

Unit 13: Treatment of Abnormal Behavior

I. Introduction

- A. History has had a very broad array of treatments for mental disorders from super harsh to super soft.
- B. The movement from harsh to soft treatments were pioneered by Philippe Pinel in France and Dorothea Dix in the U.S.
 1. They fought to get mental patients out of prisons and into mental hospitals now.
 2. The trend since the 1950s is to move the patients out of the mental hospitals, back home, and treat them through medication and support groups.
- C. Treatments today usually fall into one of two broad categories...
 1. **Psychotherapy** attacks learning-related disorders, like fears. Here, a trained psychologist uses psychological techniques to try to overcome the disorder. There are four main approaches within psychotherapy...
 - a. Psychoanalysis
 - b. Humanism
 - c. Behaviorism
 - d. Cognitive
 2. **Biomedical therapies** involve medication. They're used for things like schizophrenia.
 3. Psychologists in the biopsychosocial perspective may try both psychotherapy and medication. This is called an **eclectic approach**.

II. Psychoanalysis

- A. Sigmund Freud's ideas brought us the first psychotherapy. His techniques are used by almost no one today. Some of his ideas still exist in the **psychodynamic therapies**.
- B. A quick review of psychoanalysis...
 1. We are constantly in a struggle with ourselves. Our struggles hearken back to a childhood struggle with our parents.
 2. We do things as "grown ups" because we have repressed memories and desires and our unconscious drives us to do them.
- C. Psychoanalytic therapy tries to dig down into a person's unconscious (the part of the iceberg below the water) and root out the causes of the struggles. Then the struggles can be relieved.
 1. Freud first tried to dig into the unconscious with hypnosis, then trashed the idea.
 2. He next turned to **free association** where people speak freely and quickly. The idea is that they'll speak their unconscious and a psychoanalyst will be able to decipher it.
 - a. If a person stops speaking freely, the analyst sees it as **resistance** – the person is suppressing something they don't want to surface.
 3. Freud turned to **dream analysis** and what he called the "latent content" – the hidden but symbolic meaning of things in dreams.
 - a. Patients may feel strong emotions and **transfer** those onto the analyst.
- D. A weakness of psychoanalysis is that it's so subjective – it's one analyst's opinion and it can't be objectively proven.
- E. **Psychodynamic therapists** start with Freud's ideas.
 1. They agree that a person's childhood experiences are critical as well as the patient-therapist relationship.
 2. They agree that it's important to explore the patient's underlying thoughts and feelings.

3. They differ from Freud in that they (a) may speak face-to-face, (b) meet less frequently, and (c) for a shorter time period.
- F. **Interpersonal psychotherapy** is a 12-16 session treatment that has been successful with treating depression.
1. It tries to dig up the cause of their depression. But the real goal is to cut back the symptoms of depression.
 2. Whereas a psychodynamic therapist focuses on finding the root cause of the problem, the interpersonal psychotherapist tries to do this too, but really wants a more real result. Often the real result is improving relationships with others.

III. Humanistic therapies

- A. **Humanists** believe that people are good-at-heart and try to help people grow to reach their full potential.
1. The humanist approach and psychoanalysis are called **insight therapies** because they both have the person look inside to figure things out.
- B. Humanist therapies differ from psychoanalysis in that humanism (1) focuses on the present instead of the past, (2) the conscious instead of the unconscious, (3) holds a person accountable for his actions instead of the unconscious, and (4) it promotes growth rather than a cure.
- C. Carl Rogers innovated **client-centered therapy** where the patient speaks and, through self-awareness, moves himself toward his own conclusion. It's "self-help". The therapist listens without judgment and with as little input as possible.
1. Rogers encouraged therapists to show genuineness, acceptance, and empathy. In other words, be real, don't judge, and feel their pain.
 2. Rogers thought this encouraged the patients to "open up" and seek to grow and move on.
 3. Rogers spoke of **active listening** where the listener echoes what's heard, restates it, then seeks clarification.
 4. Rogers #1 thing was that a therapist use **unconditional positive regard** – that they listen without judging. The hints to listening...
 - a. Paraphrase what you hear.
 - b. Seek clarification to see if you got it right.
 - c. Reflect the feelings that you're hearing/sensing.

