treated. Yet, sometimes the family refuses to be treated or to recognize how they may be contributing to the child's problems. Finally, children and adolescents seldom refer themselves for treatment but instead are most often brought to treatment by their parents or other adults. This can substantially reduce their motivation to engage in therapy. Unfortunately, most children who could benefit from therapy do not receive it. Treatment facilities specializing in children's problems are not available in many parts of the world; 23 percent of countries have no programs for children. Only between 10 and 15 percent of young people with mental health problems receive help from mental health services (WHO, 2005). The child welfare system sees many troubled children, often the victims of For more Cengage Learning textbooks, visit www.cengagebrain.co.uk ª MIKAEL KARLSSON / ALAMY Many teenagers in juvenile justice facilities can have psychological health problems. abuse and neglect. Increasingly, such children are placed in long-term foster care rather than given specialized psychological treatment. Many children in the juvenile justice system suffer from psychological health problems, but few receive long-term intensive treatment. There is considerable room for the expansion of services to psychologically disturbed children. The effectiveness of psychotherapy How effective is psychotherapy? Which methods work best? In describing each of the psychotherapies, we mentioned some studies of their effectiveness. In this section, we look briefly at how research on the effectiveness of therapy is done. Evaluating psychotherapy It is difficult to objectively evaluate the effectiveness of psychotherapy because so many variables must be considered. For instance, some people with psychological problems get better without any professional treatment. This phenomenon is called spontaneous remission. People with some types of mental health problems

do improve simply with the passage of time. More often, however, improvement that occurs in the absence of treatment is not spontaneous. Rather, it is the result of external events such as the help of another person or changes in the individual's life situation. Many emotionally disturbed people who do not seek professional assistance improve with the help of a nonprofessional, such as a friend, teacher, or religious advisor. We cannot consider these recoveries to be spontaneous, but because they are not due to psychotherapy, they are included in the rate of spontaneous remission, which ranges from about 30 to 60 percent depending on the particular disorder being studied (Haaga & Stiles, 2000). To allow for those who would have improved without

treatment, evaluations of treatment often compare a treated group with a control group that receives no treatment, or in studies of biological treatments, a control group that receives an inactive placebo. Treatment is judged to be effective if the client's improvement after treatment is greater than any improvement that occurs without active treatment over the same period. The ethical problem of allowing someone to go without active treatment is sometimes resolved by composing the control group of individuals on a waiting list. Members of the waiting-list control group are interviewed at the beginning of the study to gather baseline information, but they receive no active treatment until after the study. Unfortunately, the longer the study, the harder it is to keep people on a waiting list. Other treatment evaluation studies compare two or more treatments so that all participants get some form of treatment. A second major problem in evaluating treatment is measuring the outcome. How do we decide whether a person has been helped by treatment? We cannot always rely on the individual's own assessment. Some people report that they are feeling better simply to please the therapist or to convince themselves that their money was well spent. The therapist's evaluation of the treatment as successful cannot always be considered an objective criterion, either. The therapist has a vested interest in proclaiming that the client is better. And sometimes the changes that the therapist observes during the therapy session do not carry over into real-life situations. Assessment of improvement, therefore, should include at least three independent measures: the client's evaluation of progress, the therapist's evaluation, and the judgment of third parties such as family members and friends or a clinician not involved in the treatment. Despite these problems, researchers have been able to conduct many treatment evaluation studies. We will focus here on studies of the outcomes of psychotherapy; studies of the effectiveness of drug treatments are discussed later in the chapter. We should note that for many health problems, psychotherapies have been pitted against drug therapies. Several reviews of research on the outcomes of psychotherapy over the last five decades have concluded that psychotherapy does indeed have positive effects and is better than no treatment at all or various placebos (for example, see Lambert, Shapiro, & Berkin, 1986; Westen, Novotny, & Thompson-Brenner, 2004). In 1980, for example, a group of investigators located 475 published studies that compared at least one therapy group with an untreated control group. Using the statistical procedure known as meta-analysis (see Chapter 6), they determined the magnitude of effect for each study by comparing the average change produced in treatment (on measures such as self-esteem, anxiety, and achievement in work and school) with that experienced by the control group. For more Cengage Learning textbooks, visit www.cengagebrain.co.uk TECHNIQUES OF PSYCHOTHERAPY They concluded that individuals receiving therapy were better off than those who had received no treatment. The average psychotherapy patient showed greater improvement than 80 percent of the untreated patients (Smith, Glass, & Miller, 1980). A subsequent review that analyzed a new sample of studies yielded comparable results (Shapiro & Shapiro, 1982). Comparing psychotherapies Psychotherapy

produces greater improvement than no treatment, but are the different therapeutic approaches equally effective? A number of reviews have analyzed studies in which the results of different psychotherapies (usually including behavioral, cognitive-behavioral, and sometimes client-centered therapies) were compared (Lambert & Bergen, 1994; Wampold et al., 1997). The conclusion of most of these reviews is that there is little difference in effectiveness between therapies. How can therapies that espouse such different methods produce such similar results? Numerous possible explanations have been suggested (Norcross, 2002). We will discuss two of them here. Perhaps certain therapies are effective for certain problems but relatively ineffective for others. When specific therapies are used to treat a wide range of problems, they may help in some cases but not in others. Thus, averaging results over cases may conceal the special strengths of a particular therapy. We need to know which treatment is effective for which problem (Chambless & Hollon, 1998). In several controlled studies, different types of psychotherapy were compared with drug therapy or with controls in which people received no therapy for a specific disorder. These studies clearly suggest that certain forms of psychotherapy can be highly effective in the treatment of depression, anxiety disorders, eating disorders, substance abuse disorders, and several childhood disorders (Leiblum & Rosen, 2000; Kazdin & Weisz, ª SIDNEY HARRIS, COURTESY SCIENCECARTOONPLUS.COM

