



CHAPTER OUTLINE

LEARNING OBJECTIVES

INTRODUCTION

BIOLOGICAL TREATMENTS – FROM SURGERY TO DRUGS

- Psychosurgery and ECT
- Pharmacotherapy – the role of medication
- Assessing the effects of psychotropic drugs

PSYCHOLOGICAL TREATMENTS

- Psychoanalysis and psychodynamic therapy
- Behaviour therapy
- Cognitive therapy
- Humanistic therapy
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- Assessing the effects of psychotherapy

BIOLOGICAL OR PSYCHOLOGICAL TREATMENT?

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SUMMARY

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Learning Objectives

By the end of this chapter you should appreciate that:

- there are various forms of therapy (biological and psychological) for treatment of mental illness;
- an illness with a biological manifestation does not necessarily have a biological cause;
- in severe cases, it may be necessary to administer biological forms of therapy, but psychological forms of treatment (psychotherapy) should also be considered to address the cause of the illness comprehensively;
- different forms of psychotherapy emphasize different elements of the human condition (e.g. developmental, behavioural, phenomenological, interpersonal);
- when considering the efficacy of different forms of treatment, it is important to consider possible placebo effects, ideally via the double-blind randomized clinical trial.

INTRODUCTION

Chapter 15 gave a clear picture of the devastation caused by many psychological disorders in the lives of countless people. The obvious question to ask next is: what can we do to treat these disorders?

Given the various models of abnormal behaviour outlined in chapter 15, you won't be surprised to discover that there are numerous therapies for psychological disorders. This chapter examines the two major approaches to treatment – biological and psychological.

Biological treatments make direct changes to the nervous system and are typically used by psychiatrists or other medically qualified practitioners in a hospital or outpatient setting. They include invasive surgical techniques, electroconvulsive therapy, and a range of drugs designed to

control or moderate the severity of symptoms experienced.

Psychological treatments include a variety of psychotherapies administered by numerous professionals (e.g. psychologists, psychiatrists, social workers) whose qualifications are regulated by the country in which they live. The main types of therapy are psychodynamic, behavioural, cognitive, humanistic and family- or couple-oriented therapy. Of course, we have to find a way to assess the impact and effectiveness of each type of therapy, and this too is covered.

Finally, this chapter considers the relative merits of biological and psychological approaches. Both are clearly useful, and combining treatments may be especially helpful in preventing relapse.

BIOLOGICAL TREATMENTS – FROM SURGERY TO DRUGS

Until the late eighteenth century, people suffering from a psychological disorder were thought to be possessed by demons or evil spirits. Treatment was designed to alter the body in order to let out the spirits or make it an inhospitable habitat for them.

Among the earliest biological treatments was ‘trepanning’, or removing part of the skull bone to allow evil spirits out of the body – a practice that endured until the twentieth century. Numerous other equally unpleasant biological assaults on the afflicted included bloodletting, beatings, purgatives and immersion in water to the point of near drowning.

With the demise of witchcraft, people with psychological disorders came to be seen as ill, and the traditional methods of medicine began to be applied to them. But until the advent of the twentieth century, medical treatments were little different from the methods used to drive out evil spirits and were equally unsuccessful.

PSYCHOSURGERY AND ECT

Psychosurgery

Psychosurgery involves severing or otherwise disabling areas of the brain to treat a psychological disorder in the absence of any clear organic cause. Its use was triggered by research on chimpanzees that demonstrated the role of the temporal and frontal cortex in the control of emotional behaviour and aggression.

Antônio Egas Moniz, of the University of Lisbon Medical School, developed a procedure in which the nerve fibres connecting the frontal lobe with other parts of the brain were cut. The prefrontal lobotomy became particularly popular in the USA, where a simple technique (that came to be known as ‘ice pick’ surgery)

was administered during an outpatient visit (see figure 16.1). As a result, over 50,000 lobotomies had been performed in the United States by the mid 1950s (Cosgrove, 2000).

lobotomy (or leucotomy) surgical operation in which white nerve fibres connecting the frontal lobes with other parts of the brain are severed

cingulotomy surgical procedure in which neurosurgeons make lesions in the cingulate gyrus, a section of the brain connecting the prefrontal cortex to the limbic system

was administered during an outpatient visit (see figure 16.1). As a result, over 50,000 lobotomies had been performed in the United States by the mid 1950s (Cosgrove, 2000).

The lobotomy has been replaced by the *cingulotomy*, in which neurosurgeons make lesions in the cingulate gyrus, a section of the brain connecting the prefrontal cortex to the limbic system (brain structures involved in automatic body functions and some emotion and behaviour – see chapter 3). Baer and colleagues (1995) found that this procedure, which had few side effects, successfully decreased anxiety and obsessive behaviour. But recent studies demonstrate that cingu-

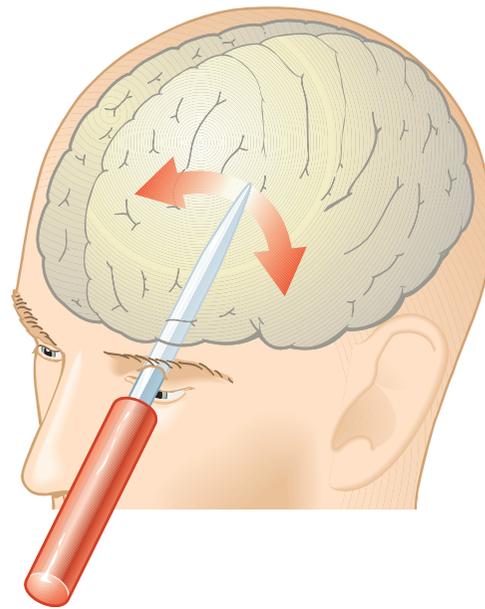


Figure 16.1

In the ‘ice pick’ lobotomy a sharp piece of metal was inserted under the eyelid and above the eye so that it entered the base of the frontal lobe. Sideways movement severed the connections between the frontal lobe and the rest of the brain.

lotomy produces substantial benefits in only about a third of patients (Cosgrove, 2000).

Although the number of psychosurgeries performed worldwide today isn’t known, it is estimated that fewer than 25 occur annually in Britain and the United States, about five a year in Sweden and one or two in Australia. Only people with very severe, disabling psychological disorders that resist other forms of treatment are even considered for psychosurgery today.

Electroconvulsive therapy

Another controversial treatment, and one that is still used fairly widely, is *electroconvulsive therapy* (ECT). In England 11,340 patients received ECT in 1999 (Department of Health, 1999).

Two electrodes are placed on the scalp and a moderately intense electric current is passed between them for about half a second. This produces a 30- to 60-second seizure, similar to those experienced by epileptics. Today, short-acting anaesthetics and muscle relaxants are given prior to ECT, reducing the seizure to a few visible twitches. The usual course involves between four and twelve treatments over a one- or two-week period.

ECT was initiated in the 1930s to treat schizophrenia, in the mistaken belief that epilepsy and schizophrenia are incompatible. It proved to be an ineffective treatment for schizophrenia but is

electroconvulsive therapy (ECT) a treatment for severe depression in which two electrodes are placed on the scalp and a moderately intense electric current is passed between them for about half a second

Pioneer



Figure 16.2

António Egas Moniz won a Nobel Prize for developing a form of psychosurgery known as the frontal lobotomy, which involved severing the nerve fibres connecting the frontal lobe with other parts of the brain – a radical procedure for treating severe psychological disorders.

António Egas Moniz (1874–1955) was born in Portugal and studied neurology in Bordeaux and Paris. He became Chair of Neurology at the University of Coimbra before entering politics, where he served as a deputy in the Portuguese parliament, Minister of Foreign Affairs and Ambassador to Spain. He left politics to return to the University of Lisbon, where, in 1936, he developed the prefrontal leucotomy (also known as frontal lobotomy) as a surgical approach for the radical treatment of several kinds of mental disorder. Moniz was awarded the Nobel Prize for Medicine and Physiology in 1949 for developing this procedure.



Figure 16.3

Electroconvulsive therapy is a controversial treatment, still used fairly widely.

now widely believed to be effective in treating severe depression (Royal College of Psychiatrists, 1995). It is often used to treat depressed people who have not responded to antidepressant medication, can't take medication because of the risk of suicide or other medical considerations, or risk death through refusal to eat.

Despite claims of 'marked improvement . . . in 80% to 90% of patients' (Silver, Yudovsky & Hurowitz, 1994, p. 983), the case for ECT is far from clear-cut. The consensus from clinical practice is that it can have beneficial effects, but research shows that the effects are relatively short-term. For example, compared to a sham treatment (i.e. the same procedure but with no current passed), ECT shows advantages four weeks later but not six months later (Buchan et al., 1992).

Relapse rates are also high. But this might not be due to the failure of ECT as a treatment. ECT is rarely incorporated into a broader, ongoing therapeutic strategy, possibly because its dramatic, rapid impact on depressive symptoms obscures the need for follow-up care. This failure to address the sociological or psychological stresses that might have initiated or exacerbated the depression could equally explain the high relapse rates for ECT.

Other criticisms include temporary disorientation following ECT, and memory loss that can last for months (indeed, it has been suggested that memory loss is one of the reasons why ECT 'works'). ECT is now often administered to the right hemisphere only in order to minimize its impact on verbal memories. In addition, up to 33 per cent of patients describe ECT as 'a very distressing experience' (Johnstone, 2003a, p. 239), and there are claims that ECT causes brain damage (Breggin, 1997), although there is no compelling evidence for this.

In contrast, the Royal College of Psychiatrists (1997) views ECT as 'among the safest medical treatments given under general anaesthesia' (p. 3) – a view echoed by the psychiatric establishment in many countries. Together with the perceived utility of ECT, these views are likely to ensure its continued use.

PHARMACOTHERAPY – THE ROLE OF MEDICATION

psychotropic drugs a loosely defined grouping of drugs that have effects on psychological function

The advent of *psychotropic drugs* revolutionized the treatment of psychological disorders. By controlling (or at least moderating) the mani-

festation of some disorders, these drugs have allowed sufferers to be treated without hospitalization.

An estimated 90 per cent of patients who see a psychiatrist are prescribed medication (Glenmullen, 2000; Olfson, Pincus & Sabshin, 1994), and general practitioners also frequently prescribe psychotropic medications, especially antidepressants and anxiolytics. So, although they can't prescribe these drugs themselves (Resnick, 2003), clinical psychologists will have clients who are either taking or in need of medication. This is why knowledge of effective medications, indications for their use, and insight into their side effects is critical for practising clinical psychologists.

Antipsychotics – a treatment for schizophrenia

antipsychotics drugs used to treat the symptoms of schizophrenia

The first psychotropic drugs introduced in the 1950s were *antipsychotics*, which have come to dominate the treatment of schizophrenia. Typ-

ical antipsychotics, such as chlorpromazine and haloperidol, reduce psychotic, or so-called 'positive' symptoms of schizophrenia (hallucinations and delusions), apparently by blocking dopamine receptors in certain brain systems (see figure 16.4). The stronger the dopamine blockade, the greater the apparent impact on symptoms (Snyder, 1976).

