

Chapter 13

Treatment and Therapy

Outline

I. A Historical Perspective

- A. Ancient Greeks and Romans believed that individuals who were depressed, manic, irrational, intellectually retarded, or who had hallucinations or delusions had offended the gods.
 - 1. It was believed that prayer and religious rituals could aid some.
 - 2. Others died as a result of their treatment or were killed.
- B. Hippocrates believed that mental disorders had physical causes.
- C. During the Middle Ages (1000-1500) and well into the eighteenth century, the prevailing attitude toward the mentally ill was that they were in league with the devil or were being punished by God.
- D. The first insane asylum opened in 1547 at St. Mary of Bethlehem Hospital in London; it is commonly referred to as “Bedlam.”
- E. In Paris, Philippe Pinel (1745-1826), a French physician in charge of an asylum, ordered the chains and shackles removed from some of the inmates.
 - 1. The symptoms of many of the patients improved.
 - 2. His belief in moral treatment for the mentally ill can be seen as the beginning of a gradual enlightenment concerning mental illness.
- F. Benjamin Rush (1745-1813) was the founder of American psychiatry.
 - 1. He published the first text on mental disorders.
 - 2. His general attitudes were very humane.
- G. Dorothea Dix (1802-1887) was an American nurse who campaigned for reform in prisons, mental hospitals and asylums.
- H. Clifford Beers published a book in 1908 that is credited with being one of the factors that contributed to the “mental health movement.”
- I. Since the early 1900s, progress has been uneven.
 - 1. World War I and the Depression reduced monies available to support institutions.
 - 2. Within the past 50 years, conditions have improved.
 - 3. There is still prejudice against persons with psychological disorders.

II. Psychosurgery

- A. **Psychosurgery** is the name we give to surgical procedures, usually directed at the brain, used to affect psychological reactions.
 - 1. The “split-brain” procedure can alleviate symptoms in extreme cases of epilepsy.
 - 2. Small surgical lesions in the limbic system have been effective in reducing or eliminating violent behaviors.
 - 3. A cingulotomy has been used successfully to reduce extreme anxiety and the symptoms of obsessive-compulsive disorder.
 - 4. Surgical techniques are being used to treat Parkinson’s disease.
 - 5. A **lobotomy** severs the major neural connections between the prefrontal lobes and lower brain centers.
- B. Prefrontal lobotomies are not done today since psychoactive drugs can produce results with fewer side effects.

III. Electroconvulsive Therapy

- A. **Electroconvulsive therapy (ECT)**, or shock treatment, involves the passing of an electric current between 70 and 150 volts across a patient's head for a fraction of a second.
 - 1. ECT has had a poor reputation in the past.
 - 2. In the United States, more than 110,000 patients receive ECT each year.
- B. The group of patients best suited for ECT are those for whom depression is a major symptom, but for whom other symptoms (such as hallucinations or delusions) are also present.
- C. No one knows exactly why ECT has the beneficial effects that it does.
- D. Because of the inherent dangers, more than 10-12 treatments in a series are seldom administered.
- E. Administering a shock to just one side of the brain, called a unilateral ECT, may be a safer yet equally effective procedure with fewer side effects.

IV. Drug Therapy

- A. **Antipsychotic drugs** alleviate or eliminate psychotic symptoms.
 - 1. Henri Laborit, a French neurosurgeon, used *chlorpromazine* in the early 1950s to calm his patients before surgery.
 - 2. The drug subsequently was used on patients with psychological disorders, and the drug revolution began.
 - 3. Most antipsychotic drugs work by blocking the receptor sites for the neurotransmitter dopamine.
 - a. These drugs are most effective in treating the positive symptoms of schizophrenia, such as delusions, hallucinations, and bizarre behaviors.
 - b. Clozapine is an exception, because it reduces negative symptoms such as social withdrawal, as well as positive ones.
 - 4. Antipsychotic drugs have revolutionized the care of psychotic patients, but they can have unpleasant side effects.
 - 5. About 30 percent of patients with schizophrenia do not respond to these drugs.
 - 6. Symptom-free patients who suddenly stop using their medication find that their symptoms return.
 - 7. If antipsychotic drugs are to be discontinued, the withdrawal must be gradual.
- B. **Antidepressant drugs** elevate the mood of persons who are feeling depressed, and there are three major classes.
 - 1. MAO (monoamine oxidase) inhibitors
 - a. These drugs inhibit the enzyme monoamine oxidase, which normally breaks down levels of serotonin, norepinephrine, and dopamine in the brain.
 - b. A major drawback is that they can be toxic and interact with foods containing tyramine.
 - 2. Tricyclics
 - a. These drugs generally are safer and more effective than the older MAO inhibitors.
 - b. They affect the operation of the neurotransmitter serotonin.
 - 3. SSRIs (selective serotonin reuptake inhibitors)
 - a. These drugs act faster to relieve symptoms and have fewer side effects.
 - b. Prozac was introduced in 1987, and works by inhibiting the re-uptake (or breaking down) of serotonin; increased serotonin level elevates mood.
 - c. Three other SSRI medications include Zoloft, Luvox, and Paxil.
 - 4. There are two classes of drugs currently being investigated for use with bipolar disorder; the newer antipsychotics, and anti-epileptic or anti-seizure medications.
 - 5. Antidepressant medications usually take two to four weeks to show any effect, and may take six weeks to be effective.
 - 6. Most of these drugs produce some kind of unpleasant side effect.
 - 7. Lithium salts are mood stabilizers that are most useful in controlling the manic stage of bipolar disorders.
 - 8. When antidepressant drugs are effective, they may actually bring about long-term cures.