596 CHAPTER 16 TREATMENT OF MENTAL HEALTH PROBLEMS 2003). Psychotherapy can also help reduce symptoms of autism and schizophrenia and lower the risk of relapse in schizophrenia (Lovaas & Smith, 2003; Spaulding et al., 2001). Not all forms of psychotherapy have undergone rigorous empirical tests for effectiveness, however. In general, proponents of behavioral and cognitive approaches have been interested in testing the efficacy of their therapies, so many studies have focused on these types of therapies. In contrast, proponents of psychodynamic and humanistic therapies have been less concerned with empirical tests of their therapies (De Rubeis & CritsCristoph, 1998). Another reason why different psychotherapies may be equally effective in helping clients is because they all share certain factors. It may be these common factors, rather than the specific therapeutic techniques employed, that promote positive change. Common factors in psychotherapies One school of therapy emphasizes insight; another, modeling and reinforcement; yet another, rational cognitions. But perhaps these variables are not the crucial ones. Other factors that are common to most psychotherapies may be more important (Garfield, 1994a,b; Snyder, Ilardi, Michael, & Cheavens, 2000). They include a strong alliance between the therapist and client, reassurance and support, desensitization, reinforcement of adaptive responses, and insight. An interpersonal relationship of warmth and trust Regardless of the type of therapy, in a good therapeutic relationship the client and the therapist have mutual respect and regard. The client must believe that the therapist understands and is concerned with his or her problems. A therapist who understands our problems and believes we can solve them earns our trust, which increases our sense of competence and our confidence that we can succeed. Our problems often seem insurmountable and unique to us. Discussing them with an expert who accepts our difficulties as not unusual and indicates that they can be resolved is reassuring. Having someone help us with problems that we have not been able to solve alone also provides a sense of support and a feeling of hope, and hope may be critical to recovery from psychological problems (Snyder et al., 2000). In fact, the most successful therapists, regardless of method, are those who form a helpful, supportive relationship with their clients. Desensitization We have already talked about systematic desensitization, the specific techniques of behavior therapy aimed at helping individuals lose their fear of certain objects or For more Cengage Learning textbooks, visit

www.cengagebrain.co.uk situations. But many types of psychotherapy can encourage a broader kind of desensitization. When we discuss troubling events and emotions in the accepting atmosphere of a therapy session, they gradually lose their threatening quality. Problems that we brood about alone can become magnified beyond proportion, and sharing those problems with someone else often makes them seem less serious. Several other hypotheses can also explain how desensitization occurs in psychotherapy. For example, putting disturbing events into words may help us reappraise the situation in a more realistic manner. From the viewpoint of learning theory, repeatedly discussing distressing experiences in the security of a therapeutic setting may gradually extinguish the anxiety associated with them. Whatever the process, desensitization does appear to be common to many kinds of psychotherapy. Reinforcement of adaptive responses Behavior therapists use reinforcement as a technique to increase positive attitudes and actions. But any therapist who wins the trust of a patient serves as a reinforcing agent because the therapist tends to express approval of behaviors or attitudes that are conducive to better adjustment, while ignoring or expressing disapproval of maladaptive attitudes or responses. Which responses are reinforced depends on the therapist's orientation and therapeutic goals. The use of reinforcement may be intentional or unintentional; in some instances, the therapist may be unaware that he or she is reinforcing or failing to reinforce a particular behavior. For example, client-centered therapists believe in letting the client determine what is discussed during the therapy sessions, and they do not wish to influence the trend of the client's conversation. However, reinforcement can be subtle; a smile, a nod, or a simple 'um hmm' in response to certain statements may increase the likelihood of their recurrence. Because the goal of all psychotherapies is to bring about a change in the client's attitudes and behaviors, some type of learning must take place in therapy. The therapist needs to be aware of his or her role in influencing the client by means of reinforcement and should use this knowledge to facilitate desired changes. Understanding or insight All of the psychotherapies we have been discussing provide an explanation of the client's difficulties – how they arose, why they persist, and how they can be changed (Frank & Frank, 1991; Ingram, Hayes, & Scott, 2000). For a patient in psychoanalysis, this explanation may take the form of gradual understanding of repressed childhood fears and the ways in which these unconscious feelings have contributed to current problems. A behavior therapist might inform the client that current fears are the result of previous conditioning and can be conquered by learning responses that are incompatible with the current

CUTTING EDGE RESEARCH Innovative Neurostimulation Treatments The effectiveness of electroconvulsive therapy (ECT) in treating depression (see page 601) suggests that stimulating the brain can have positive effects on mood. ECT remains controversial, however, and has potentially severe side effects. Thus, scientists have been searching for alternative methods for stimulating the brain that do not involve the application of electricity. Two new methods that hold much promise are repetitive transcranial magnetic stimulation (rTMS) and vagus nerve stimulation (VNS). Repetitive transcranial magnetic stimulation (rTMS) uses very strong magnetic pulses to stimulate targeted areas of the brain. In the procedure, hand-held stimulating coils are applied directly to the head to send repeated, high-intensity magnetic pulses that are focused on particular brain structures. For example, when treating depressed people, researchers have targeted the left prefrontal cortex, which tends to show abnormally low metabolic activity in some depressed people. Several studies have suggested that depressed patients given rTMS daily for at least a week tend to experience relief from their symptoms (see Martin, Barbanoj, Schlaepfer, Thompson, Perez, & Kulisevsky, 2003). Electrical stimulation of neurons can result in long-term changes in