But what of the other, 'negative', schizophrenic symptoms – lack of social skills, appropriate affect, motivation and life skills? Atypical antipsychotics, such as clozapine and risperidone, reduce both positive and negative symptoms. These drugs appear to block both dopamine and serotonin receptors, implying a dopamine–serotonin interaction in schizophrenia (though some researchers argue that their effectiveness is due to selective dopamine blockade).

How effective are antipsychotic drugs? The first controlled studies of antipsychotics showed that they were clearly superior to placebos (inactive pills) for improving psychotic symptoms (73 per cent vs. 23 per cent), and subsequent research has replicated this finding. A review of 35 studies shows a similar superiority (16.2 per cent vs. 57.6 per cent) when it comes to relapse (Davis & Andriukaitis, 1986). But antipsychotics neither cure schizophrenia nor alter its progress, and they have potent side effects, including constipation, blurred vision, restlessness and difficulty sitting still (akathisia), cardiac arrhythmia, diminished spontaneity and difficulty initiating usual activities (akinesia). Prolonged treatment can lead to 'rabbit syndrome'

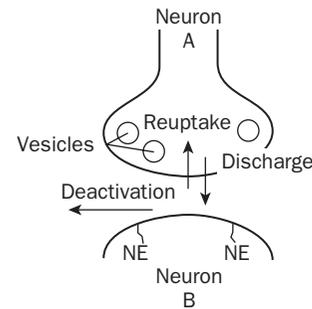


Figure 16.4

Two ways in which a drug may increase the available supply of a neurotransmitter. A neurotransmitter (e.g. norepinephrine, NE) is discharged by neuron A to stimulate neuron B. The amount of NE available to B can be decreased through reuptake (a process in which NE is pumped back into A) or through deactivation (where enzymes such as MAOs break down the NE and make it ineffective). Tricyclic drugs (such as Tofranil) and MAO inhibitors (such as Nardil; see p. 341) increase the amount of NE (and serotonin) available but in different ways. Tricyclics interfere with reuptake whereas MAO inhibitors prevent breakdown of the neurotransmitters. SSRIs (such as Prozac and Seroxat) block neurotransmitter reuptake, but act selectively on serotonin and do not appreciably alter reuptake of other neurotransmitters.

(rapid movement of the lips that mimics the chewing movement of rabbits).

Particularly troubling is that antipsychotics interfere with dopamine systems that control movement. These systems sometimes degenerate in older people, giving rise to Parkinson's disease, and so this side effect of antipsychotic medication is known as pseudo-parkinsonism. The symptoms are just as real as parkinsonism, and include tremors, drooling, slowed movements, muscular rigidity, difficulty breathing and small handwriting (micrographia). Additional drugs are usually prescribed in schizophrenia to deal with these side effects. Because antipsychotics can mimic neurological disease, they are sometimes referred to as *neuroleptics*.

Prolonged use of antipsychotics can also result in *tardive dyskinesia*, 'tardive' meaning 'late developing' and 'dyskinesia' meaning 'disturbance in movement'. This serious disorder is characterized by involuntary movements of the face, trunk or extremities.

As a consequence of these side effects and risks, many schizophrenic patients don't take their medication reliably, resulting in periodic worsening of symptoms and rehospitalizations. In fact, it is not uncommon for people suffering from schizophrenia to become 'revolving door patients'.

neuroleptics antipsychotic drugs

tardive dyskinesia a serious movement disorder, characterized by involuntary movements, that can arise as a side-effect of taking antipsychotic drugs

Antidepressants and antimanics – treatments for mood disorders

Treatments for the two major mood disorders that were discussed in chapter 15 (major depressive disorder and bipolar disorder) were developed soon after the introduction of antipsychotics.

1 Antidepressants Two classes of drugs for the treatment of depression were introduced in the late 1950s, tricyclic antidepressants (so-called because of their three-ring chemical structure) and monoamine oxidase inhibitors (MAOIs). Both these drugs increase the availability of catecholamine neurotransmitters (norepinephrine and serotonin) though they do so by different mechanisms (see figure 16.4). The tricyclics were more widely used because strict dietary restrictions must be followed when using MAOIs (Burke & Preskorn, 1995). While relatively safe, tricyclics have many side effects, including weight gain, increased pulse, dry mouth, dizziness, concentration difficulties and sexual dysfunction.

Drug treatment of depression changed dramatically in 1988 with the introduction of the first ‘designer drug’ (Kramer, 1993). Prozac (designed to have a minimal effect on norepinephrine and a maximal effect on serotonin) marked the development of a new class of anti-depressants called selective serotonin reuptake inhibitors (SSRIs). SSRIs have fewer side effects and are much safer to use than tricyclics and MAOIs. An overdose of SSRIs is not as lethal as one involving tricyclics, with MAOIs falling in between the two. This is an important consideration given the increased incidence of suicide attempts in depressed patients. The safety of SSRIs is no doubt one of the factors that has facilitated their widespread use (perhaps over-use) by physicians in general practice. But SSRIs can cause nausea, diarrhoea, insomnia and a loss of sexual desire or response (Montgomery, 1995).

Approximately 70 per cent of patients respond positively to antidepressants, with declines in symptoms apparent within two to six weeks for tricyclics, one to three weeks for MAOIs and two to four weeks for SSRIs (Silver, Yudofsky & Hurowitz, 1994). Patients may do better on one type of antidepressant than another, and sound clinical judgement is needed to find the best antidepressant for each individual. If a patient doesn’t respond to a standard antidepressant, his depression is said to be refractory, and he will most likely be treated with two antidepressants simultaneously.

In 1997 a dual-action antidepressant became available, which both blocks serotonin receptors and inhibits its reuptake. Although too early to document its effectiveness, it is likely that this, like other antidepressants, is more than just an antidepressant. This medication has also proven useful in treating panic disorder, eating disorders like bulimia, migraine headache and obsessive-compulsive disorder (Heninger, 1995; Montgomery, 1995).

2 Antimanics People with bipolar disorder are often resistant to taking medication because they miss the ‘high’ experienced in the initial phase of a manic episode. Yet not taking medication is dangerous, because patients often engage in risky behaviours during their manic phase and are at particularly high risk for suicide during the depressive phase.

Despite their name, antimanics help to prevent depressive episodes in bipolar disorder (they are also referred to as mood stabilizers). The first antimanic used was lithium carbonate, which remains the treatment of choice for preventing both manic and depressive episodes in bipolar disorder. Acute manic episodes respond to lithium within seven to fourteen days. Because acute mania has the potential to seriously disrupt patients’ lives, a supplemental medication (usually an antipsychotic) is administered in the acute phase of the condition, to bring behaviour under control as soon as possible.

Lithium is effective with about 60–70 per cent of bipolar patients. The mechanism by which it works remains largely unknown (Calabrese & Woyshville, 1995), although it may work by regulating dysfunctional neuronal firing (see chapter 15). Patients remain symptom-free for years, provided they keep taking the medication. Commonly occurring side effects are nausea, diarrhoea, excessive urine production, fine hand tremor and fatigue. Because lithium is toxic at high levels, it is a risky treatment when there is a suicide risk involved, and patients need to have their blood levels checked regularly.

Two newer antimanics are anticonvulsant drugs that have been used to treat epilepsy. These drugs – carbamazepine and valproate – often work for bipolar patients who have not responded to lithium. They tend to be tolerated much better by many patients.

Anxiolytics – a treatment for anxiety disorders

Popularly known as tranquilizers, *anxiolytics* are the most widely used psychotropic drugs.

anxiolytics drugs that produce sedation and reduce anxiety, popularly known as tranquilizers

In 1960, a new class of drugs, benzodiazepines, was developed that had a specific effect on anxiety. Some, such as Valium (diazepam), Librium (chlor-diazepoxide) and Xanax (alprazolam) have been prescribed so often that they have almost become household words. Benzodiazepines slow nerve cell electrical activity by augmenting the effect of gamma-aminobutyric acid (GABA), an inhibitory neurotransmitter. They are fast acting and can affect anxiety following a single dose. Although useful in treating generalized anxiety disorder, post-traumatic stress disorder, panic disorder and insomnia, they are highly addictive, interact dangerously with alcohol and impair psychomotor performance (so patients are advised to avoid driving during treatment).

A newer generation anxiolytic is buspirone, a drug that is chemically distinct from other anxiolytics, is not addictive and does not interact with alcohol or impair psychomotor performance. On the other hand, nausea, headache, insomnia, dizziness and lightheadedness are more common with buspirone. It also has a slow onset action and full therapeutic action takes weeks, making it unsuitable for transient or acute anxiety, where fast relief is needed. Buspirone is as effective as the benzodiazepines in treating generalized anxiety disorder, but less so for panic disorder (Sheehan et al., 1990).

In 1962, imipramine, a tricyclic antidepressant, was found to be effective in treating panic attacks. Since then, other antidepressants have been shown to be useful in treating not only panic disorder, but also social phobia and obsessive–compulsive disorder (OCD). But because most OCD patients achieve only a 35–50 per cent decrease in obsessions and compulsions with drug treatment (Jenike, 1990), they need to undergo psychotherapy at the same time.

ASSESSING THE EFFECTS OF PSYCHOTROPIC DRUGS

Why a whole section on testing drugs for effectiveness? Don't we simply give the drug to a group of patients and compare their symptoms before and after?

This pre–post treatment design seems sensible, but it has many weaknesses. Most obviously, as with any form of therapy, it ignores the possibility that the symptoms may have remitted spontaneously, without the treatment. It also neglects the fact that symptoms of several disorders fluctuate over time. Improvement in the condition may therefore simply reflect spontaneous remission or natural fluctuation rather than any actual drug effect. As we saw in chapter 2, a control group is critical to assessing the effect of an experimental manipulation – in this case the administration of a drug. When we compare the effect and value of treatment(s) against a control using patients, it is termed a clinical trial.

The placebo effect and double-blind procedure

So is it sufficient to have two groups of equivalent patients – one receiving the drug and one not? Certainly, in this design, any differences after treatment would not be due to spontaneous remission or the natural course of the disorder, as these factors would affect both groups. But neither could the differences be unequivocally attributed to the drug.

placebo effect phenomenon whereby patients show some form of real improvement after being treated with an inert substance (a placebo) such as a sugar pill

We also have to account for the *placebo effect* – a widely documented phenomenon in the treatment of various diseases from flu to heart disease. It has been shown that up to 70 per cent of patients actually show some real functional improvement after being treated with an inert substance (a placebo) such as a sugar pill. Interestingly, practitioners often make use of the placebo effect in treating patients (Benson & Friedman, 1996). But researchers must eliminate it. Can we do so by simply administering a placebo to our control group, so that they get the same amount of attention and 'treatment' as the group treated with the real drug?

single-blind procedure in order to evaluate the effect of a therapy, the patient is kept uninformed (blind) as to the true nature of the treatment

While this is a dramatic improvement on the basic pre treatment–post treatment design, there is still a problem with this *single-blind procedure* – so-called because

the patient is kept 'blind' to the true nature of the treatment. But it is essential that all the patients believe they are receiving real medicine, and this can't be guaranteed when the administering staff themselves know who is getting the real drug and who is getting the placebo. Even without explicitly revealing the true nature of the treatment to the patient, the knowledge of the staff can subtly influence the patient. It is therefore imperative for all staff who have contact with the patients to remain unaware throughout the study about who is receiving which treatment. This is called a *double-blind procedure*. A very powerful experimental technique is the combination of the double-blind procedure with random assignment of patients to treatment condition – *randomized clinical trial* (RCT).

double-blind procedure in order to evaluate treatment efficacy, the patient and all staff having contact with the patient remain uninformed (blind) as to the true nature of the treatment

randomized clinical trial (RCT) random assignment of patients to treatment conditions in order to evaluate the efficacy of a treatment

But we still have another couple of problems to overcome. It is unethical to withhold an acceptable treatment in order to administer a placebo, so many RCTs compare the impact of a new drug to treatment as usual. This helps address another problem that sometimes arises with the use of a placebo – side effects can make it apparent to both staff and patients who is receiving the experimental drug. Obvious differences in side effects between treatments tend to be muted when the comparison is with a standard treatment. In RCTs of new drugs, the question is usually one of relative efficacy compared to the currently best available treatment. But even if a new drug is only equivalent to an existing treatment, it may be preferred because of lower cost, or fewer side effects. For example, among antidepressants the newer drugs are generally preferred over older ones, not because they are more effective overall, but because of more acceptable side effects (Thase, 1999).