9. For patients who do not respond to drug therapy, ECT may be appropriate.
- C. **Anti-anxiety drugs** (tranquilizers) help reduce the felt aspect of anxiety.
1. Some are muscle relaxants, such as Miltown or Equanil.
 2. The majority are benzodiazepines (e.g., Librium, Valium, and Xanax), which act directly on the CNS.
 - a. These drugs are very effective and are the most commonly prescribed of all medications.
 - b. Dependency and addiction can develop.
 - c. These drugs are prescribed more frequently for women over age 45 than they are for men.

V. Who Provides Psychotherapy?

- A. People with different training and cultural experiences provide psychotherapy.
 1. A *clinical psychologist* can provide psychotherapy.
 - a. This person usually has a Ph.D. in psychology, with a one-year internship, and extensive training in psychodiagnostics.
 - b. A Psy.D. degree emphasizes more practical, clinical work.
 2. A *psychiatrist* is the only therapist permitted to prescribe medications.
 - a. This person is a medical doctor, who completes an internship and residency in a mental hospital.
 - b. Psychiatry is a specialty area in medicine.
 3. The *counseling psychologist* usually has a Ph.D. in psychology, and typically works with less disturbed patients.
 4. A *licensed professional counselor* will have a degree in counseling and will have met state requirements for licensure.
 5. A *psychoanalyst* is a label given to a psychologist or psychiatrist who has received training and certification in the methods of Freudian psychoanalysis.
 6. *Clinical social workers* may have a master's degree or Ph.D.; they traditionally have been involved in family and group therapy.
- B. People in related professions also may provide therapy.
 1. Included are those with a master's degree in psychology, occupational therapists, psychiatric nurses, and pastoral counselors.
 2. Mental health technicians typically have an associate degree in mental health technology, but seldom provide unsupervised therapy.
- C. Some therapists have special training in dealing with clients from various cultures or ethnic groups.

VI. How Do I Choose the Right Therapist?

- A. Many people and agencies can serve as good resources.
- B. Check with your family physician, clergy person, local mental health center, college counseling center, psychology instructor, family and friends.
- C. Give the therapist at least three to four sessions to see if working together will be effective.
- D. If you do not feel that you are benefiting from therapy, discuss this with the therapist and be prepared to change if necessary.

VII. SPOTLIGHT: Psychotherapy and Minority Groups

- A. In general, members of any of the minority groups are less likely to seek help for psychological disorders.
 1. Of research studies reported between 1990 and 1999, only half even mentioned the ethnic/racial characteristics of the participants.
 2. Failure to seek therapy is even true for those minority group members who can afford such treatment.
 3. African Americans are significantly more likely than Caucasians to terminate therapy once it has begun.
- B. Many members of ethnic minorities feel alienated, feel a stigma is attached to hospitalization, fear being labeled, and feel that they can solve their own problems.

1. They tend not to be as “open” as Caucasian clients/patients.
2. Cultural and ethnic minorities strongly prefer “ethnically similar” therapists.