neurotransmission across synapses by depolarizing neurons (George et al., 2003). Neurotransmission can be enhanced or blunted, depending on the frequency of the stimulation. By stimulating the left prefrontal cortex of people with depression, researchers have been able to increase neuronal activity, which in turn has had an antidepressant effect. Patients who receive rTMS report few side effects, usually only minor headaches treatable by aspirin. Patients can remain awake, rather than having to be anesthetized, as in electroconvulsive therapy (ECT), thereby avoiding possible complications of anesthesia. Thus, there is a great deal of ones. A client in a cognitive-behavior treatment program might be told that his or her difficulties stem from the irrational belief that one must be perfect or must be loved by everyone. How can such different explanations all produce positive results? Perhaps the precise nature of the insights and understanding provided by the therapist is relatively unimportant. It may be more important to provide the client with an explanation for the behavior or feelings that are so distressing and to present a set of activities (such as free association or relaxation training) that both the therapist and the client believe will alleviate the distress. A person who is experiencing disturbing For more Cengage Learning textbooks, visit www.cengagebrain.co.uk TECHNIQUES OF PSYCHOTHERAPY hope that rTMS will be an effective and safe alternative therapy, particularly for people who do not respond to drug therapies and may not be able to tolerate ECT. Another new method that holds considerable promise in the treatment of serious depression is vagus nerve stimulation (VNS) (Marangell, Martinez, & Niazi, 2004). The vagus nerve is part of the autonomic nervous system and carries information from the head, neck, thorax, and abdomen to several areas of the brain, including the hypothalamus and amygdala, which are involved in depression. In vagus nerve stimulation, the vagus nerve is stimulated by a small electronic device much like a cardiac pacemaker, which is surgically implanted under a patient’s skin in the left chest wall. Stimulating the vagus nerve induces changes in blood flow in the brain that are similar to those seen when antidepressant drugs are administered (Marangell, Martinez, Jurdi,, & Zboyan, 2007). Vagus nerve stimulation was originally used to control seizures in epileptic patients, and some investigators noticed that the therapy also improved mood in these patients (George et al., 2003). The mood effects of VNS occurred even in epileptic patients who were still having seizures, so researchers began studying the mood effects of VNS in patients with depression. VNS has been tested primarily with patients who have major depression that appears to be resistant to drug therapy. About 30 percent of these patients show significant improvement in their moods after twelve months of VNS (Marangell et al., 2007). This may seem like a low response rate, but it is significantly better than the approximately 10 to 15 percent response rate in these treatment-resistant patients who are given antidepressant medication alone. VNS has some side effects, including voice alteration, increased cough, neck pain, and laryngismus (Marangell et al., 2007). Thus, there is hope that new brain stimulation techniques may supplement other biologically-based therapies to provide additional means of treating serious depressions. symptoms and is unsure of their cause or how serious they might be will feel reassured by a professional who seems to know what the problem is and offers ways of relieving it. The knowledge that change is possible gives rise to hope, and hope is an important variable in facilitating change. Our discussion of the factors shared by all forms of psychotherapy is not intended to deny the value of some specific treatment methods. Perhaps the most effective therapist is one who recognizes the importance of these common factors and utilizes them in a planned manner for all patients but also selects the specific procedures that are most appropriate for each individual.

598 CHAPTER 16 TREATMENT OF MENTAL HEALTH PROBLEMS INTERIM SUMMARY l Behavior therapies apply methods based on learning principles to modify the client's behavior, including systematic desensitization, in vivo exposure, reinforcement of adaptive behaviors, modeling and rehearsal of appropriate behavior, and techniques for self-regulation of behavior. l Cognitive-behavior therapies use behavior modification techniques but also incorporate procedures for changing maladaptive beliefs. The therapist helps the client replace irrational interpretations of events with more realistic ones. l Psychoanalysis, which was developed by Freud, uses techniques such as free association, dream analysis, and transference, to help the patient gain insight into problems. Contemporary psychodynamic therapies are briefer than traditional psychoanalysis and place more emphasis on the client's current interpersonal problems. l Humanistic therapies help clients become aware of their real selves and solve their problems with a minimum of intervention by the therapist. Carl Rogers, who developed client-centered psychotherapy, believed that the therapist must have three characteristics in order to promote the client's growth and self-exploration: empathy, warmth, and genuineness. l Sociocultural approaches view individuals as embedded in larger social systems, including families and societies. Community-based programs seek to integrate people with mental health problems back into the community while providing treatment. l The effectiveness of psychotherapy is hard to evaluate because of the difficulty of defining a successful outcome and controlling for spontaneous remission. Factors common to the various psychotherapies – a warm and trustful interpersonalrelationship, reassuranceand support, desensitization, insight, and reinforcement of adaptive responses – may be more important in producing positive change than the specific therapeutic methods used. CRITICAL THINKING QUESTIONS 1 How might a psychotherapist adapt the therapeutic methods described in this section to help a person with schizophrenia? Which methods do you think would be helpful for a person with schizophrenia? Which methods would not be helpful? 2 If a child is determined to have a significant mental health problem that can be treated, but his or her parents do not want treatment, does the government have a right to require the parents to seek treatment? Why or why not? For more Cengage Learning textbooks, visit www.cengagebrain.co.uk BIOLOGICAL THERAPIES The biological approach to abnormal behavior assumes that mental health problems, like physical illnesses, are caused by biochemical or physiological dysfunctions of the brain. Biological therapies include the use of drugs and electroconvulsive shock. Psychotherapeutic drugs By far the most successful biological therapy is the use of drugs to modify mood and behavior (see the Concept Review Table for a review). The discovery in the early 1950s of drugs that relieved some of the symptoms of schizophrenia represented a major breakthrough in the treatment of severely disturbed individuals. Intensely agitated patients no longer had to be physically restrained by straitjackets, and patients who had been spending most of their time hallucinating and exhibiting bizarre behavior became more responsive and functional. As a result, psychiatric wards became more manageable, and patients could be discharged more quickly. A few years later, the discovery of drugs that could relieve severe depression had a similar beneficial effect on hospital management and population. Antipsychotic drugs The first drugs that were found to relieve the symptoms of schizophrenia belonged to the family called phenothiazines. Examples are chlorpromazine and fluphenazine. These drugs have been called major tranquilizers, but this term is not really appropriate because they do not act on the nervous system in the same way as barbiturates or antianxiety drugs. They may cause some drowsiness and lethargy, but they do not induce deep sleep, even in massive doses. They also seldom create the pleasant, slightly euphoric feeling associated with low doses of antianxiety drugs. In fact, the psychological effects of the antipsychotic drugs when administered to normal individuals are usually unpleasant. These drugs