Criteria for effectiveness

Finally, we must consider the criteria used to judge the efficacy of a treatment. Usually we look at patient reports and, where possible, ratings by hospital or clinic staff. Assessments by psychologists and medical tests may also be used. But how do we decide if a change is clinically meaningful, rather than simply a statistical measure? This is an important issue that can dramatically alter the inferences we draw about a treatment's efficacy.

For example, suppose reports from depressed patients are statistically different from a comparison group after treatment (see chapter 2), and yet these same patients show little difference in their ability to function in everyday life and remain severely depressed. One way to address this issue is to test whether patient self-reports fall into the non-depressed range of scores. Another method that can be used is to apply more novel statistical techniques (beyond the scope of this book) such as comparing the 'effect size' underlying the statistical difference. A further criterion that is increasingly emphasized is the cost-effectiveness of

a treatment. So we might ask whether a new treatment for drug dependence leads to fewer arrests and days in prison, or whether a new antidepressant leads to fewer lost work days, and so on. In economically difficult times, care is sometimes subordinated to cost, making the use of psychotropic drugs particularly attractive for the treatment of psychological disorders. The fact that they are often fast acting only adds to their appeal (although, as we have seen, the duration of these beneficial effects may be a quite different matter – we explore this question further in the next section).

The limits of drug therapy

There is no doubt that modern psychotropic drugs have revolutionized the treatment of psychological disorders and restored the lives of many sufferers. No one should be treated for schizophrenia or bipolar disorder without suitable medication being available, and drugs can be appropriate for many other psychological disorders too. And yet the use of psychotropic drugs is controversial, with some asserting that the beneficial effects are quite limited (Fisher & Greenberg, 1989). Others have raised concerns about over-use (Olson et al., 1998), abuse (especially regarding anxiolytics such as valium) and possible addiction. Furthermore, some researchers have argued that the impact of psychotropic drugs largely reflects a placebo effect (Kirsch & Sapirstein, 1998).

In any event, drug treatments have some obvious limits:

1. Not everyone responds to the drug.
2. Side effects may preclude their use for some patients, and may lead others to discontinue their use – a particularly important consideration for treatments like antipsychotics and antimanic, when ongoing maintenance doses are needed to control symptoms effectively.
3. Drug treatment does nothing to help patients learn how to cope with life experiences that may have contributed to the disorder in the first place.

This leads us neatly into the essential role of psychological treatments.

PSYCHOLOGICAL TREATMENTS

Treatments that use psychological methods rather than direct changes to the body are known collectively as psychotherapy.

There are many different kinds of psychotherapy (see table 16.1). Treatment is always by a trained therapist with expertise in handling psychological disorders, and the clients enter into a professional relationship with the therapist to work on alleviating the disorder. Training in psychotherapy usually involves completion of an advanced degree and supervised treatment experience, but its exact nature depends on the disciplinary background of the therapist (who might be a psychiatrist, psychologist, social worker or psychiatric nurse), and the regulations that govern practice in their country. In many countries, people with minimal or no training may still call themselves ‘psychotherapists’, so it is essential to exercise good judgement in seeking psychotherapy.

Psychotherapy may take place in outpatient or inpatient settings. Either way, the psychotherapeutic relationship is a purposeful, nurturant alliance. The psychotherapist needs good communication and relationship-building skills, self-awareness and self-monitoring, and other specific skills associated with their particular type of therapy.

In the next sections we consider some of the major forms of psychotherapy that are currently in clinical use.

PSYCHOANALYSIS AND PSYCHODYNAMIC THERAPY

Classical psychoanalysis

Classical psychoanalysis was developed by Freud (see chapter 15). Its goals are to help the person gain *insight* into the ‘true’ (usually

insight an individual’s understanding of the unconscious reasons for his or her maladaptive behaviour – central to psychoanalysis

Table 16.1 Treatments for psychological disorders, organized according to the model of abnormal behaviour on which they are based.

Model	Examples of treatment	Examples of treatment techniques	Goals of treatment
Biological	Psychosurgery, medication	Lobotomy, monoamine oxidase inhibitor	Alter neurological system, correct chemical imbalance
Psychoanalytic/ contemporary psychodynamic	Psychoanalysis, interpersonal therapy	Free association, interpretation, analysis of transference	Psychosexual maturity via insight, strengthening ego functions
Behavioural	Systematic desensitization, contingency management	Counter-conditioning, modelling	Changes in behaviour via new learning
Cognitive	Cognitive therapy, rational-emotive therapy	Collaborative empiricism, identifying automatic thoughts	Changing cognitive processing of events
Humanistic	Client-centred therapy	Unconditional positive regard, active listening	Personal growth, self-acceptance, self-actualization
Family and couples/ relationship dysfunction	Behavioural marital therapy, strategic family therapy	Communication training, paradoxical directive	Change interpersonal context of psychological disorder

unconscious) reasons for their maladaptive behaviour, to work through their implications and associated feelings, and to strengthen the ego's control over the id and superego.

1 Uncovering repressed memories In this framework, recovery of unconscious memories is facilitated by the method of free association, in which the client says whatever comes to mind without editing or censorship. This is a difficult procedure, which rarely reveals repressed memories clearly. According to the traditional view, the analyst has to piece together patterns of association while dealing with the patient's 'resistance' (the tendency to avoid the task at hand by, for example, changing topic or forgetting what they were about to say). Resistance is seen as a sign that the patient is on the verge of recalling a painful memory.

Freud also used dreams to uncover unconscious material by regarding the content of the dream as symbolic of something else. But he believed that recollection without emotion has little therapeutic value, so psychoanalysis is considered useful only if the patient is released from the emotional forces that had kept the insight repressed.

2 Transference and countertransference Central to psychoanalysis is *transference*. This is the notion that the client projects

transference projection by a client onto the therapist of characteristics that are unconsciously associated with parents and other important figures

(transfers) onto the analyst characteristics that are unconsciously associated with parents and other important interpersonal figures from the client's past. Using the transference-charged relationship, the analyst effectively holds

up a mirror, allowing the client to see how he reacts to important people in his life. Through many experiences like this, it is argued that the patient's symptoms gradually diminish. To be able to 'stand in' for significant others in the patient's early life, it is important for the analyst to remain neutral. They must not allow countertransference (i.e. their own unconscious feelings towards the patient) to distort the process. Not surprisingly, trainees must undergo psychoanalysis themselves before qualifying as a psychoanalyst.

Contemporary psychodynamic therapy

The now stereotypical analytic couch is foregone in contemporary psychodynamic therapies in favour of chairs and face-to-face interaction. Classical psychoanalysts focused on what happens during analysis, so the patient's life outside the consultation room ideally needed to remain stable until the analysis was complete. In contrast, contemporary psychodynamic therapists use a model of abnormal behaviour that involves not only intrapsychic conflict relating to early childhood, but also current interpersonal relationships. They therefore pay close attention to the links between what goes on during therapy and the client's life in between sessions.

Emphasis on accountability and cost-effectiveness in health care have no doubt played a role in the recent emergence of

short-term dynamic psychotherapy (Levenson & Strupp, 1999). Here the goal is pragmatic – to help the client cope with a current problem or crisis in 20 sessions or fewer. Therapists are usually more active and may refer clients to self-help groups, ask them to do homework between sessions and use other procedures not typically associated with psychoanalytically derived psychotherapies.

Do these therapies work?

A major limitation of psychoanalytic and psychodynamic therapies is that they seem best suited to verbal, intelligent people with relatively mild psychological problems who are motivated to spend a substantial amount of time trying to uncover unconscious conflicts. Psychoanalysis is also expensive and usually only available to those who can afford private practice.

The basic principles that underlie these therapies have received very little empirical attention. In a study of free association, Erdelyi (1985) found that the method resulted in more material being reported, but it wasn't clear whether this reflected actual memory enhancement (see chapter 11). In fact, it may not be possible to test these therapies at all because the theoretical framework underpinning them frequently seems to explain all possible outcomes equally well (see chapter 15). For example, when a patient obtains insight and changes behaviour, this is said to provide evidence of treatment efficacy. But when a patient obtains insight but shows no behaviour change, in the psychoanalytic framework this doesn't reflect on treatment efficacy as the insight is said to be merely 'intellectual'. The picture is brighter when it comes to some of the more recent psychodynamic therapies. There is some evidence that interpersonal therapy (a short-term psychodynamic therapy that focuses on the client's interpersonal relationships and current circumstances) is effective in treating depression (Weissman & Markowitz, 1994). For the most part, however, the jury is still out when it comes to research evaluations of contemporary psychodynamic therapies.

BEHAVIOUR THERAPY

Just as behaviourism was a rejection of existing systems in psychology (see chapter 1), behaviour therapy represented a rejection of psychoanalytic and psychodynamic thinking. Behaviour therapy is concerned with what the person does that causes distress. The problematic behaviour is seen to be learned, just like any other behaviour, and is not viewed as a symptom of an underlying 'illness'. The therapist uses techniques based on the principles of learning to change the maladaptive behaviour. Consistent with its roots in the work of Pavlov, Thorndike and Skinner (see chapter 4), behaviour therapy is highly pragmatic and focuses on the 'here and now' rather than early experiences.

And yet it would be a mistake to conclude that behaviour therapy is a completely mechanistic, impersonal procedure. Like other psychotherapists, behaviour therapists emphasize the need for a strong, supportive therapeutic relationship between the therapist and the client in their work.

Exposure techniques

As the name implies, exposure techniques involve exposing clients to stimuli that, through pairing with anxiety responses (classical conditioning), have come to evoke anxiety or fear. Exposure is extensively used to treat agoraphobia and the panic attacks that often precede its development. In severe cases, it is usually combined with drug treatment.