VIII. Psychoanalytic Techniques

- A. Freud was a therapist first, and a personality theorist second.
- B. **Psychoanalysis** is based on several assumptions involving conflict and the unconscious mind.
 1. The biological, sexual, aggressive strivings of the id are often in conflict with the superego, associated with being overly cautious and experiencing guilt.
 2. The id also can be in conflict with the rational ego, which may be called upon to mediate between the id and superego.
 3. Conflicts that are unresolved are repressed into the unconscious.
 4. Freud believed that the way to rid oneself of anxiety was to identify the repressed conflict, bring it into the open, and resolve it.
 5. The goals of psychoanalysis are insight and resolution of repressed conflict.
- C. Freud’s approach to psychoanalysis included some of the following ideas.
 1. The major task of the patient was to talk openly about all aspects of life, which was a time-consuming process.
 2. The method of **free association** encouraged patients to say aloud whatever entered their minds.
 3. **Resistance** refers to the unwillingness or inability to discuss freely some aspect of one’s life.
 4. Dream interpretation was referred to as the “royal road” to the unconscious.
 - a. Manifest content refers to dreams as they are recalled.
 - b. Latent content refers to the dream as a symbolic representation of the contents of the unconscious.
 5. **Transference** occurs when the patient unconsciously comes to view and feel about the analyst in much the same way he or she feels about another important person in his or her life.
 - a. The relationship between the analyst and patient can become complex and emotional.
 - b. Countertransference refers to an analyst allowing his or her feelings and experiences to interfere with objective interactions with the patient.

IX. Post-Freudian Psychoanalysis

- A. In recent years, psychoanalysis has become less common, and strict Freudian analysis, rare.
- B. The most significant change is the concern for shortening the length of analysis.
- C. Today’s analyst will take a more active role in therapy.
- D. More emphasis is directed to the present rather than to childhood experiences.

X. **Humanistic techniques** and existential therapies have a concern for self-examination, personal growth, and development.

- A. The goal of **client-centered therapy**, founded by Carl Rogers, is to help an individual self-actualize.
 1. The focus is on the present, not the past or childhood.
 2. Another focus is on one’s feelings or affect.
 3. The therapist attempts to mirror the feelings of the person.
 - a. This requires that the therapist be an active listener.
 - b. The therapist also needs to be **empathic**, or able to understand and share the essence of another’s feelings.
 - c. The therapist will try to express unconditional positive regard.
- B. Gestalt therapy is associated with Fritz Perls (1893-1970).
 1. The goal is to assist a person to integrate his or her thoughts, feelings, and actions, and increase self-awareness, acceptance, and growth.
 2. Sessions are often convened in small group settings.

XI. Behavioral Techniques

- A. **Behavior therapy** is a collection of techniques founded on the principles of learning.
- B. **Systematic desensitization** involves applying classical conditioning to alleviate feelings of anxiety, particularly those associated with phobic disorders.
- C. Exposure and response prevention has shown promise as a treatment for OCD.
- D. In **aversion therapy**, a stimulus that may be harmful but that produces a pleasant response is paired with an aversive, painful stimulus until the original stimulus is avoided.
- E. **Contingency management** occurs when the therapist can manage the control of rewards and punishments to modify the behavior of a patient.
- F. **Contingency contracting** amounts to establishing a contract with a client so that exhibiting certain behaviors will result in certain rewards.
- G. **Modeling** involves the acquisition of an appropriate response through the imitation of a model.
 - 1. For children with phobias, modeling by other children can be effective.
 - 2. Modeling also is used in assertiveness training to aid individuals in expressing how they feel and think in social situations.

XII. Cognitive Techniques

- A. **Rational-emotive therapy** is associated with Albert Ellis.
 - 1. Its premise is that psychological problems arise when people try to interpret what happens in the world on the basis of irrational beliefs.
 - 2. The therapist takes a directive role in interpreting the client's system of beliefs and encourages active change.
- B. **Cognitive restructuring therapy** is associated with Aaron Beck.
 - 1. It is less confrontational and direct than RET.
 - 2. The patient is given opportunities to test his or her beliefs, which will lead to positive outcomes.

XIII. Group Approaches

- A. Group therapy is a label applied to a variety of situations in which a number of people are involved in a therapeutic setting at the same time.
 - 1. A participant can realize that he or she is not the only one with problems.
 - 2. One can receive support from others.
 - 3. Helping someone else can be therapeutic.
 - 4. A participant can learn to present himself or herself more effectively to others.
- B. In **family therapy**, the roles, interdependence and communication skills of family members are addressed.
 - 1. One assumption is that each family member is a part of a system where his or her thoughts, feelings, and behavior impact other family members.
 - 2. A second assumption is that difficulties arise from improper methods of family communication.

XIV. Evaluating Psychotherapy

- A. Evaluating psychotherapy is a difficult task.
 - 1. Sometimes there is a spontaneous remission of symptoms.
 - 2. It is difficult to agree on what is meant by recovery or cure.
- B. Two large meta-analysis studies showed positive results for psychotherapy.
- C. In general, there is no evidence that any one type of therapy is universally better than others.
 - 1. There is evidence that some types of therapy are better suited for some types of problems than others.
 - 2. Which therapy is best suited for which disorder is one of the most active areas of research in psychotherapy.
 - 3. There is evidence that some therapists are more effective than others.
- D. Many studies have indicated that when the primary treatment is medical, psychotherapy and medication together yield the best prognosis.
- E. Each variety of psychotherapy has its strengths and weaknesses.