are seldom abused. In Chapter 15, we discussed the theory that schizophrenia is caused by abnormal activity of the neurotransmitter dopamine. Antipsychotic drugs block dopamine receptors. Because the drugs' molecules are structurally similar to dopamine molecules, they bind to the postsynaptic receptors of dopamine neurons, thereby blocking the access of dopamine to its receptors. (The drug itself does not activate the receptors.) A single synapse has many receptor molecules. If all of them are blocked, transmission across the synapse will fail. If only some of them are blocked, transmission will be weakened. The clinical potency of an antipsychotic drug is directly related to its ability to compete for dopamine receptors. Antipsychotic drugs are effective in alleviating hallucinations and confusion and restoring rational thought

processes. These drugs do not cure schizophrenia, and most patients must continue to use the drugs to function outside of a hospital. Many of the characteristic symptoms of schizophrenia – emotional blunting, seclusiveness, difficulties in sustaining attention – remain. This may be because these types of symptoms are not caused by excess dopamine, but by other types of dysfunction in the brain. Nevertheless, antipsychotic drugs shorten the length of time patients must be hospitalized, and they prevent relapse. Studies of people with schizophrenia living in the community find that 78 percent of those who discontinue using the drugs relapse within one year, and 98 percent within two years, compared to about a third of people who continue on their medications (Gitlin et al., 2001; Sampath et al., 1992). Unfortunately, about 25 percent of people with schizophrenia do not respond to the antipsychotic drugs (Spaulding, Johnson, & Coursey, 2001). In addition, the drugs have unpleasant side effects – dryness of the mouth, blurred vision, difficulty in concentrating – that prompt many patients to discontinue their medication. One of the most serious side effects is a neurological disorder known as tardive dyskinesia, which involves involuntary movements of the tongue, face, mouth, or jaw. Patients with this disorder may involuntarily smack their lips, make sucking sounds, stick out their tongue, puff their cheeks, or make other bizarre movements, over and over again. Tardive dyskinesia is often irreversible and may occur in more than 20 percent of people who use antipsychotic drugs for long periods (Spaulding et al., 2001). In recent years, new drugs called atypical antipsychotics have been found to reduce symptoms of schizophrenia without causing so many side effects (Dossenbach et al., 2004). These drugs include clozapine, risperidone, aripiprazole, quetiapine, and olanzapine. They appear to work by binding to a different type of dopamine receptor than the other drugs, although they also influence several other neurotransmitters, including serotonin. These drugs are effective with many people with schizophrenia who have not responded to the older antipsychotics, and appear to reduce a wider range of symptoms. Antidepressant drugs Antidepressant drugs help elevate the mood of depressed individuals, apparently by regulating two neurotransmitter systems (norepinephrine and serotonin) (see Chapter 15). Antidepressant drugs act in different ways to increase neurotransmitter levels. Monoamine oxidase (MAO) inhibitors ª PAIGE FOSTER j DREAMSTIME.COM Medications are the primary biological treatment for most mental disorders. CONCEPT REVIEW TABLE Drug treatments for mental disorders These are the major types of drugs used to treat several kinds of mental disorders. Type of drug Purpose Mode of action Antipsychotic drugs Reduce symptoms of psychosis (loss of reality testing, hallucinations, delusions) Block dopamine receptors Antidepressant drugs Reduce symptoms of depression Increase functional levels of serotonin and norepinephrine Lithium Reduce symptoms of bipolar disorder (mania and depression) Regulates levels of serotonin, norepinephrine, and other neurotransmitters Antianxiety drugs Reduce symptoms of anxiety Depresses central nervous system Stimulants Increase attention and concentration Possibly by increasing levels of dopamine BIOLOGICAL THERAPIES For