The most widely used technique is systematic desensitization, developed in laboratory studies of cats by the South African psychiatrist Joseph Wolpe. Wolpe reasoned that, 'If a response antagonistic to anxiety can be made to occur in the presence of the anxiety-evoking stimuli so that it is accompanied by a complete or partial suppression of the anxiety responses, the bond between these stimuli and anxiety responses will be weakened' (1958,

p. 71). When this principle of *reciprocal inhibition* (counter-conditioning) is applied to humans, muscle relaxation is usually used to inhibit anxiety.

The client is first taught progressive muscle relaxation (tensing and then releasing

muscle groups) until she is able to relax her muscles on cue. Then the therapist works with her to develop a hierarchy of situations that she finds increasingly anxiety-provoking.

For example, suppose the target behaviour is fear of speaking up in class. The following hierarchy might be developed:

- At home, the night before I go to class.
- Driving to school before the class.
- Walking to my class.
- Walking inside the classroom.
- Looking around at the people in the room.
- Walking in and saying 'hello' to someone in the room.
- Sitting down in the front row.
- Catching the professor's eye and smiling.
- Nodding or agreeing with a comment made in class.
- Asking the professor a question from the front of the room.
- Asking the professor a question from the back of the room.
- Answering a short question from the front of the room.
- Answering a short question from the back of the room.
- Answering a longer question.
- Making a comment on a particular point to the class.

The client is therefore exposed to the least frightening situation while deeply relaxed. When the situation no longer evokes anxiety, the therapist moves on to the next stage in the hierarchy, progressing accordingly until the client can encounter the most anxiety-provoking situation while still remaining relaxed. Exposure to the anxiety-provoking situation is usually achieved through imagination, but can also be achieved in real life. More recently, simulated environments created using virtual reality technology have been used effectively to treat acrophobia (fear of heights), aviophobia (fear of flying) and post traumatic stress disorder (Rothbaum et al., 1995; 2001; 2002).



Figure 16.5

Flooding is a technique used to reduce anxiety, such as that associated with particular phobias like arachnophobia, by prolonged exposure to the trigger of the anxiety – i.e. spiders.

An alternative to the brief/graduated exposure used in systematic desensitization is *flooding* – a technique that involves prolonged exposure to highly threatening events.

The client's anxiety response diminishes through habituation and eventually disappears completely. When used to treat obsessive-compulsive disorder, exposure is accompanied by response prevention (clients are prevented from performing the rituals they normally use to reduce their anxiety). For example, suppose someone has a fear of contact with objects 'contaminated' by other people, such as doorknobs. If they normally reduce their anxiety in such situations with repetitive hand-washing, they would be prevented from doing so at the same time as flooding therapy is administered.

flooding a technique used in behaviour therapy that involves exposing the patient to highly threatening events for a prolonged period of time

Operant techniques

Operant, or instrumental, conditioning occurs when behaviour is governed by the consequences that immediately follow it. A family of therapeutic techniques has emerged from this type of conditioning, generically termed 'contingency management'. One example is the token economy – in a controlled environment (such as a psychiatric ward or classroom), tokens are used to increase the likelihood of targeted behaviours. The tokens can be exchanged for desired items or activities (e.g. snacks, TV), much as we use money in everyday life. Token economies are widely used in hospitals that treat people with chronic, severe psychological disorders like schizophrenia, and have proved to be highly effective (Chambless et al., 1998). Contingency management is also used in individual behaviour therapy. In the context of a warm, supportive relationship with the client, a behaviour therapist uses social reinforcers (e.g. nods, smiles, approval) to help bring about behaviour change.

Time out is a form of contingency management that can reduce the frequency of an undesirable behaviour by removing the person from the situation in which the behaviour is reinforced. For example, sending a child to a quiet, boring location for a short period following misbehaviour is an effective way of changing the behaviour, especially when it is coupled with positive reinforcement of appropriate behaviour. Another punishment contingency is response cost, which involves loss of a reward following a behaviour that we seek to change (such as smoking, aggression or self-abuse). Response cost suppresses behaviour longer than other forms of punishment and is considered more acceptable than more severe forms of punishment, such as are used in aversion therapy.

Aversion therapy

aversion therapy a problem behaviour is paired with an aversive stimulus in an attempt to establish an aversive response to the behaviour (e.g. fear, disgust)

Aversion therapy can draw on the principles of both classical and operant conditioning. When based on classical conditioning, a problem behaviour is paired with exposure to an aversive unconditioned stimulus in an attempt to establish an aversive response to the behaviour (e.g. fear or disgust). For example, an alcoholic is made nauseous (by the drug emetine) and is then given a glass of his favourite drink. After a few pairings the nausea becomes associated with the drink. In one study using this technique, abstinence was successfully induced for a year in 63 per cent of 685 hospitalized alcoholics, and 33 per cent were still dry after three years (Wiens & Menustik, 1983; see review by Elkins, 1991). However, a problem with this method is that exposure to the original stimulus (in this case drinking alcohol) over time tends to weaken the classically conditioned response enough to result in relapse.

When based on operant conditioning, the aversive stimulus acts as a punishment and is delivered immediately after the problematic behaviour. The *Everyday psychology* box in chapter 1 gives an example of how aversion therapy was used in this way to treat ruminative vomiting and save a child's life.

Aversion therapy has been used to treat a variety of problems, including alcoholism, smoking, overeating, compulsive gambling, self-injurious behaviour and some sexual deviations such as exhibitionism. One of the drawbacks, however, is that it does not teach alternative behaviours to replace the problem activities. There are also serious ethical problems, especially when the cognitive functioning of the client prevents them giving informed consent (as in the case of young children). So aversion therapy tends to be used as a last resort after other treatments have failed, to control acute behaviours that threaten the client's or others' wellbeing (such as self-abuse or uncontrollable physical violence).

covert sensitization a form of aversion therapy in which the client imagines a problem behaviour followed by an aversive stimulus

A more acceptable and less intrusive form of aversion therapy is *covert sensitization*. Here the client imagines both the problem behaviour and the aversive stimulus. Perhaps



Figure 16.6

Using the 'rapid smoking technique', behaviour therapists force smokers to puff every few seconds for a prolonged period of time until they feel sick and disgusted with cigarettes.

surprisingly, in many patients a nauseous response to alcohol, for instance, can be induced in this way.

Modelling

Vicarious learning by observing and imitating the behaviour of others is also used in behaviour therapy. The therapist models the behaviour for the client, who is then reinforced for performing it and encouraged to try it outside the therapy session. For example, a therapist can treat phobias by encouraging the client to exhibit the modelled behaviour when in the feared situation. The client first observes the model, then makes gradual contact with the feared object. Modelling is most effective when the model is similar to the client, has high status and is reinforced (e.g. receives social approval such as praise) for his action (Bandura, 1986). The similarity between the client and the model can be increased by having the model initially display fear before successfully performing the desired behaviour (Meichenbaum, 1971).

Social skills

A lack of social skills necessary for interpersonal relationships can exacerbate or even partly account for psychological disorders. So behaviour therapists include social skills training in treatment of depression (Bellack et al., 1983), anxiety disorders (van Dam-Baggen & Kraaimat, 2000) and schizophrenia (McQuaid et al., 2000).

The first step is to determine skill deficits in concrete terms (e.g. avoiding eye contact, speaking too softly) before developing more appropriate behaviour through modelling and social reinforcement. Assertiveness training is widely used, especially when the inability to express personal needs appropriately leads someone to be depressed or aggressive. It is designed to help clients express their feelings in ways that don't infringe upon the rights of others, rather than suffering in silence or exploding in anger. Social skills training has been expanded in recent years to promote a broader array of skills, such as making conversation and participating in interpersonal problem solving.

Does it work?

Critics of behaviour therapy argue that it is superficial and deals only with symptoms rather than their root causes. As a

symptom substitution the emergence of new symptoms after treating the symptoms of a disorder (as opposed to its 'root' cause)

result, critics argue that new symptoms are likely to arise (a process known as *symptom substitution*). While it is no doubt true that many problem behaviours arise in response to past circumstances, there

is no evidence for symptom substitution. A second criticism is that behaviour therapy doesn't pay attention to thought processes that might support problem behaviour. One view of abnormal behaviour is that it results from distorted thinking (see chapter 15). Is it therefore possible that it isn't just stimulus-response connections or reinforcement that matter, but also the way we perceive events in our life? The internal psychological processes deemed irrelevant by strict behavioural therapists might themselves be maladaptive and need to be changed.

In response to these concerns, a range of techniques have been developed to influence maladaptive ways of thinking directly.

COGNITIVE THERAPY

Cognitive therapy is a relatively short-term treatment (about 20 sessions) designed to get clients thinking about events in their life – including the symptoms of their disorder – in new ways. Sessions focus on concrete problems and help clients to challenge their beliefs about the problem. Although the cognitive therapist engages the client in behavioural tasks, cognitive therapy differs from behaviour therapy in focusing on the patient's internal (cognitive and affective) experiences.

Central to cognitive therapy is the identification of the client's latent dysfunctional *schema* – or underlying rules of life. For

example, if a person evaluates everything he does in terms of his competence, his thinking might be dominated by the schema, 'Unless everything I do is perfect, I'm a failure.' To change dysfunctional schemas such as this one, the cognitive therapist uses an active, structured and directive approach, focusing on the 'here and now', and not offering interpretations of the unconscious origins of problems in childhood.

Beck's cognitive therapy

Aaron Beck developed one of the most influential cognitive therapies to treat depression. Beck maintains that the depressed person's negative view of self, the world and the future (the 'cognitive triad') results from the operation of maladaptive *automatic thoughts* – the spontaneously generated thoughts associated with specific moods or situations (e.g. 'Everything I do turns out wrong'). In depression, these cognitive distortions can take many forms including dichotomous thinking ('I'm either a success or a failure'), overgeneralization ('Whatever I say just shows how stupid I am'), arbitrary inference ('He glanced over my shoulder while talking to me. I'm a social failure') and magnification ('My mistake in answering the test question just shows that I'm an idiot who shouldn't be at university').

automatic thoughts used in cognitive therapy to refer to spontaneously generated thoughts associated with specific moods or situations

Whatever form the cognitive distortion takes, a primary goal in cognitive therapy is to help the client identify automatic thoughts and evaluate them. The therapist helps the client to do this by asking questions like, 'What is the evidence for this idea?', 'Is there another way to look at the situation?', 'Are these facts, or your interpretation of the facts?' The therapist also formulates a hypothesis regarding the automatic thought and invites the client to test the validity of the hypothesis in a systematic way – a process called *collaborative empiricism*. In taking this approach, ultimately more realistic, accurate interpretations should replace the automatic thoughts, distorted beliefs and assumptions.

collaborative empiricism cognitive therapy procedure in which the therapist formulates a hypothesis and then helps the client test the validity of the hypothesis

Here's an example of cognitive therapy in action. A depressed, attractive woman in her twenties had the following interchange with her therapist. Notice how the therapist engages her in collaborative empiricism when dealing with her automatic thoughts about being ugly and undesirable.

Therapist: Other than your subjective opinion, what evidence do you have that you are ugly?

Client: Well, my sister always said I was ugly.

Therapist: Was she always right in these matters?

Client: No. Actually, she had her own reasons for telling me this.

But the *real reason* I know I'm ugly is that men don't ask me out. If I weren't ugly, I'd be dating now.