IV. Behavior therapies

- A. Behaviorists disagree that resolving unconscious conflicts or getting to know yourself will solve your mental issues. Behaviorists say you've learned these things through rewards and punishments. But, just as you've learned them, you can unlearn them too.
- B. Behaviorism got its start with Ivan Pavlov and his dogs.
1. In behaviorism, a person (or dog), is conditioned to associated two things together.
 2. Bed-wetting was classically conditioned with being awakened by an alarm. This stopped the bed-wetting.
- C. **Counterconditioning** is where we "unlearn" something by conditioning or pairing a trigger stimulus with a new response.
1. For example, suppose a person has acrophobia—fear of heights.
 2. There are two main types of counterconditioning...
 - a. **Exposure therapy** exposes people to what they try to avoid. It tries to associate the bad thing (heights) with a good thing (like eating). Slowly, the person is moved closer to the ledge or higher up. Eventually, the height is associated with the eating.
 - i. **Systematic desensitization** says you can't be worried and relaxed at the same time. So, while relaxed, you "face your fears" in small baby steps and work up to the "big fear."

1. The therapist trains you to use “progressive relaxation” to keep calm when you feel the first hints of anxiety.
2. The trick here is to take it very slowly, in baby steps.
- ii. **Virtual reality exposure therapy** puts the person in virtual world where they can “face-their-fears”. Results have been promising at facing fears and interacting in social virtual worlds.
- b. **Aversive conditioning** tries to condition a person to not do something. It pairs a negative result with an unwanted stimulus. Two examples...
 - i. To stop nail biting, use nasty tasting nail polish. This pairs a yucky taste with nail biting.
 - ii. To stop drinking alcohol, put a nausea inducing drug in the drink. This pairs nausea with drinking alcohol.
 - iii. Aversive conditioning works, but it may be only temporary. The pairing or association may wear off. This is because cognition (thinking) steps in. We know when we’ve put on the nasty nail polish, we know when the drink has been drugged.
- D. **Operant conditioning** techniques can be used too. This is where the person’s actions interplay with the stimulus and results (it’s not just biological or automatic, as in classical conditioning).
 1. B. F. Skinner and his Skinner box pioneered this. The rat interacted with his environment—what he did as a stimulus affected the results.
 2. Essentially, “behavior modification” techniques withhold rewards until a desired behavior is done. Or, punishments are given out when an unwanted behavior is done.
 - a. Rewards might be food or a “**token economy**”. This is receiving tokens which can be spent for things like candy, TV time, etc. It’s like earning points in a video game which can be used for various things.
 - b. Critics say behavior modification means the behaviors are done just to get silly things like plastic tokens. Behaviorists say they slowly take a person off the tokens, and ask, “Their behavior is better, so where’s the harm?”
- V. Cognitive therapies
 - A. **Cognitive therapists** start with the belief that what we think influences what we feel.
 1. In other words, what we *think* about a situation impacts what we *feel* in response to a situation.
 2. If we blame ourselves for something bad, we’re likely to feel depressed. If we think it through and see something else as the cause, we don’t.
 - B. Aaron Beck was trained as a Freudian. He saw themes of loss, rejection, and abandonment. He tried to change this negativity through cognitive therapy.
 1. Beck’s technique was to engage the patient in conversation, then gently reveal how irrational they were being. The hope was that the patient would see how irrational (stupid) they were being and change their outlook.
 2. In essence, Beck and cognitive psychologists try to logically show patients their illogical thinking.
 - C. Donald Meichenbaum focused on the wording that people used. Negative wording equates to negative thoughts and thus negative feelings.
 1. His conclusion was that if you talk negatively to yourself, you feel badly. But, the more positively you talk to yourself, the better you feel.

- D. The **cognitive-behavioral therapy** tries to change the way people think and act. It's widely practiced. Its goals are to...
1. Get folks to recognize their negative thinking.
 2. Change the negativity into positive thinking.
 3. Get folks to act on the new positive thoughts.
 4. Techniques included...
 - a. Relabeling the bad into something else. Instead of labeling the bad thing and then dwelling on it, they re-name it and move forward.
 - b. Doing something else. This re-directs the brain into other areas. PET scans support that these techniques work.