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600 CHAPTER 16 TREATMENT OF MENTAL HEALTH PROBLEMS block the activity of an enzyme that can decrease both norepinephrine and serotonin, thereby increasing the concentration of these two neurotransmitters in the brain. Tricyclic antidepressants prevent the reuptake of serotonin and norepinephrine, thereby prolonging the action of the neurotransmitter. (Recall that reuptake is the process by which neurotransmitters are drawn back into the nerve terminals that released them.) Both classes of drugs have proved effective in relieving depression. Like the antipsychotic drugs, the antidepressants can produce some undesirable side effects. The most common of these are dry mouth, blurred vision, constipation, and urinary retention. They can also cause a severe drop in blood pressure when a person stands up, as well as changes in heart rate and rhythm. An overdose of tricyclic antidepressants can be fatal, a serious concern when a depressed patient may be suicidal. The MAO inhibitors can interact with certain foods, including cheese, chocolate, and red wine, to create severe cardiac problems. The search for drugs that are more effective, have fewer side effects, and act more quickly has intensified in the past 30 years. As a result, new drugs appear on the market almost daily. The selective serotonin reuptake inhibitors (SSRIs) increase serotonin levels by blocking its reuptake. Examples are fluoxetine, paroxetine, sertraline, fluvoxamine, citalopram, and escitalopram. Even more recent drugs, known as serotonin-norepinephrine reuptake inhibitors (SNRIs) increase the availability of both serotonin and norepinephrine (such as venlafaxine). In addition to relieving depression, these drugs have proved helpful in treating the anxiety disorders, including obsessive-compulsive disorder and panic disorder (Schatzberg, 2000). They tend to produce fewer side effects than the other antidepressants, although they can cause inhibited orgasm, nausea and diarrhea, dizziness, and nervousness. People with bipolar disorder often take an antidepressant medication to control their depression but must take other drugs to control their mania. Lithium reduces extreme mood swings and returns the individual to a more normal emotional state. It appears to do so by stabilizing a number of neurotransmitter systems, including serotonin and dopamine, and may also stabilize levels of the neurotransmitter glutamate (Thase et al., 2002). People with bipolar disorder who take lithium must take it even when they are not suffering from acute mania. Otherwise, about 80 percent will lapse into new episodes of mania or depression (Geddes et al., 2004). Unfortunately, only about 30 to 50 percent of people with bipolar disorder respond to lithium (Bowden, 2000; Thase et al., 2002). In addition, it has severe side effects, including abdominal pain, nausea, vomiting, diarrhea, tremors, and twitches. Patients complain of blurred vision and problems in concentration and attention that interfere with their ability to work. Lithium can cause kidney dysfunction, birth defects, and a form of diabetes if taken by women during the first trimester of pregnancy. For more Cengage Learning textbooks, visit www.cengagebrain.co.uk Anticonvulsant medications (such as divalproex sodium, carbamazepine, lamotrigine, gabapentin, and topiramate) are now commonly used to treat bipolar disorder. These drugs can be highly effective in reducing the symptoms of severe and acute mania but do not seem to be as effective as lithium for long-term treatment of bipolar disorder (Ghaemi et al., 2004). The side effects of the anticonvulsants include dizziness, rash, nausea, and drowsiness. Antipsychotic medications may also be prescribed for people who suffer severe mania. Antianxiety drugs Several drugs traditionally used to treat anxiety belong to the family known as benzodiazepines. They are commonly known as tranquilizers and include diazepam, chlordiazepoxide, and alprazolam. Antianxiety drugs reduce tension and cause drowsiness. Like alcohol and the barbiturates, they depress the action of the central nervous system. Family physicians often prescribe tranquilizers to

help people cope during difficult periods in their lives. The drugs are also used to treat anxiety disorders, withdrawal from alcohol, and physical disorders related to stress. For example, in the treatment of a phobia, antianxiety drugs may be combined with systematic desensitization to help the individual relax when confronting the feared situation. In recent years, researchers have discovered that certain antidepressant drugs also reduce symptoms of anxiety. This is particularly true of the serotonin reuptake inhibitors discussed previously. These drugs may relieve anxiety as well as depression because they affect biochemical disturbances that are common to both conditions. Stimulants Stimulant drugs are used to treat the attentional problems of children with attention deficit hyperactivity disorder (ADHD). One of the most commonly used stimulants is methylphenidate. Although it may seem odd to give a stimulant to a hyperactive child, between 70 and 85 percent of children with ADHD respond to these drugs with decreases in disruptive behavior and increases in attention (Joshi, 2004). Stimulant drugs may work by increasing levels of dopamine in the synapses of the brain. Other drugs that are not stimulants, but affect levels of norepinephrine, are sometimes used to treat ADHD, including clonidine, guanfacine, and atomoxetine. Children must be accurately diagnosed with ADHD before any drugs are prescribed. In sum, drug therapy has reduced the severity of some types of mental health problems. Many individuals who would require hospitalization otherwise can function within the community with the help of these drugs. On the other hand, there are limitations to the application of drug therapy. All therapeutic drugs can produce undesirable side effects. Many people with medical problems,

as well as women who are pregnant or nursing, often cannot take psychoactive drugs. In addition, many psychologists feel that these drugs alleviate symptoms without requiring the patient to face the personal problems that may be contributing to the disorder or may have been caused by the disorder (such as marital problems caused by the behaviors of a manic person). Electroconvulsive therapy In electroconvulsive therapy (ECT), also known as electroshock therapy, a mild electric current is applied to the brain to produce a seizure similar to an epileptic convulsion. ECT was a popular treatment from about 1940 to 1960, before antipsychotic and antidepressant drugs became readily available. Today it is used primarily in cases of severe depression when the patient has failed to respond to drug therapy. ECT has been the subject of much controversy, and rates of the use of ECT vary greatly across nations (Eranti & McLouglin, 2003). At one time it was used indiscriminately in mental hospitals to treat such problems as alcoholism and schizophrenia, for which it produced no beneficial results. Before more refined procedures were ª NAJLAH FEANNY/STOCK BOSTON Electroconvulsive therapy is relatively effective in the treatment of depression. For more Cengage Learning textbooks, visit www.cengagebrain.co.uk BIOLOGICAL THERAPIES developed, ECT was a frightening experience for the patient, who was often awake until the electric current triggered the seizure and produced momentary unconsciousness. The patient frequently suffered confusion and memory loss afterward. Occasionally, the intensity of the muscle spasms accompanying the brain seizure resulted in physical injuries. Today, ECT is much safer. The patient is given a shortacting anesthesia and injected with a muscle relaxant. A brief, very weak electric current is applied to the brain, typically to the temple on the side of the nondominant cerebral hemisphere. The minimum current required to produce a brain seizure is administered, because the seizure itself – not the electricity – is therapeutic. The muscle relaxant prevents convulsive muscle spasms. The individual awakens within a few minutes and remembers nothing about the treatment. Four to six treatments are usually administered over a period of several weeks. The most common side effect of ECT is memory loss. Some patients report a gap in memory for events that occurred up to six months before ECT, as well as impaired ability to retain

new information for a month or two after the treatment. However, if very low dosages of electricity are used (the amount is carefully calibrated for each patient to be just sufficient to produce a seizure) and administered only to the nondominant side of the brain, memory problems are reduced (Glass, 2001). No one knows how the electrically induced seizures relieve depression. Brain seizures cause massive release of norepinephrine and serotonin, and, as noted in Chapter 15, deficiencies of these neurotransmitters may be an important factor in some cases of depression. Currently, researchers are trying to determine the similarities and dissimilarities between ECT and antidepressant drugs in terms of the way each affects neurotransmitters. However it works, ECT is effective in bringing some people out of severe, immobilizing depression, and it does so faster than drug therapy. Combining biological and psychological therapies Although in this chapter we divided therapies into psychological and biological therapies, today there is a movement toward combined biological and psychological treatments. In depression and the anxiety disorders, often both the patient's biochemistry and his or her functioning in social and occupational settings are affected by the disorder, and it can be helpful to provide treatment at both the biological and psychosocial levels. Even in disorders like schizophrenia, whose primary cause is biological, the patient often experiences severe losses in social skills and ability to function on a job. Supplementing antipsychotic drugs with psychotherapy designed to help the person cope with the consequences of schizophrenia can be very useful.