Therapist: That is a possible reason why you are not dating. But there's an alternative explanation. You told me that you work

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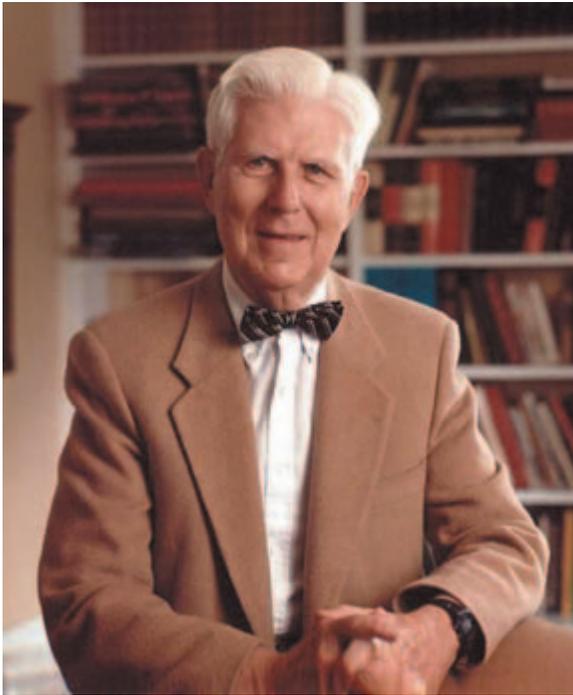


Figure 16.7

Aaron Beck rejected the psychoanalytic approach and developed a cognitive therapy for depression, based on the belief that a depressed person's negative view of self, the world and the future results from maladaptive automatic thoughts.

Aaron T. Beck (1921–) graduated from Yale University in psychiatry in 1946 and completed formal training in psychoanalysis at the Philadelphia Psychoanalytic Institute in 1956. He then began to conduct research to validate psychoanalytic theories. But when his research did not support his hypotheses, he rejected the psychoanalytic approach and developed a cognitive therapy for depression. His well-known tests to assess depression include the Beck Depression Inventory and the Scale for Suicide Ideation. Among his several influential books are *Depression: Clinical, Experimental, and Theoretical Aspects* (1967), *Cognitive Therapy and the Emotional Disorders* (1979) and *Cognitive Therapy of Depression* (1979, with Rush, Shaw and Emery).

in an office by yourself all day and spend your nights alone at home. It doesn't seem like you're giving yourself opportunities to meet men.

Client: I can see what you're saying but still, if I weren't ugly, men would ask me out.

Therapist: I suggest we run an experiment: that is, for you to become more socially active, stop turning down invitations to parties and social events and see what happens.

Following this interchange, the client became more active and was able to relinquish the thought that she was ugly. Therapy then focused on helping her change her assumption that her worth was based on her appearance. The treatment went on to deal with her assumption that she could not be happy without love (or attention from a man).

Therapist: On what do you base this belief that you can't be happy without a man?

Client: I was really depressed for a year and a half when I didn't have a man.

Therapist: Is there another reason why you were depressed?

Client: As we discussed, I was looking at everything in the distorted way. But I still don't know if I could be happy if no one was interested in me.

Therapist: I don't know either. Is there a way we could find out?

Client: Well, as an experiment, I could not go out on dates for a while and see how I feel.

Therapist: I think that's a good idea. Although it has its flaws, the experimental method is still the best way currently available to discover the facts. . . . If you find you can be happy without a man, this will greatly strengthen you and also make your future relationships all the better.

(Beck et al., 1979, pp. 253–4)

Although initially formulated to treat depression, Beck's cognitive therapy has been applied to the treatment of anxiety disorders, personality disorders, eating disorders and as a complement to antipsychotic drug therapy for schizophrenia (Wright & Beck, 1994). Numerous controlled studies show that cognitive therapy is effective for depression, producing acute symptomatic relief and lower relapse rates than drug treatment. In one study the relapse rate was just 23 per cent at two years, as opposed to 78 per cent after drug treatment (Blackburn et al., 1981). There is also evidence of effectiveness for anxiety disorders, particularly generalized anxiety disorder and panic disorder.

Rational emotive therapy

Albert Ellis developed one of the earliest forms of cognitive therapy – rational emotive therapy (RET). According to Ellis (1973), when an emotional consequence (C) follows an activating event (A), it is not A that causes C but the individual's beliefs (B) (figure 16.8).

The goal of RET is to change pervasive patterns of irrational thinking. It 'largely consists of the use of the logico-empirical

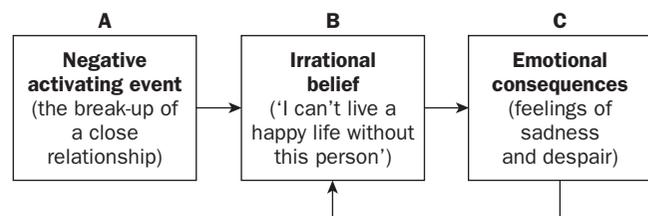


Figure 16.8

A-B-C model that underlies the use of rational emotive therapy. According to Ellis (1973), emotional distress is caused by irrational beliefs. This distress, in turn, helps to sustain irrational beliefs.

method of scientific questioning, challenging and debating' (Ellis, 1977, p. 20). So the RET therapist is challenging and confrontational, asking questions like, 'Where is it written that life has to be fair?' or 'Who says you'll have a breakdown if your partner breaks up with you?'

A common technique used in this form of therapy is to engage in shame-attacking exercises, in which clients are encouraged to deliberately do something they find embarrassing to show that the consequences are not catastrophic.

Does it work?

Two criticisms of cognitive therapy are that the linear causality on which it is based (cognition → behaviour) is too simple, and that it emphasizes internal events (cognition) at the expense of contextual events. But the cognitive perspective on which cognitive therapy is based is actually closer to a diathesis–stress model, in which life events, thoughts, behaviour and emotions are inextricably linked and exert reciprocal effects on each other. Indeed, attention to behaviour is central to cognitive therapy, and so the distinction between behavioural and cognitive therapy has been blurred. Beck's therapy is generally viewed as a cognitive–behavioural therapy, and RET is now often referred to as rational emotive behaviour therapy (Ellis, 1993; 2001).

Although criticized for being too simplistic, RET itself can be useful in clinical practice. But, while there is evidence that the tendency to endorse irrational thoughts is associated with a variety of disorders (Alden & Safran, 1978), Ellis's a priori identification of a core set of irrational beliefs has been questioned. Critics argue that the utility of beliefs needs to be taken into account when we decide on their rationality. A client's 'irrational' belief can be effective and desirable in their circumstances, while a 'rational' belief may be maladaptive in a certain situations (Arnkoff & Glass, 1982). Finally, critics question whether the positive effects of cognitive therapy reflect something specific to cognitive therapy, or to some mechanism that it shares with other psychotherapies.

HUMANISTIC THERAPY

Humanistic therapies focus on the phenomenology (conscious experience) of the client and view psychological problems as disturbances in awareness or undue restrictions on existence. According to this framework, a client's problems can be understood only when viewed from his or her own point of view. The aims of humanistic therapies (also called experiential or phenomenological therapies) are to help people get in touch with their feelings, experience their 'true selves' and develop meaning in their life. This is done through the nature of the therapeutic relationship and the client's tendency to grow as a unique individual (a process known as self-actualization).

Gestalt therapy

Developed by Fritz Perls, Gestalt therapy reflects the view that people often control their own thoughts, behaviours and feelings

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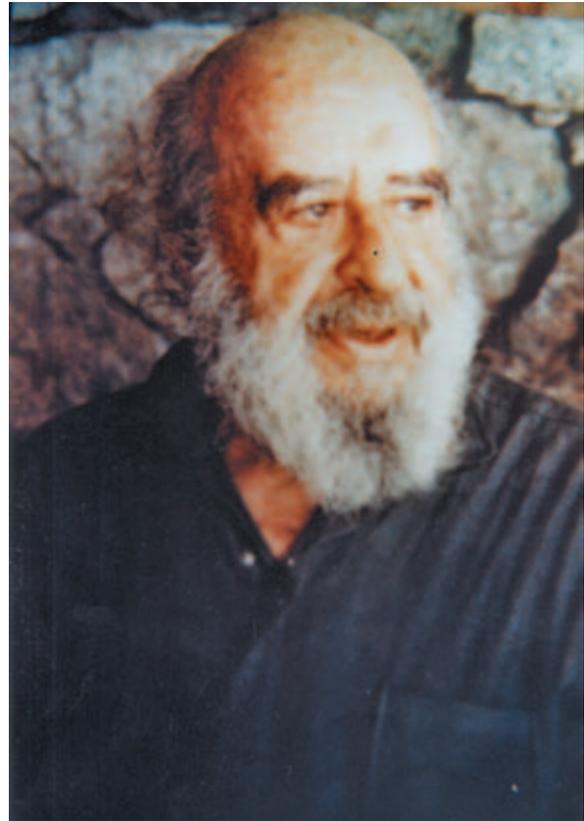


Figure 16.9

Frederick 'Fritz' Perls founded Gestalt therapy, which roots the client in the 'here and now' and helps them to achieve a whole sense of the self.

Frederick 'Fritz' Perls (1893–1970) was born in Germany, earned his MD degree in 1926, and then worked at the Institute for Brain Damaged Soldiers in Frankfurt. He became a psychoanalyst before developing Gestalt therapy. Perls moved to South Africa in the early 1930s, where he wrote *Ego, Hunger, and Aggression: A Revision of Freud's Theory and Method* (1946). In 1946 he moved to New York City and wrote *The Beginning of Gestalt Therapy* (with Ralph Hefferline and Paul Goodman) in 1951. Perls and his wife organized the New York Institute of Gestalt Therapy before moving to California in 1960, where he continued to offer Gestalt therapy workshops until his death in 1970.

too much, losing touch with their emotions and authentic selves. The Gestalt therapist aims to enhance the client's awareness of herself, which helps the client to grow (Perls, 1969). According to this viewpoint, talking about the past or future obstructs therapy, as it is an escape from the reality of the 'here and now', which is

of paramount importance in Gestalt therapy. Awareness in the here and now supposedly leads to change. Consistent with the Gestalt principle of holism (the whole is greater than the sum of the parts; see chapter 1), the goal is to help the client, through change, to integrate polarities (e.g. feminine and masculine sides of the personality), and achieve a whole sense of the self. The Gestalt therapist may often be quite confrontational in forcing the client to focus on the here and now and deal honestly with his feelings. Indeed, according to one commentator, Perls 'was often seen as inhumane in application of his technique' (Cottonne, 1992, p. 148).

Role-playing is used extensively in Gestalt therapy to explore interpersonal games, conflicts between different parts of the self, and so on. Sometimes an empty chair is placed near the client, and he is asked to imagine that the person towards whom he experiences repressed emotions is sitting in the chair. The client can then safely experience his feelings by 'talking' to the person. In a similar vein, two chairs might be used to allow the client to 'seat' two different sides of the same conflict, one in each chair. The client then plays the part of each side of the conflict, as a way of learning to allow the polarities to exist. Enactment (or putting feelings or thoughts into action) is another form of role-play used in this approach.