- F. A recent push from many psychologists calls for **empirically supported therapies**.
1. The implication is that only therapies with demonstrated empirical research support would be offered.
 2. There are several problems with this approach.
 - a. “Cognitive therapy,” for example means different things to different people.
 - b. Many would rather not get into the business of “prescribing specific therapies.”

Practice Test Questions

Multiple Choice

1. We can claim that the treatment of persons with psychological disorders in humane, systematic ways was a generally accepted practice
 a. during the Greek and Roman empires.
 b. early in the Middle Ages (approximately 1200 A.D.).
 c. late in the seventeenth century.
 d. at the beginning of the twentieth century.
2. Descriptions of persons with psychological disorders can be traced as far back as
 a. the earliest written records of history.
 b. the era of Plato and Hippocrates.
 c. the Dark Ages and the Crusades.
 d. the time of the French Revolution (late 1700s).
3. Throughout history, the treatment of the psychologically disordered has been guided mostly by
 a. those politicians in power and wanting to remain in power.
 b. whatever religion happened to dominate the era.
 c. the profit motive—the desire of a few to profit from the grief of others.
 d. the contemporary view of what caused the disordered symptoms.
4. Who is credited as being one of the first to treat the mentally ill in his care humanely and with compassion, unchaining them from the shackles in the institution?
 a. Phillipe Pinel
 b. Martin Luther
 c. Johann Malleus
 d. Clifford Beers
5. Insane asylums
 a. were first found in ancient Greece.
 b. provided a safe haven for the mentally ill.
 c. had virtually disappeared by the late 1700s.
 d. provided asylum for the general population, not the inmates.
6. A prefrontal lobotomy
 a. severs connections between the cerebral cortex and lower brain centers.
 b. lesions or removes the corpus callosum, thus separating the two hemispheres of the brain.
 c. destroys the part of the limbic system (the amygdala) involved in emotionality and violent behaviors.
 d. involves gradually removing more and more brain tissue until the psychotic symptoms stop.
7. Prefrontal lobotomies
 a. were very dangerous—nearly one-quarter of lobotomized patients died.
 b. were discovered by accident when a patient was shot in the head and his symptoms disappeared.
 c. are now outlawed in the United States.
 d. were performed on tens of thousands of persons in the 1940s and 1950s.
8. Why does electroconvulsive therapy produce the effects that it does?
 a. Levels of the neurotransmitter dopamine are increased.
 b. Pleasure centers in the brain are stimulated.
 c. Unpleasant, depressing memories are destroyed.
 d. No one really knows for sure why it works.

9. The first antipsychotic drug used effectively was
 a. chlorpromazine. c. lithium salts.
 b. Valium. d. Prozac.
10. Anti-anxiety drugs
 a. have long-lasting effects.
 b. are classified as either MAO inhibitors or tricyclics.
 c. cure the symptoms of hallucinations and delusions.
 d. ease or alleviate the symptoms of anxiety.
11. What makes a psychiatrist different from a psychologist is that the psychiatrist
 a. practices psychotherapy.
 b. is more knowledgeable in matters of testing and diagnostics.
 c. went to medical school.
 d. is more likely to be Freudian in orientation and practice psychoanalysis.
12. What do all of the psychotherapies have in common?
 a. They all involve talking and listening.
 b. They all are used to assist with medical treatments.
 c. They all seek to discover repressed conflicts.
 d. They all require a long-term (two-to-three year) commitment.
13. Freudian psychoanalysis is based on many assumptions, including each of the following EXCEPT that
 a. the patient may be truly unable to tell the analyst why he or she is experiencing anxiety.
 b. early childhood experiences can have an impact on the way that one feels as an adult.
 c. once the analyst gets the patient to act better, he or she will think and feel better.
 d. the true nature of the patient's problem may be revealed in the content of his or her dreams.
14. In Freudian psychoanalysis, the process of coming to feel about the analyst as one used to feel about an important or significant other person is a process called
 a. transference. c. latent analysis.
 b. free association. d. resistance.
15. One thing that psychoanalysis after Freud still holds as a basic assumption is that
 a. there is no good reason for anxiety to feel so negative and unpleasant.
 b. hypnosis can be a useful way of developing transference.
 c. anxiety stems from some sort of repressed conflict.
 d. analysis is meant to be a time-consuming process, usually lasting for years.
16. What do client-centered therapy and psychoanalysis have in common?
 a. the assumption of an active role by the therapist to interpret and evaluate what the person has to say
 b. an assumption that, at least at the beginning of therapy, the client may not understand the source of his or her distress
 c. the assumption that the focus of therapy should be on what the person feels and not on what the person thinks
 d. the assumption that earlier, even childhood, experiences are more important or significant than how one feels currently
17. To be an active listener and to be able to share and understand the feelings of others is to
 a. offer unconditional positive regard. c. self-actualize.
 b. be existential. d. be empathic.