602 CHAPTER 16 TREATMENT OF MENTAL HEALTH PROBLEMS The fact that a wide range of both psychotherapies and drugs are effective in the treatment of some problems (especially depression) suggests that intervening at one level of a person's bio-psycho-social system can affect all levels of the system. For example, intervening at the psychological level may cause changes in the patient's biochemistry and social behaviors. When this occurs, it is because our biochemistry, our personalities and thought processes, and our social behaviors are so thoroughly intertwined that each can affect the other in both positive and negative ways. INTERIM SUMMARY l Biological therapies include electroconvulsive therapy (ECT) and the use of psychotherapeutic drugs. Of the two, drug therapy is by far the more widely used. l Antipsychotic drugs, which alter levels of the neurotransmitter dopamine, have proved effective in the treatment of schizophrenia. l Antidepressants help to elevate the mood of depressed patients by affecting levels of the neurotransmitters serotonin and norepinephrine. Lithium has been effective in treating bipolar disorders. l Antianxiety drugs depress the action of the central nervous system and are used to reduce severe anxiety and help clients cope with life crises. l Stimulant drugs are used to treat attention deficit hyperactivity disorder in children. CRITICAL THINKING QUESTIONS 1 Many people currently using psychoactive drugs, particularly the serotonin reuptake inhibitors, are not suffering from a severe mood disorder but from the stresses of everyday living. Do you think this is an appropriate use of these drugs? Why or why not? 2 Do you think people with mental health problems should be forced to take drugs to control their symptoms? Would your answer depend on the type of symptoms they suffered? ENHANCING MENTAL HEALTH Aside from seeking professional help, there are many ways in which we can positively influence our own psychological well-being. By monitoring our feelings and For more Cengage Learning textbooks, visit www.cengagebrain.co.uk behavior, we can determine the kinds of actions and situations that cause us pain or get us into difficulty and, conversely, the kinds that benefit us the most. By trying to analyze our motives and abilities, we can enhance our capacity to make active choices in our lives instead of passively accepting whatever happens. The problems that people face vary greatly, and there are no universal guidelines for staying psychologically healthy. However, a few general

suggestions have emerged from the experiences of therapists. Accept your feelings Anger, sorrow, fear, and a feeling of having fallen short of ideals or goals are all unpleasant emotions, and we may try to escape anxiety by denying these feelings. Sometimes we try to avoid anxiety by facing situations unemotionally, which leads to a false kind of detachment or 'cool' that may be destructive. We may try to suppress all emotions, thereby losing the ability to accept as normal the joys and sorrows that are part of our involvement with other people. Unpleasant emotions are a normal reaction to many situations. There is no reason to be ashamed of feeling homesick, being afraid when learning to ski, or becoming angry at someone who has disappointed us. These emotions are natural, and it is better to recognize them than to deny them. When emotions cannot be expressed directly (for example, it may not be wise to yell at your boss), it helps to find another outlet for releasing tension. Taking a long walk, pounding a tennis ball, or discussing the situation with a friend can dissipate anger. As long as you accept your right to feel emotion, you can express it in indirect or alternative ways when direct channels of expression are blocked. Know your vulnerabilities Discovering the kinds of situations that upset you or cause you to overreact may help you guard against stress. Perhaps certain people annoy you. You could avoid them, or you could try to understand just what it is about them that disturbs you. Maybe they seem so poised and confident that they make you feel insecure. Trying to pinpoint the cause of your discomfort may help you see the situation in a new light. Perhaps you become very anxious when you have to speak in class or present a paper. Again, you could try to avoid such situations, or you could gain confidence by taking a course in public speaking. (Many colleges offer courses on controlling speech anxiety.) You could also reinterpret the situation. Instead of thinking, 'Everyone is waiting to criticize me as soon as I open my mouth', you could tell yourself, 'The class will be interested in what I have to say, and I'm not going to let it worry me if I make a few mistakes.'

ª GALINA BARSKAYA j DREAMSTIME.COM Developing interests and hobbies is one key to psychological well-being. Many people feel especially anxious when they are under pressure. Careful planning and spacing of work can help you avoid feeling overwhelmed at the last minute. The strategy of purposely allowing more time than you think you need to get to classes or appointments can eliminate one source of stress. Develop your talents and interests People who are bored and unhappy seldom have many interests. Today's college and community programs offer almost unlimited opportunities for people of all ages to explore their talents in many areas, including sports, academic interests, music, art, drama, and crafts. Often, the more you know about a subject, the more interesting it (and life) becomes. In addition, the feeling of competence gained from developing skills can do a great deal to bolster self-esteem. For more Cengage Learning textbooks, visit www.cengagebrain.co.uk ENHANCING MENTAL HEALTH Become involved with other people Feelings of isolation and loneliness are at the core of most emotional health problems. We are social beings, and we need the support, comfort, and reassurance provided by other people. Focusing all your attention on your own problems can lead to an unhealthy preoccupation with yourself. Sharing your concerns with others often helps you view your troubles in a clearer perspective. Also, being concerned for the welfare of other people can reinforce your feelings of self-worth. Know when to seek help Although these suggestions can help promote emotional well-being, there are limits to self-understanding and selfhelp. Some problems are difficult to solve alone. Our tendency toward self-deception makes it hard to view problems objectively, and we may not be aware of all the possible solutions. When you feel that you are making little headway toward gaining control over a problem, it is time to seek professional help. Willingness to seek help is a sign of emotional maturity, not weakness; do not wait until you feel