Gestalt therapy has been aptly summarized as follows: 'The Gestalt therapist places more value in action than in words, in experience than in thoughts, in the living process of therapeutic interaction, and the inner change resulting thereby, than in influencing beliefs' (Naranjo, 1970, p. 47).

Client-centred therapy

This most influential humanist therapy was developed by Carl Rogers, who believed that 'it is the client who knows what hurts, what directions to go, what problems are crucial, what experiences have been deeply buried' (1961, pp. 11–12). In his system, called either client-centred or person-centred therapy, the client determines what to talk about and when to do so, without direction, judgement or interpretation by the therapist.

Rogers argued that a person's natural tendency to grow as a unique individual (self-actualize) is thwarted by judgements imposed on them by other people – what he called *conditions of worth*. He therefore emphasized the importance of affirming the worth of the client, who typically is not interrupted or questioned by the therapist. This is achieved by the exercise of three therapeutic attitudes:

1. Unconditional positive regard is established by showing the client that she is valued, no matter what. It conveys that the therapist cares about the client, accepts her and trusts in her ability to change. It does not mean that the therapist must agree with or approve of what the client says, but it does mean that the therapist non-judgementally accepts everything the client says as a reflection of her as a person. Given these tenets, Rogerian therapists understandably do not offer advice – to do so would imply that the client is not competent and is dependent on help.

Pioneer



Figure 16.10

Humanist Carl Rogers developed a client-centred approach to therapy, in which the client's self-worth is reinforced by keeping sessions free from judgement, direction or interpretation by the therapist.

Carl Rogers (1902–87) was reared in a strict religious environment. He entered the Union Theological Seminary, New York, in 1924 and became involved in working with disturbed children. When his interests shifted to clinical psychology, he obtained a doctoral degree from Columbia University. He taught at Ohio State University, the University of Chicago and the University of Wisconsin, before settling at the Center for Studies of the Person in La Jolla, California. As the founder of nondirective (later relabelled person-centred, or client-centred) therapy, he wrote many influential books, including *Counseling and Psychotherapy: Newer Concepts in Practice* (1942), *Client-Centered Therapy* (1951), *On Becoming a Person* (1961) and *A Way of Being* (1980). He was nominated for a Nobel Peace Prize in 1987.

2. Also essential to the Rogerian therapist is empathy – an emotional understanding of what the client is experiencing by seeing things from his point of view. Empathy is conveyed by active listening and the use of reflection – a paraphrasing of what the client has said, which identifies the

feelings and meanings underlying the statement. Clients often elaborate on their feelings and concerns following a reflection, so this technique helps the client to raise material without the therapist having to ask disruptive questions. The impact of reflection is evident in everyday life: people who reflect back what has been said to them are often viewed as good listeners.

The following interaction between Carl Rogers and a young man illustrates the technique of reflection. Rogers skilfully helps the client clarify his feelings for his stepfather. Without direct prompting from Rogers, the client moves from a blunt assertion of mutual hatred to one of unilateral hatred to one in which he expresses respect for his stepfather and the reasons for that respect.

Client: You see I have a stepfather.

Therapist: I see.

Client: Let's put it this way. My stepfather and I are not on the happiest terms in the world. And so, when he states something and, of course, she goes along, and I stand up and let her know that I don't like what he is telling me, well, she usually gives in to me.

Therapist: I see.

Client: Sometimes, and sometimes it's just the opposite.

Therapist: But part of what really makes for difficulty is the fact that you and your stepfather, as you say, are not . . . the relationship isn't completely rosy.

Client: Let's just put it this way, I hate him and he hates me. It's that way.

Therapist: But you really hate him and you feel he really hates you?

Client: Well, I don't know if he hates me or not, but I know one thing, I don't like him whatsoever.

Therapist: You can't speak for sure about his feelings because only he knows exactly what those are, but as far as you are concerned . . .

Client: . . . he knows how I feel about it.

Therapist: You don't have much use for him?

Client: None whatsoever. And that's been for about eight years now.

Therapist: So for about eight years you've lived with a person whom you have no respect for and really hate?

Client: Oh, I respect him.

Therapist: Ah. Excuse me. I got that wrong.

Client: I have to respect him. I don't have to, but I do. But I don't love him, I hate him. I can't stand him.

Therapist: There are certain things you respect him for, but that doesn't alter the fact that you definitely hate him and don't love him?

Client: That's the truth. I respect anybody who has bravery and courage and he does . . .

Therapist: . . . You do give him credit for the fact that he is brave, he has guts or something?

Client: Yeah. He shows that he can do a lot of things that, well, a lot of men can't.

Therapist: M-hm, m-hm.

Client: And also he has asthma, and the doctor hasn't given him very long to live. And he, even though he knows he's going to die, he keeps working and he works at a killing pace, so I respect him for that, too.

Therapist: M-hm. So I guess you're saying that he really has . . .

Client: . . . what it takes.

(Raskin, 1985, pp. 167–8)

3. Finally, congruence between the therapist's actions and feelings, sometimes called genuineness, is important in this form of therapy. A therapist who is experiencing fatigue in the therapy session would not mention it in most psychotherapy approaches, but, for Rogers, mentioning the fatigue 'strengthens the relationship because the therapist is not trying to cover up a real feeling. It may reduce or eliminate the fatigue and restore the therapist to a fully attending and empathic state' (Raskin & Rogers, 1989, p. 172).

Does it work?

Humanistic therapy has been criticized for emphasizing 'awareness', which is seen as counterproductive when distressed individuals may well be already over-aware. Gestalt therapy is also sometimes said to border on game-playing, despite its positive view of human nature (Cottone, 1992).

Ironically, Rogers was among the first to recognize the need to evaluate psychotherapy using scientific research, and yet there is little data available to substantiate the effectiveness of his client-centred therapy. He was the first to record therapy sessions, but analysis of those sessions shows that out of eight different categories of client statement, Rogers consistently followed only one type of statement (i.e. those expressing progress) with a positive response, such as 'Uh-uh. That's nice' or 'Oh really. Tell me more.' It perhaps comes as no surprise, then, that his clients increasingly expressed progress during therapy. But this observation doesn't in itself invalidate client-centred therapy. It merely shows the power of social reinforcers in influencing behaviour. In recognition of this form of therapeutic control, Rogers changed the original description of his therapy from 'non-directive' (which it clearly was not) to 'person-centered'.

FAMILY AND COUPLES THERAPY

Individual psychological disorders often reflect disturbance in family relationships – Framo said that 'whenever you have a disturbed child you have a disturbed marriage' (1965, p. 154). And the association between problems in couple relationships and various psychological disorders is well documented (Fincham, 2003). So it's hardly surprising that couples and family therapies have become major psychotherapeutic approaches.

Family therapy

We can trace family therapy back to the family theories of schizophrenia in the 1950s (recall the concept of the 'schizophrenogenic mother' described in chapter 15). The proponents of these theories, such as Bateson and colleagues (1956) emphasized distorted communication as the cause of schizophrenia. They offered a radical new perspective on psychological disorders by focusing on the interaction taking place when the behaviour occurs and moved away from considering individual behaviour isolated from an interpersonal context.

The goal of family therapy is to change dysfunctional patterns of interaction. Structural family therapy (Minuchin, 1974), as the name suggests, focuses on the organization or structure of the family and uses direct, active interventions to disrupt dysfunctional interactions. For example, a therapist working with a family who had an anorexic daughter discovered that the father felt closer to his daughter than to his wife and forbade his children to close their bedroom doors. The therapist surmised that a breakdown in generational boundaries might underlie the girl's refusal to eat. So the first stage of treatment was a directive from the therapist for the daughter to be allowed to close her bedroom door for two hours a day, and for the husband and wife to spend an hour together each evening in their bedroom with the door shut (Hoffman, 1981). This constituted the beginning of a successful intervention in which family boundaries were redefined.

Couples therapy

Traditionally focused on the marital dyad, couples therapy is also used with gay and lesbian couples and non-married heterosexual couples. Like family therapy, various types of couple therapy are practised in an attempt to change interactional patterns. An example of such a pattern is a husband who withdrew whenever the wife raised a topic on which they disagreed – a response pattern that was extremely distressing to the wife. This response to conflict was a pattern developed in his family of origin. The conflict between his mother and father had been so distressing that, with help, the husband was eventually able to recall climbing into his wardrobe and covering his ears when his mother and father disagreed with each other. The therapist also discovered that a prior attempt to stop the conflict between his parents had

Research close-up 1

Can family involvement improve treatment of drug abuse?

The research issue

A resurgence in heroin use is making it the most commonly used illicit drug by people entering drug abuse treatment programmes. And the UK has the fastest-growing number of heroin users of any country in Europe (*The Guardian*, July 6, 2003).

Naltrexone is a medication that blocks the effects of heroin and other opioids (a class of drugs that includes heroin, morphine and codeine). Although an effective treatment for opioid abuse, naltrexone has not been widely used in drug abuse treatment, largely because of poor patient compliance in taking the medication. The present study examined whether behavioural family counselling, which involved a 'recovery contract' with a family member, would improve patient compliance and treatment outcomes.

Design and procedure

Participants were male opioid-dependent patients seeking outpatient treatment for substance abuse who lived with a parent, a spouse or other intimate partner, or other family member willing to participate in the treatment (and who did not also have a current substance use disorder).

At the beginning of treatment all patients were given a prescription for naltrexone (50 mg/day) and were then randomly assigned to one of two treatment groups: behavioural family counselling (BFC) or individual-based treatment (IBT). In BFC, patients had an individual and a family session each week for 16 weeks and took naltrexone daily while the family member observed and verbally reinforced the patient's medication ingestion (e.g. 'I really appreciate you taking your medication'). In IBT, patients were started on naltrexone and were asked in their twice-weekly counselling sessions whether they had taken their daily dose, but there was no family involvement or compliance contract.

Results and implications

Patients in the two treatment groups were equally satisfied with the therapy they received. But BFC patients took naltrexone on more days during treatment than did IBT patients. Urine screening also showed that they had longer periods of continuous abstinence from opioid use during treatment and in the 12-month follow-up period than patients in the IBT condition. Finally, patients who received BFC had better secondary outcomes: that is, they had more days of abstinence from drugs other than opioids and displayed more positive psychosocial functioning (they experienced fewer drug-related, legal and family problems).

This study demonstrates the importance of involving the patient's significant others in treatment. It shows how a daily recovery contract can serve as a noncoercive method to encourage compliance with pharmacotherapy and commitment to treatment. Its significance is emphasized by the fact that medication can only be effective if it is taken.

Fals-Stewart, W., & O'Farrell, T., 2003, 'Behavioral family counseling and naltrexone for male opioid-dependent patients', *Journal of Consulting and Clinical Psychology*, 71, 432–42.



Figure 16.11

In couples therapy, participants are encouraged to develop communication and problem-solving skills.

resulted in a severe beating, so avoidance of conflict had been adaptive. Decades later, this response was now unconsciously guiding his interaction with his wife.