18. Most of the techniques of behavior therapy come from
 a. suggestions made by previous patients.
 b. Freud's theories.
 c. the learning laboratory.
 d. research in education.
19. Everything else being equal, which therapy seems best suited for a client who is very dependent and not terribly intelligent?
 a. psychoanalysis
 b. client-centered therapy
 c. contingency management
 d. cognitive therapy
20. Which of these is based more on the principles of classical conditioning than on the principles of operant conditioning?
 a. systematic desensitization
 b. contingency management
 c. token economies
 d. contingency contracting
21. Which behavior therapy technique derives most clearly from the work of Albert Bandura?
 a. aversion therapy
 b. contingency contracting
 c. implosive therapy
 d. modeling
22. A basic premise of cognitive therapy is that people
 a. do not realize how they feel.
 b. develop irrational beliefs about themselves and the world.
 c. do strange things in order to be reinforced by others.
 d. act out childhood fantasies when they become adults.
23. One type of disorder for which cognitive therapy seems particularly well suited is
 a. schizophrenia.
 b. personality disorder.
 c. depression.
 d. phobia.
24. Which of these techniques consistently takes a cognitive approach to psychotherapy?
 a. person-centered therapy
 b. systematic desensitization
 c. family therapy
 d. rational-emotive therapy

True/False

1. ___ True ___ False “Psychosurgery” means “lobotomy.”
2. ___ True ___ False ECT produces a seizure in the brain, very much like an epileptic seizure.
3. ___ True ___ False Antipsychotic medications suppress symptoms, but rarely can they be said to cure a disorder.
4. ___ True ___ False Anybody can be a psychotherapist, but only a person with an MD can be certified as a psychoanalyst.
5. ___ True ___ False All psychotherapies are designed to ultimately bring about a change in a person’s affect, behavior, and/or cognition.
6. ___ True ___ False As opposed to its latent content, the manifest content of a dream is the content as expressed and described by the patient.
7. ___ True ___ False By definition, contingency contracting is essentially the opposite of unconditional positive regard.
8. ___ True ___ False All psychotherapies are equally effective for any particular psychological disorder.