overwhelmed. INTERIM SUMMARY l Accepting your feelings is the first step to responding effectively to them. l Knowing your vulnerabilities allows you to avoid triggers for distress and seek help in overcoming certain vulnerabilities. l Developing your talents gives you multiple sources of self-esteem and joy. l Seeking out others is a good strategy for distress. Helping others can increase your self-esteem. l Not all problems can be handled alone; it's important to seek help when you need it. CRITICAL THINKING QUESTIONS 1 In what circumstances do you think self-help books are helpful, and when might they not be helpful? 2 Some people seem never to be overwhelmed by stress and appear able to handle almost anything. What do you think makes such people super-resilient?

SEEING BOTH SIDES IS ALCOHOLICS ANONYMOUS (AA) AN EFFECTIVE INTERVENTION FOR ALCOHOL MISUSE? AA helps problem drinkers Keith Humphreys, Stanford University and Veterans Affairs Palo Alto Health Care System Alcoholics Anonymous (AA) is a worldwide fellowship of approximately 2 million alcohol-dependent individuals who are committed to helping each other permanently abstain from alcohol, as well as become more honest, humble, compassionate, and spiritually serene. In over 50 nations, AA members meet in mutual help groups on a regular basis, where they use AA principles (e.g., the 'Twelve Steps') and their personal 'experience, strength, and hope' to promote sobriety. In the United States, AA is the most commonly sought source of help for alcohol problems (Weisner, Greenfield, & Room, 1995), far outstripping all professional interventions combined. AA also enjoys an excellent reputation among most treatment professionals. At the same time, some clinicians and researchers doubt AA's effectiveness (Ogborne, 1993), noting that the organization offers a loosely monitored and unstandardized program based primarily on the experience and spiritual outlook of its members rather than a standardized professional treatment derived from objective, scientific research. AA attempts to change many aspects of members' lives, and hence the question of whether AA 'works' can be framed in many different ways. Here, I focus on one of AA's intended benefits – abstinence from alcohol – and describe how recent studies provide credible evidence that AA helps problem drinkers stop consuming alcohol. For example, Cross and colleagues (Cross, Morgan, Martin, & Rafter, 1990) followed up a sample of 158 alcohol dependent patients ten years after treatment to determine what factors (e.g., problem severity, age, sex) predicted long-term abstinence from alcohol. Of all the variables examined, only AA involvement increased the likelihood of abstinence. These findings supporting AA's effectiveness were essentially replicated in an eight-year follow-up of a sample of 628 alcohol-abusing individuals conducted by a different research group (Humphreys, Moos, & Cohen, 1997). Although not a study of AA per se, the randomized clinical trial known as Project Match (Project Match Research Group, 1997) demonstrated that counseling facilitating AA involvement is as effective at reducing alcohol consumption as are other established psychotherapies for alcohol-dependent clients. Because AA attendance is free of charge, the organization is probably the most cost-effective way for alcohol-dependent individuals to become abstinent. One study of 201 alcohol abusers illustrating this point compared 135 individuals who initially chose to attend AA with 66 individuals who initially chose to seek professional outpatient treatment (Humphreys & Moos, 1996). Despite the fact that individuals were not randomly assigned to each condition, at baseline, there were no significant differences between groups on demographic variables, alcohol problems, or psychopathology. By the three-year follow-up, the AA attendees had reduced their daily alcohol intake an average of 75 percent and had decreased their alcohol dependence symptoms (e.g., blackouts) an average of 71 percent. Individuals receiving professional treatment improved comparably. However, alcohol-related health care costs over the

three-year study were 45 percent ($1,826 per person) lower in the AA group than in the treated group. Hence, AA not only promotes abstinence, but does so in a cost-effective fashion that probably takes a substantial burden off of the formal health care system. Research on the effects of AA participation has improved substantially in recent years, but still has considerable room for growth. Confidence in AA's effectiveness would be increased if more studies employed longitudinal designs, included comparison groups, and used biological tests or collateral data sources to confirm self-reports of abstinence. Further, even welldesigned studies do not show that AA works for every participant or that its benefits are always substantial. However, the same could be said for virtually every professional psychosocial treatment for alcohol dependence. Therefore, particularly in light of AA's availability and minimal financial cost, it clearly is one of society's more important resources for helping alcoholdependent individuals recover. CHAPTER 16 TREATMENT OF MENTAL HEALTH PROBLEMS For more Cengage Learning textbooks, visit www.cengagebrain.co.uk