The most thoroughly evaluated couple therapy is based on the premise that 'distress results from couples' aversive and ineffectual response to conflict' (Koerner & Jacobson, 1994, p. 208). Interactions of distressed couples are characterized by negative reciprocity – the tendency for one partner to respond with negative behaviour when the other partner behaves negatively, resulting in long chains of escalating negative interaction. In such cases, the goal of therapy is to help couples develop communication and problem-solving skills that will allow them to avoid such cycles, and to break out of them should they occur. This form of therapy therefore tends to focus on changing behaviour and so is really a form of behaviour therapy.

Do couples and family therapies work?

Because many family therapies have been developed by highly skilled, charismatic therapists, some critics argue that the attraction of these therapies may reflect little more than this charisma. This concern is reinforced by the relative lack of research on many of these therapies. Indeed, when fifteen different approaches to family and couples therapy were cross-tabulated across ten different psychological disorders, it was found that systematic evaluations of the efficacy of these therapies had been conducted on only 35 of the 150 method-by-problem combinations (Gurman et al., 1986). This is a circumstance that has improved only slightly since this time. Nevertheless, it has been reported that bona fide treatments produce beneficial outcomes for about two-thirds of cases in 20 sessions or fewer, and these treatments are probably as effective or even more effective than many individual treatments for problems relating

to family or relationship conflict (Alexander, Holtzworth-Munroe & Jameson, 1994).

ASSESSING THE EFFECTS OF PSYCHOTHERAPY

In 1994, 180,000 subscribers to *Consumer Reports*, a popular magazine in the USA, were asked to respond to questions about mental health, including whether they had received help for a mental health problem since 1991. Of the 2,900 respondents who had received psychotherapy, 90 per cent stated that the therapy helped at least 'somewhat', with 54 per cent reporting that it had 'helped a great deal'. Martin Seligman, an eminent psychologist (see chapter 15), has argued that these findings contribute to the 'empirical validation of psychotherapy' (1995, p. 895).

The earlier discussion of evaluating psychotropic drugs applies equally well to the appropriate evaluation of psychotherapy. Clearly the absence of a control group in the *Consumer Reports* study means that we cannot attribute any individual change to treatment. Also, relying solely on client report is dubious at best, given the client's stake (for example, his/her personal investment in terms of time and money) in believing the psychotherapy worked – a clear example of cognitive dissonance (see chapter 17). In the end the *Consumer Reports* survey was dismissed as uninterpretable (Hollon, 1996; Jacobson & Christensen, 1996) for several reasons, including:

- the minimal response rate – 1.9 per cent of the original sample;
- the unknown nature and metric of the outcome variable – what exactly constitutes being 'helped' and the scale used by clients to rate this outcome are both unknown; and
- the self-selected nature of the sample.

Yet, although best viewed as an informal survey of client satisfaction rather than a systematic study of psychotherapy efficacy, the controversy generated by this piece had the salutary effect of forcing both proponents and critics of psychotherapy to clarify issues regarding the its evaluation.

How can we assess psychotherapies?

There has been sustained attention to evaluating the effectiveness of psychotherapy since the 1950s. The continued need to clarify how best to do this attests to the difficulty of the task.

The first difficulty is one of sheer magnitude. With some 400 therapies and over 150 psychological disorders (Garfield & Bergin, 1994), there are potentially 60,000 treatment/disorder combinations to evaluate. To do so systematically would require 47 million comparisons. Needless to say, only a minute fraction of this number of analyses has been conducted. Some treatments have not been investigated at all, as their proponents assert simply that they 'work' and that objective verification is unnecessary.

Taking drug assessment as a model in fact raises more difficulties. For example, what constitutes an appropriate control group in evaluating psychotherapy? In drug evaluations, a placebo group is a useful starting point, and placebo effects also occur in psychotherapy. But suppose in our evaluation of psychotherapeutic efficacy we set up an 'attention placebo control group', in which regular meetings with another human being involve theoretically inert therapeutic content. Is this truly a placebo, when the experimental treatment is premised on the therapeutic value of a human relationship? Moreover, while it is possible to use single-blind procedures in psychotherapy research, it is virtually impossible to conduct double-blind studies.

Another vexing problem in applied settings is that clients choose whether to seek psychotherapy, choose the type of psychotherapy and determine how long they will remain in therapy. This self-selection means that different types of people are likely to select and remain in different type of therapies, resulting in biased samples. Added to this is the difficulty of obtaining a stable group sample (clients may change therapists or discontinue therapy completely).

These are just a few examples from a long list of problems confronting psychotherapy evaluation.

What do we know about psychotherapy's effectiveness?

Recognizing the evolving nature of its evaluation, what have we learned about the effectiveness of psychotherapy over the last 50 years?

Hans Eysenck published a landmark paper on the topic in the early 1950s. Although he was not the first to address psychotherapy outcome, it was distinguished from its predecessors by its reliance on empirical data and by its unpopular conclusions. Eysenck (1952) concluded that approximately two thirds of neurotic patients (i.e. patients with anxiety disorders and depression) recovered spontaneously, compared to 60 per cent who received psychotherapy. In other words, in these groups of patients psychotherapy had no beneficial effect! However, the studies reviewed failed to meet even the minimal methodological criteria that must now be met to qualify for systematic evaluation. Nevertheless, when Eysenck reviewed the literature again eight years later, including studies that were more adequate methodologically, he reached the same conclusion: 'With the single exception of therapeutic methods based on learning theory, results of published research . . . suggest that the therapeutic effects of psychotherapy are small or non-existent' (1960, p. 245).

The value of Eysenck's work may lie in the stimulus it provided to improve the quality of psychotherapy outcome research, which has since dramatically increased. In hindsight, it is also clear that Eysenck overestimated the rate of spontaneous improvement, which, according to a subsequent review, is around 30 per cent, depending on the diagnostic composition of the group (Bergin, 1971). From this revised perspective, the 60

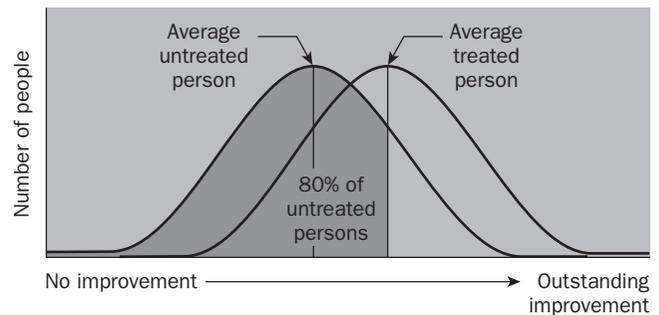


Figure 16.12

The effects of psychotherapy. Using meta-analysis to summarize the results of 475 studies, Smith et al. (1980) found that the average psychotherapy client shows more improvement than 80 per cent of the no treatment controls. From these results, the authors concluded that 'psychotherapy benefits people of all ages as reliably as schooling educates them, medicine cures them, or business turns a profit'. Source: Smith, Glass and Miller (1980).

per cent improvement rate found for psychotherapy provides some modest evidence for its efficacy.

In an analysis of 475 studies involving 25,000 patients treated by a variety of psychotherapies, substantial data were accumulated. Smith, Glass and Miller (1980) executed this monumental task using meta-analysis, a quantitative method for combining results across a number of studies. Meta-analysis involves examining effect sizes (a measure of association between two variables in a standard metric that can be applied across studies). In this case, effect sizes were the average difference in improvement in treated and untreated clients in each study. These average differences were computed from a variety of outcome variables, including client report, therapist rating of client improvement and improvement observed by friends and family. Smith, Glass and Miller averaged the effect sizes across outcome variables in each study, and then averaged them across all studies. They found that the average client who received treatment was better off than 80 per cent of the clients who went untreated (figure 16.12). These findings were repeated when clients were studied months or years after their treatment (Nicolson & Berman, 1983).

More recent meta-analyses have reached similar conclusions (e.g. Anderson & Lambert, 1995; Shadish et al., 1997; Weisz et al., 1995). We now know that for 50 per cent of clients, beneficial effects begin to appear after about six to eight sessions of psychotherapy, and that 75 per cent of those who show improvement do so by the 26th session (Howard et al., 1996).

What can we conclude?

Can we therefore conclude that psychotherapy is effective? The data certainly support this conclusion, but there are still some concerns. For example, examine figure 16.12 carefully and you will see that some treated clients end up worse off than the

Everyday Psychology

Young men and suicide

Youth suicide has long been a topic of concern. Indeed, suicide among high school students was the theme of the first meeting of the Viennese Psychoanalytic Society, attended by Sigmund Freud and Alfred Adler in 1910. With the recent rise in suicide rates among young people, especially young men, it has become a major issue.

A recent survey conducted in Ireland indicated that the suicide rate for men aged 15 and over in 1977 was 8.9/100 000 population (Swanwick & Clare, 1997). By 1996 this figure had risen to 17.38/100 000 (NWHB, 1998). This increase may partly be due to better recording of the relevant data, but better recording should affect data relating to both men and women of all ages. So the increased incidence appears to be real rather than artefactual. It affects most acutely men aged between 20 and 24 years.

Apart from being male, other factors that appear to increase the risk of suicide include being unemployed, living alone or with parents (for young males), being married (for young females), rural living (particularly for males) and underlying mental illness or personality disorders.

Foster et al. (1997) conducted 'psychological autopsies' on 118 of 154 deaths due to suicide in Northern Ireland (July 1992 – July 1993) and ascribed DSM-III-R axis I and/or axis II diagnoses to 90 per cent of these deaths. Major DSM-III-R axis I diagnoses implicated were: alcohol dependence (37 per cent), unipolar depression (32 per cent) and anxiety disorders (10 per cent).

Remember, though, that these diagnoses don't necessarily indicate direct causality (see chapter 2): for example, dependence on alcohol may be a reaction to a more fundamental problem, which itself causes both the alcohol dependency and the ultimate suicide.

Using similar 'psychological autopsy' techniques, Lesage et al. (1994) compared 75 young men (aged 18–35) who had committed suicide with 75 living young men matched for age and socio-economic background. They found that 88 per cent of the suicide group, compared with only 37 per cent of the controls, were diagnosed with DSM-III-R axis I disorders. Furthermore, young people who have been psychiatric patients during childhood and adolescence are known to be at increased risk from suicide.

Working with Men, a London-based organization, published a report in 1997 (*Young Men and Mental Health Project*) on work carried out by agencies dealing with young people. The report notes that young men aged 16–25 tend to approach these agencies seeking advice on practical issues rather than for personal counselling. Younger boys seem to prefer short visits and want immediate answers to problems. Men tend to come alone, delay help-seeking (48 per cent left their problems more than a month before tackling them) and have difficulty asking for help. The report recommends:

- working with young men on help-seeking, recognition of feelings, and relationships in school or youth club environments;
- developing public education initiatives targeted at young men;
- improving drop-in services, as self-referral to the agencies seems most popular with young men;
- more information sharing among those working with young men in order to identify best practice.

Lesage, A.D. et al., 1994, 'Suicide and mental disorders: A case control study of young men', *American Journal of Psychiatry*, 151 (7), 1063–8.

average untreated client. So you might justifiably wonder whether psychotherapy can be harmful.