Key Terms and Concepts

psychosurgery _____

lobotomy _____

electroconvulsive therapy _____

psychoactive drugs _____

antipsychotic drugs _____

psychotic symptoms _____

antidepressant drugs _____

antianxiety drugs _____

psychoanalysis _____

free association _____

resistance _____

manifest content _____

latent content _____

transference _____

client-centered therapy _____

Gestalt therapy _____

empathic _____

systematic desensitization _____

aversion therapy _____

contingency management _____

contingency contracting _____

modeling _____

cognitive therapy _____

rational-emotive therapy (RET) _____

cognitive restructuring therapy _____

cognitive-behavior therapy (CBT) _____

group therapy _____

family therapy _____

empirically supported therapies _____

Answers to Practice Test Questions

Multiple Choice

1. **d** Although there were those throughout history who took a humane approach to the mentally ill, a general acceptance of such treatments was really a 20th century phenomenon.
2. **a** We may be much more aware of psychological disorders today, but reports of persons with disorders can be found among the earliest records of written history.
3. **d** How anyone goes about treating psychological disorders is driven—more than anything else—by an understanding of the nature and the causes of those disorders. This is true today, and always has been.
4. **a** It was Phillipe Pinel who, late in the 18th century, discovered the effects of unchaining the insane (as they were called in those days) and treating them humanely.
5. **d** The truth of it is that the persons who experienced most of the asylum when insane asylums were in vogue were those in the general population who no longer had to confront the psychologically disordered on a daily basis. The insane, then, could be “put away.”
6. **a** Regardless of the specific procedures involved, lobotomies sever connections between the controlling cerebral cortex and lower brain centers.
7. **d** None of the first three statements is true. It is true, however, that tens of thousands of these operations were performed in the mid-twentieth century.
8. **d** Yes, we do have some reasonable hypotheses, but the truth is that we still do not know with any precision why ECT has the beneficial effects that it does.
9. **a** I typically don't like to ask questions about specific drugs because there are so many of them and because new ones are being introduced continuously. However, I do think it noteworthy that chlorpromazine was the first psychoactive medication, introduced by Henri Laborit.
10. **d** This one is so easy, you may have a problem with it. Anti-anxiety medications do just what their name suggests they do: they alleviate the feelings of extreme anxiety.
11. **c** The only possible problem with this item is its simplicity. Both practice psychotherapy. I'd hate to make the statement in alternative **b** in a room full of psychologists, and psychoanalysts are likely to be Freudian, whether they be psychologists or psychiatrists.
12. **a** Freud correctly characterized psychotherapy as “talk therapy.” The last three alternatives may be true of some forms of therapy, but are not true “generally.”
13. **c** Alternative **c** is a better statement for a goal of behavior therapy than for Freudian analysis.
14. **a** This statement provides a reasonable definition of the Freudian concept of transference.
15. **c** Psychoanalysis today is significantly changed from the way that Freud practiced it, but what makes it psychoanalysis is the same basic assumption that disordered symptoms reflect repressed conflict of some sort.
16. **b** Both types of therapist would agree that patients, or clients, may not be aware of the true source of their distress, at least at the outset of therapy.
17. **d** Here we have a rather straightforward definition of empathy.
18. **c** Behavior therapies in general are aimed at bringing about relatively permanent changes in one's behaviors following principles derived from the psychology of learning laboratories.
19. **c** Alternatives **a**, **b**, and **d** presuppose an active, involved, introspective client. Only contingency management will be truly effective in this scenario.
20. **a** The last three techniques are applications of operant conditioning procedures, while the first is a classical conditioning procedure.
21. **d** You should know this one even without reading the chapter if you remember from our discussion of learning that Albert Bandura is associated with social learning theory and modeling.
22. **b** Cognitive therapy deals with cognitions—in particular, irrational cognitions or beliefs about one's self and one's place in the world.
23. **c** Yes, cognitive therapy can be—and has been—used for virtually all disorders, but of these choices, it is best suited for treating depression—often in conjunction with drug treatment.
24. **d** By definition, rational-emotive therapy is the only one of these techniques that is specifically cognitive in orientation.

True/False

1. **F** Lobotomy is a type of psychosurgery, but it is not correct to equate the two as synonyms. There are other types of psychosurgery.
2. **T** Just why this has beneficial effects is not known, as we noted in item #8 above, but as stated, this is true.
3. **T** For individuals, we can find exceptions, but by-and-large, anti-psychotic medications are more likely to suppress symptoms than to cure disorders. We make this statement on the basis that when medications are withheld, psychotic symptoms tend to reappear.
4. **F** This one is false on two counts. Not just anybody can be a psychotherapist, and psychoanalysts can be psychologists as well as psychiatrists.
5. **T** This is the one thing that all psychotherapies have in common—a goal of bringing about some sort of lasting change. The differences have to do with how to go about making that change.
6. **T** Latent content is the “hidden” symbolic content of dreams, whereas manifest content is the content as the person describes it.
7. **T** This one takes some thought. Unconditional positive regard provides reinforcement for virtually everything the client says (or does), whereas contingency management will provide conditional positive regard; one earns reinforcement only for doing what is appropriate. Hence, they are, in this way, opposites.
8. **F** This item is simply not true. Yes, in general, all are effective, but for any particular disorder, some are more effective than are others.

EXPERIENCING PSYCHOLOGY

Designing Your Own Mental Health Directory

Given the statistics on the prevalence of the psychological disorders, it is very unlikely that any of us can go very long without the need for some sort of psychotherapy or treatment for psychological disorders—either for ourselves or for someone close to us. When the need arises, there are many options available to you. You may contact your psychology instructor, family doctor, or clergy person. You may contact the student services office on your campus, or a local community mental health facility. You may ask friends, family, or the local office of the Mental Health Association for a referral.

It will only take a few minutes now to explore the possibilities for therapy, counseling, or treatment. Look through the campus directory, or the yellow pages of the phone book for names, addresses, and phone numbers. Make a list of resources or agencies that you could call if you encounter a need for mental health services. Put the list someplace handy—in with your notes, in your address book, wherever. The need for psychotherapy seldom arises as an emergency situation, where seconds count. Nonetheless, it just makes good sense to be prepared, to have a course of action ready should the need arise.