SEEING BOTH SIDES IS ALCOHOLICS ANONYMOUS (AA) AN EFFECTIVE INTERVENTION FOR ALCOHOL MISUSE? AA is not the only way G. Alan Marlatt, University of Washington Although Alcoholics Anonymous (AA) is the most well-known self-help group for many people who are recovering from alcoholism, it is not the only way to help many individuals to stop drinking, and for some problem drinkers, AA may be a barrier to successful treatment. Studies show that of every two people who attend their first meeting of AA, only one returns for a second or subsequent meeting. Why does AA appeal to some and not to others? Although AA is described as a 'spiritual fellowship' and is not explicitly identified with any specific religious group, many first-timers are put off by the requirement to admit that one is powerless over one's drinking and that only by turning over personal control to a 'higher power,' is recovery possible. Others are discouraged by the AA doctrine that alcoholism is basically a physical disease that cannot be cured, only 'arrested' by total lifelong abstinence from any alcoholic beverages. For those adherents of the disease model, including almost all AA members, there is no possibility of future moderate or controlled drinking. Once an alcoholic, always an alcoholic, according to AA beliefs. Research has yet to reveal whether it is the specific teachings (theory) associated with AA, or the group support that the meetings provide that is most effective in helping people change their personal habits. Recent evidence indicates the latter is primarily responsible for AA success, which suggests other groups with different theories or beliefs about alcoholism and recovery can also be effective. In recent years, several new self-help groups for alcoholics have become available, including (1) Rational Recovery, based on rational principles of behavioral change without the need for a 'higher power' in order to maintain abstinence; (2) Self Management and Recovery Training (SMART), based on the principles of cognitive-behavioral therapy such as relapse prevention and social skills training; and (3) Women for Sobriety, for women who have problems relating to the mainly masculine flavor of many AA meetings and who could benefit from addressing alcohol problems shared by many women drinkers. Another alternative to AA is 'Moderation Management' selfhelp groups. After several failed attempts at making AA work for her, Audrey Kishline (1994) developed 'Moderation Management', a program of drinking moderation that has been used in many self-help groups in recent years (including some groups that meet on the Internet rather than in person). Moderate or controlled drinking programs are also known in the addictions treatment field as examples of a 'harm-reduction' approach. The goal of harm-reduction programs (such as moderation for heavy drinkers, nicotine replacement therapy for smokers who can't fully kick the habit, etc.) is to reduce the harmful consequences to oneself, one's family, and one's community caused by the drug problem. Although abstinence is accepted as an ideal goal for recovery, any steps toward this goal

that reduce harm are considered steps in the right direction toward enhanced health and the prevention of disease. Harm-reduction programs have been successful in teaching high-risk college students to drink more safely. Alcohol harmreduction programs are designed to teach the novice drinker skills about drinking behavior and corresponding levels of intoxication. A recent study of high-risk, first-year college students found those who attended the program showed a significant drop in binge drinking, black-outs, severe hangovers, and acts of vandalism, and so on compared with students in a control group who did not receive this training program. Thus for students who choose to drink and are at risk for experiencing serious drinking problems, harm reduction offers a viable alternative to abstinence (see my article in the August 1998 issue of the Journal of Consulting and Clinical Psychology). In AA, if someone does not accept the requirement of total abstinence, he or she is likely to be told to go away and not to come back until having 'hit bottom' – in other words, until the person has experienced such profound negative consequences from drinking that he or she sees no other choice but to go back to AA and pursue total abstinence. But what do we do with those drinkers who have not yet 'hit bottom', even though they may be experiencing serious harmful consequences? Harm reduction offers a variety of helpful strategies for this group to get them started on the road to recovery. ENHANCING MENTAL HEALTH For more Cengage Learning textbooks, visit www.cengagebrain.co.uk

606 CHAPTER 16 TREATMENT OF MENTAL HEALTH PROBLEMS CHAPTER SUMMARY Treatment of people with mental health problems has progressed from the ancient notion that abnormal behavior resulted from possession by evil spirits that needed to be punished, through custodial care in asylums, to modern psychiatric hospitals. The policy of deinstitutionalization, despite its good intentions, has added to the number of homeless people with mental health problems, causing concern about civil rights and adequate care. Psychotherapy is the treatment of mental health problems by psychological means. Behavior therapies apply methods based on learning principles to modify the client's behavior. These methods include systematic desensitization (the individual learns to relax in situations that previously produced anxiety), reinforcement of adaptive behaviors, modeling and rehearsal of appropriate behavior, and techniques for self-regulation of behavior. Cognitive-behavior therapies use behavior modification techniques but also incorporate procedures for changing maladaptive beliefs. The therapist helps the client replace irrational interpretations of events with more realistic ones. Psychoanalysis, which was developed by Freud, uses methods such as free association and dream analysis, to bring repressed thoughts and feelings to the patient's awareness. By interpreting these dreams and associations, the analyst helps the patient gain insight into his or her problems. Transference, the tendency to express feelings toward the analyst that the client has for important people in his or her life, provides another source of interpretation. Contemporary psychodynamic therapies are briefer than traditional psychoanalysis and place more emphasis on the client's current interpersonal problems (as opposed to a complete reconstruction of childhood experiences). Humanistic therapies help clients become aware of their real selves and solve their problems with a For more Cengage Learning textbooks, visit www.cengagebrain.co.uk minimum of intervention by the therapist. Carl Rogers, who developed client-centered psychotherapy, believed that the therapist must have three characteristics in order to promote the client's growth and self-exploration: empathy, warmth, and genuineness. Sociocultural approaches view individuals as embedded in larger social systems, including families and societies. Group therapy provides an opportunity for clients to explore their attitudes and behavior in interaction with others who have similar problems. Marital therapy and family therapy are specialized forms of group therapy that help couples, or parents and children,

learn more effective ways of relating to one another and handling their problems. Community-based programs seek to integrate people with mental health problems back into the community while providing treatment. The effectiveness of psychotherapy is hard to evaluate because of the difficulty of defining a successful outcome and controlling for spontaneous remission. Research results indicate that psychotherapy does help but that different approaches do not differ greatly in effectiveness. Factors common to the various psychotherapies – a warm and trustful interpersonal relationship, reassurance and support, desensitization, insight, and reinforcement of adaptive responses – may be more important in producing positive change than the specific therapeutic methods used. Biological therapies include electroconvulsive therapy (ECT) and psychotherapeutic drugs. Of the two, drug therapy is by far the most widely used. Antipsychotic drugs have proved effective in the treatment of schizophrenia, antidepressants help to elevate the mood of depressed patients, and lithium has been effective in treating bipolar disorders. Antianxiety drugs are used to reduce severe anxiety and help clients cope with life crises.

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