It is estimated that about 5–10 per cent of clients deteriorate after psychotherapy, but the causes of such changes are poorly understood (Shapiro & Shapiro, 1982; Smith et al., 1980). In addition to a bad therapist–client relationship and therapist incompetence (Hadley & Strupp, 1976; Smith et al., 1980), it is also possible that for some clients psychotherapy disrupts a stable pattern of functioning without offering a clear substitute (Hadley & Strupp, 1976).

Clearly much remains to be learned if we are to answer the 'ultimate question' about psychotherapy: 'What treatment, by

whom, is most effective for this individual with that specific problem, under what set of circumstances?' (Paul, 1969, p. 44).

BIOLOGICAL OR PSYCHOLOGICAL TREATMENT?

Both psychotropic medication and psychotherapy are clearly useful in treating psychological disorders. But if medication reduces psychological symptoms, does this mean that the roots of psychological disorders lie in biological dysfunction? On the other

Research close-up 2

Combining psychotropic drugs and psychotherapy in the treatment of depression

The research issue

Major depression tends to be both chronic and recurrent (see chapter 15). Biological and psychological therapies are both effective in treating depression. However, there is little evidence that administering both types of treatment at the same time yields better outcomes than administering either treatment alone. This study adopts a different approach to combining treatments by examining their sequential application. In particular, the researchers wondered whether cognitive behavioural treatment (CBT) after successful pharmacological treatment of depression would improve relapse rates.

Design and procedure

To examine this question, Fava et al. randomly assigned consecutive outpatients who had experienced three or more episodes of depression, to one of two treatment groups: pharmacotherapy and CBT, or pharmacotherapy and clinical management (CM). CBT consisted of Beck's cognitive therapy and 'lifestyle modification' (patients were instructed that relapse might ensue if inappropriate lifestyle behaviours continued and were encouraged to modify their schedules, arrangements, etc. accordingly). CM consisted of monitoring medication, reviewing the patient's clinical status and providing the patient with support and advice if necessary.

Results and implications

Short-term CBT after successful antidepressant drug therapy decreased relapse rate after discontinuation of antidepressants. As shown in figure 16.13, those who experienced CBT had a much lower relapse rate (25 per cent) during the two-year follow-up than those assigned to CM (80 per cent).

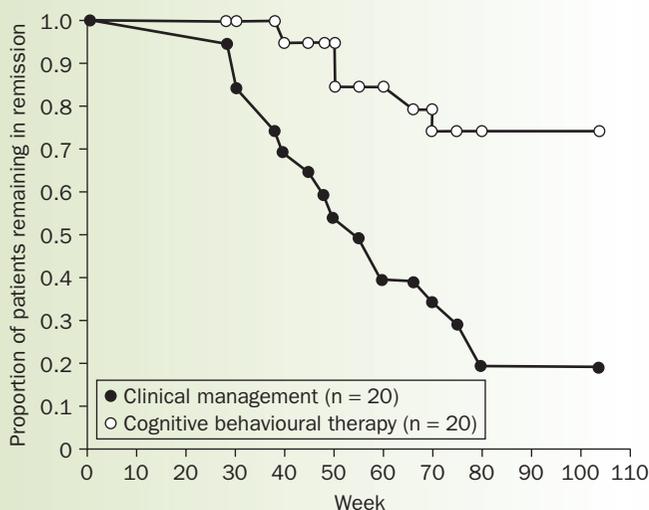


Figure 16.13

The proportion of patients who remain in remission as a function of treatment received and time since the completion of treatment. Source: Fava et al. (1998).

This study challenges the widely held view that long-term drug treatment is the best tool to prevent relapse in patients with recurrent depression. Although maintenance pharmacotherapy may be necessary for some patients with recurrent depression, CBT appears to offer an alternative for others. This study adds to an emerging body of research (e.g. Paykel et al., 1999) that emphasizes the value of cognitive therapy in preventing relapse in depression.

Fava, G.A., Rafanelli, C., Grandi, S., Conti, S., & Belluardo, P., 1998, 'Prevention of recurrent depression with cognitive behavioral therapy: Preliminary findings', *Archives of General Psychiatry*, 55, 816–20.

hand, does successful psychotherapy mean that the causes of psychological disorders are necessarily psychological?

An affirmative answer to either question would mean we have fallen prey to the *treatment-etiology fallacy* – a logical error in

treatment-etiology fallacy a logical error in which treatment mode (e.g. psychopharmacology) is assumed to imply the cause of the disorder (e.g. biological)

which treatment mode is assumed to imply the cause of the disorder. After all, very few people would wish to argue that because aspirin relieves headache, headache is actually due to the lack of aspirin in the body. So even

though an antidepressant medication regulates neurotransmitters in the brain, it is quite possible that a psychological event gave rise to the neurotransmitter changes in the first place. How then do we choose between biological and psychological treatments? In trying to answer this question we must watch out for another logical error, *similia similibus curantur* – like is cured by like (a principle used in homeopathy). In fact, psychotherapy can be used to treat biologically caused psychological disorders and vice versa, although treatment of bipolar disorder, schizophrenia and other psychotic disorders without medication would be irresponsible.

For anxiety disorders and depression, neither biological nor psychological treatment appears to be clearly superior (Antonuccio, Danton & DeNelsky, 1995). A large-scale, multi-site study of 240 people suffering from depression found that two forms of psychotherapy (i.e. cognitive and interpersonal) administered together were generally as effective as a tricyclic antidepressant

(Elkin et al., 1989). However, drug treatment effects appeared sooner, were more consistent across sites and appeared to be more effective in treating severe depression. Similar findings have been obtained in studies of generalized anxiety disorder (Gould et al., 1997) and obsessive-compulsive disorder (Abramowitz, 1997).

What about combining the two forms of treatment? Surprisingly, studies that address this issue have found that concurrent, joint use of medication and psychotherapy produces little additional advantage (Elkin, 1994; Hollon, Shelton & Loosen, 1991). But it does appear that combined treatment can be more effective for some disorders, including attention deficit hyperactivity disorder in children, alcoholism, panic disorder and obsessive-compulsive disorder (e.g. DeBeurs et al., 1995; Engeland, 1993).

Recent evidence suggests that combining treatments sequentially may be helpful, especially in preventing relapse. A combined treatment approach is particularly valuable with clients who may initially be too depressed or anxious to participate fully in psychotherapy. In these cases, symptomatic relief through drug therapy may be adequate, but if it is not, the drugs will most likely alleviate the symptoms sufficiently to allow the person to participate in, and benefit from, psychotherapy. An alternative, conservative approach would be to treat the patient with psychotherapy first (as it usually has no major side effects) and to add or change to medication only when it becomes apparent that the psychotherapy is not producing results. However, such an approach may be risky when there is perceived to be significant risk of suicide.

FINAL THOUGHTS

We have explored biological and psychological interventions for psychological disorders and noted that great progress has been made since the traditional methods of medicine were first applied to the treatment of psychological disorders.

What has emerged from this brief survey is that there is a role for both biological and psychological forms of treatment. Each may be implemented in a variety of ways, and these implementations require careful evaluation in clinical trials to rule out placebo effects and demonstrate that they are effective.

Determining disorders and conditions under which biological and psychological interventions are best used alone or combined, either concurrently or sequentially, presents a challenge for future research. Just as the biological vs. psychological source of a disorder is not determinative in deciding the best course of treatment, nor is the validity of a theoretical framework that has been formulated to *explain* the disorder. As we saw, the models used to account for psychological disorders in chapter 15 do inform their treatment. But the validity of a model used to account for a psychological disorder is quite distinct from the efficacy of a treatment regime derived from it. There is simply no substitute for establishing the efficacy of a treatment directly by means of empirical research.

Summary

- The last chapter dealt with the field of abnormal psychology (i.e. behavioural syndromes or sets of symptoms that result in impairment in people's lives). In this chapter, we considered the kinds of therapy that are available to treat these disorders.
- We first considered the major biological approaches to treating mental disorders. We noted that, because an illness has a biological manifestation, this does not necessarily mean that the illness has a biological cause.
- Treatment with drugs can be very useful for certain types of mental illness, especially in the acute stages, but this form of therapy alone does not necessarily help the client come to terms with some of the key psychological issues that may underlie their functional impairment. The same consideration may be applied to other forms of biological intervention, such as ECT and psychosurgery.
- In extreme cases, it may be necessary to administer these forms of therapy (e.g. where there is a serious risk of harm to the client or to others, or even suicide). However, psychological forms of treatment should also be considered to address the cause of the illness.
- Different forms of psychotherapy emphasize different elements of the human condition (e.g. developmental, behavioural, phenomenological). It is frequently important to consider the status of the individual's mental health within the context of his or her family and other significant relationships.
- When considering the efficacy of different forms of treatment (e.g. biological, psychological), it is important to consider possible placebo effects. The best way of addressing this is via the double-blind randomized clinical trial. However, this is not always possible (for example, in evaluating psychotherapy).

REVISION QUESTIONS

1. What are the major biological approaches to treating mental disorders?
2. Is psychosurgery merely of historical interest, or does it have a future in the treatment of psychological disorders?
3. Is the decision to administer ECT simply a medical judgement, or is it also an ethical judgement?
4. What are the limitations of pharmacotherapy for treating psychological disorders?
5. What is a double-blind randomized clinical trial, and what advantages does it confer in evaluating the efficacy of a drug treatment?
6. What is psychotherapy? How do you account for the existence of different types of psychotherapy?
7. What assumptions do humanistic therapies make about human behaviour that distinguishes them from other therapies?
8. Is psychotherapy effective?
9. What are the relative advantages of biological treatments over psychotherapy and vice versa? Are there clear indicators for the use of psychotropic medication with some clients regardless of their receipt of psychotherapy? If so, what are they?

FURTHER READING

Dattilio, F.M. (ed.) (1998). *Case Studies in Couple and Family Therapy*. New York: Guilford Press.

A useful complement to Oltmanns et al. (1995; see below) as DSM-IV does not have a relationship dysfunction diagnosis.

Kazdin, A.E. (1994). *Behavior Modification in Applied Settings*. Pacific Grove, CA: Brooks/Cole.

Numerous illustrations of the application of behaviour therapy in a variety of settings.

Nietzel, M.T., Bernstein, D.A., Kramer, G.P., & Milich, R. (2003). *Introduction to Clinical Psychology*. 6th edn. Englewood Cliffs, NJ: Prentice Hall.

A very user-friendly introduction to clinical interventions and other tasks performed by the clinical psychologist.

Oltmanns, T.F., Neale, J.M., & Davison, G.C. (1995). *Case Studies in Abnormal Psychology*. 4th edn. Chichester: John Wiley & Sons.
Case studies of all the major disorders found in DSM-IV, each including a section on treatment.

Snyder, C.R., & Ingram, R.E. (eds) (2000). *Handbook of Psychological Change: Psychotherapy Processes and Practices for the 21st Century*. New York: John Wiley & Sons.

Comprehensive analyses of a variety of topics pertaining to psychological treatment of mental disorders.

Vervaeke, G.A.C., & Emmelkamp, P.M.G. (1998). Treatment selection: What do we know? *European Journal of Psychological Assessment*, 14, 50–9.

A short review of the main findings in psychotherapy research that contribute to the selection of a successful treatment.

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