Using the Internet to Expand Your Appreciation of Psychology

1. A HISTORICAL PERSPECTIVE (pp. 454-455)

Reports of persons with psychological disorders are as old as recorded history. Part of that history also includes accounts of how persons with mental illness were cared for by the societies in which they lived. In most cases, what tended to drive approaches to treatment was the prevailing understanding of what caused the disordered thinking and behaviors in the first place. There is a large literature on the history of the treatment of persons with psychological disorders. Here are a few good Internet sites on the subject:

<http://cscwww.cats.ohiou.edu/~ridges/history.html>

(a brief presentation, with sections on hospitalization, moral management, and societal cooperation/interaction)

<http://www.mind.org.uk/Information/Factsheets/History+of+mental+health/Notes+on+the+History+of+Mental+Health+Care.htm>

(a glorious and detailed account from Great Britain – goes way back to BC, with detailed accounts of treatment by the Greeks and Romans)

<http://intotem.buffnet.net/mhw/29ap.html>

(a bit more recent – a review of 20th century approaches to treatment)

http://www.brainyencyclopedia.com/encyclopedia/b/be/bethlem_royal_hospital.html

(a wonderful site, focusing on “Bedlam” with many additional links)

2. PSYCHOSURGERY (pp. 456-458)

As you know, psychosurgery does not begin and end with the prefrontal lobotomy, although that impression is a common one. If one defines psychosurgery in general terms as “a surgical technique usually directed at the brain, used to affect psychological functioning,” there are several procedures that qualify. These websites look at both the old and the new.

<http://www.psychosurgery.org>

(subtitle: “Remembering the tragedy of lobotomy,” calling it “a psychiatric mistake of the past”)

<http://nobelprize.org/medicine/articles/moniz>

(Egas Moniz did win a Nobel Prize for his work on lobotomies; this is his story)

<http://cms.psychologytoday.com/articles/pto-19920301-000030.html>

(a general article on psychosurgery with an excellent case history of a patient)

<http://neurosurgery.mgh.harvard.edu/Functional/psysurg.htm>

(a most excellent summary by two MDs of the Departments of Neurosurgery and Psychiatry, Massachusetts General Hospital and Harvard Medical School)

3. ELECTROCONVELSIVE THERAPY (pp. 458-459)

There are few techniques in all of medicine or psychology that continue to be quite as controversial as electroconvulsive therapy (ECT), or simply “shock therapy.” As in most controversies there are divergent points of view and different sides to the story. See if these websites help.

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

(about the one largest website on ECT you will find)

<http://www.ect.org>

(a site hosted by someone who has received ECT—very comprehensive)

4. DRUG THERAPY (pp. 459-463)

Now the issue is the use of psychoactive drugs to either treat psychological disorders or, at least, suppress the symptoms of such disorders. The following sites cover this issue for the antipsychotic, antidepressant, and antianxiety medications.

<http://www.abc.net.au/health/depression/anti.htm>

(from Australia, an informative site on antidepressants with many links)

http://www.healthatoz.com/healthatoz/Atoz/ency/antianxiety_drugs.jsp

(encyclopedic, but a nice summary on antianxiety medications)

<http://www.endallthepain.com/AntiAnxietyDrugs.html>

(more of a listing than anything else, but good summaries of antianxiety drugs)

<http://www.breggin.com/minortranqs.html>

(a most excellent summary article on the tranquilizers—or antianxiety drugs)

5. WHO PROVIDES PSYCHOTHERAPY? (pp. 463-466)

There are a great many approaches to psychotherapy, so many that it can honestly be said that no two psychotherapists approach their sessions in exactly the same way. No two people are alike and that also holds for psychotherapists. About the only thing we can say about psychotherapy is that they do not involve surgery, shocking, or administering drugs of any sort. Psychotherapies involve listening, interacting, and guiding. These are general websites on psychotherapy and choosing a therapist.

<http://www.guidetopsychology.com/choosing.htm>

(an excellent, large website on “Choosing a Psychologist”)

<http://www.psychotherapyguild.com/choosing.html>

(a straightforward discussion on “How to Choose a Therapist”)

<http://www.metanoia.org/choose.gethelp01/htm>

(a first-hand approach on “How to Choose a Competent Counselor”)

<http://healthyminds.org/multimedia/choosingapsych.pdf>

(from the American Psychiatric Association)

6. PSYCHOANALYTIC TECHNIQUES (pp. 467-470)

As you know, psychoanalysis originated with the work of Sigmund Freud. Let's explore to Internet to first find out more about Freud himself and then take a look at psychoanalytic approaches to therapy.

<http://www.freud.org.uk>

(the life and times of Sigmund Freud from London's Freud Museum)

<http://users.rcn.com/brill/freudarc.html>

(scroll down to the links that make this a HUGE Freud site)

<http://www.freudfile.org>

(if you've not found it yet; find it here—another HUGE Freud

<http://www.wawhite.org/Journal>

(this journal (*Contemporary Psychoanalysis*) is technical, but worth a look)

<http://www.icpla.edu>

(the homepage of The Institute of Contemporary Psycholoanalysis)

<http://www.psychoanalysis.org.uk/psatoday.htm>

(*Psychoanalysis Today* from the British Psychoanalytic Society)

7. HUMANISTIC TECHNIQUES (pp. 470-471)

To talk about humanistic approaches to psychotherapy is largely a matter of studying the works of Carl Rogers on person-centered therapy and Fritz Perls on Gestalt therapy.

<http://www.allanturner.co.uk>

(the links and resources available here are impressive indeed)

<http://psychclassics.yorku.ca/Rogers/therapy.htm>

(“Significant aspects of client-centered therapy” by Carl Rogers (1946))

<http://www.adpca.org/articles.html>

(they’re all good, but Barbara Brodley’s article is very useful)

<http://www.gestalt.org>

(not particularly easy to navigate, but this “Gestalt Therapy Page” has excellent links)

<http://www.aagt.org>

(website for The Association for the Advancement of Gestalt Therapy)

8. BEHAVIORAL TECHNIQUES (pp. 471-473)

There are many approaches to psychotherapy that can be classified as behavioral. They share the common goal of using the experiences of the psychology laboratory (mostly the learning laboratory) to bring about changes in behavior. The assumption is that if behaviors are changed, affects and cognitions will change as well. As there are many behavior therapies, there are many websites devoted to them. This is a small sample.

<http://www.aabt.org>

(the homepage for the Association for the Advancement of Behavior Therapy)

<http://www.guidetopsychology.com/sysden.htm>

(a rich website devoted to systematic desensitization)

http://www.glbtq.com/social-sciences/aversion_therapy.html

(a summary of aversion therapy --- --- from a gay/lesbian perspective)

9. COGNITIVE TECHNIQUES (pp. 473-475)

As you know, cognitions include such mental events as perceptions, beliefs, and thoughts. Cognitive therapists take the position that working to change how a person thinks (usually about herself or himself) can lead to positive changes in behavior and emotional state. Your text addresses rational-emotive therapy, cognitive restructuring therapy, and cognitive-behavior therapy—so do the following websites.

<http://www.rebt.org>

(the Albert Ellis “Rational Emotive Behavior Therapy” website)

<http://www.threeminutetherapy.com/rebt.html>

(an individual’s site on rational-emotive behavior therapy)

<http://mentalhelp.net/psyhelp/chap14/chap14g.htm>

(a nice, readable essay on R.E.T.)

<http://www.beckinstitute.org>

(the Beck Institute for Cognitive Therapy and Research; takes some searching, but good things to be found)

<http://www.academyofct.org>

(the Academy of Cognitive Therapy website—great links)

<http://www.cognitivetherapy.org>

(self-described as “The Cognitive Behavior Website”)

<http://www.nacbt.org>

(website for the National Association of Cognitive Behavioral Therapists)

<http://www.drugabuse.gov/TXManuals/CBT/CBT1.html>

(a wonderful CBT website from the National Institute of Drug Abuse)

10. GROUP APPROACHES (pp. 475-476)

For some folks, talking about personal problems in front of anyone is difficult. Such discussions with a professional therapist may be acceptable, but sitting in a group of people talking about personal “issues” is a real challenge for some. Nonetheless, there are some real benefits from an approach to psychotherapy that is referred in general as “group therapy.”

<http://www.group-psychotherapy.com>

(a well-organized website with many helpful links)

<http://psychematters.com/group.htm>

(not a large site, but has very useful links)

<http://www.groupsinc.org/group/consumersguide2000.html>

(a guide to group therapy from the American Group Therapy Association)

<http://www.rci.rutgers.edu/~rccc/groupbro.html>

(a brochure on group therapy from the Rutgers College Counseling Center)

11. EVALUATING PSYCHOTHERAPY (pp. 476-479)

There are many unknowns to define and consider when trying to evaluate psychotherapy in general. It is often easier to evaluate a particular type of therapy as practiced by a particular therapist with a particular type of patient. The only general consensus is that psychotherapy in general is better than no psychotherapy. See if these websites help.

<http://counsellingresource.com/types/effectiveness.html>

(a strange site, but with a nice summary article on evaluating psychotherapy)

<http://www.beta.nl/eep.htm>

(an excellent—if slightly dated—summary article)

<http://www.psych.upenn.edu/~dchamb/ESTs/EST.html>

(be patient, search links and be reinforced by definitive pieces/articles on Empirically Supported Therapies)

http://www.apa.org/divisions/div12/rev_est

(a “Guide to Beneficial Psychotherapy—Empirically Supported Therapies—hosted by the APA’s Division 12, The Society of Clinical Psychology)