VI. Group and family therapies

- A. Group therapy is the most common type of therapy—it saves therapist time and patient money.
- B. It shows patients that they are not alone and that others share their problems.
- C. Family therapy is a type of group therapy. It stresses the importance of being an individual and a member of a family.
 1. **Family therapy** sees a person not solely as an individual but as a component. It's like a spark plug as a part of an engine—both individual yet part of the whole.
 2. Usually, family-therapy seeks to help a relationship issue.
- D. Support or self-help groups usually hit on things that are hard to talk about, like alcoholism or eating disorders.
 1. The most famous support group is AA (Alcoholics Anonymous).
 - a. AA uses a 12-step program. It starts with admitting dependence and seeking more help.
 - b. AA's success rate is high, but so are other treatments like cognitive-behavior therapy or "motivational therapy".

VII. Is psychotherapy effective?

- A. It's hard to measure the effectiveness of psychotherapy. But, three ways seem to stand out...
 1. How the patient feels about its success.
 - a. The patient, or client, almost always feels that psychotherapy is effective.
 - b. Still, skeptics say (1) people enter therapy in a crisis and once it's over, they feel better naturally, (2) no one wants to admit the time and money was a waste, and (3) clients tend to like their therapists on a personal level.
 - c. Also, selective recall and confirmation bias means people tend to pull out the facts that support their thinking, while ignoring facts that don't.
 2. How the therapist feels about its success.
 - a. Therapists, or clinicians, tend to report success too.
 - b. The problem here is that the (1) feedback is usually only received from "successful" cases, and (2) patients usually leave happier than when they entered, but the cause of the improvement isn't necessarily the therapy.
 3. How much the behavior has changed.
 - a. The two views above are purely subjective (patient and therapist opinions). To get an objective view, we look at behaviors.
 - b. To do this, we need an experiment with control and experimental groups.
 - i. In one study, a group was "treated" with psychotherapy and a control group got nothing. Both groups healed. The lesson—time is a great healer.
 - ii. A **meta-analysis** (a summary study of many studies to determine the bottom-line) determined that the average

treated person winds up being better-off than 80% of the non-treated group. The bottom line: people *not* getting treatment are likely to improve, but those who get treatment are more likely to improve.

4. Psychotherapy also cuts costs. It cuts down on more-expensive medical treatment.

VIII. The relative effectiveness of different therapies

- A. The different types of therapies all seem to yield good results. A rule of thumb—the more specific the problem, the more treatable it is. The more general the problem, the harder it is to treat.
- B. Some therapies have “specialties” though...
 1. Behavioral therapy is best for specific problems, like phobias, bed-wetting, compulsions, and marital problems.
 2. Cognitive therapies are best for depression and suicide issues.
- C. There are some “voodoo therapies” to avoid...
 1. Energy therapies – dealing with supposed invisible energy fields around a person.
 2. Recovered memory therapy – try to dig up supposed “suppressed memories.”
 3. Rebirthing therapy – to re-enact the supposed trauma of birth.
 4. Facilitated communication – where an assistant touches the typing hand of an autistic child.
 5. Crisis debriefing – which forces people to re-live and verbalize traumatic events.
- D. Some people argue that if the patient said the therapy worked, then it worked.
- E. The key is to rely on evidence that the therapy worked. This is called **evidence-based practice** and is encouraged by the APA (American Psychological Association).

IX. Evaluating alternative therapies

- A. It’s hard to nail down the effectiveness of alternative therapies because time often heals anyway.
 1. So, after a person goes through an alternative therapy and gets better, the question then is, “Was the improvement due to the therapy or simply due to time?”
- B. Scientific evidence can be assessed in two types of alternative therapies...
 1. **EMDR – Eye Movement Desensitization and Reprocessing**
 - a. EMDR was developed by Francine Shapiro. It’s having your eyes dart to and fro and is supposed to relieve anxiety.
 - b. The person thinks of a traumatic experience, then darts his/her eyes back and forth. Shapiro reports 84% to 100% success.
 - c. Skeptics say the eye movement really does nothing except that it magnifies the **placebo effect**. Thus, EMDR is effective. But, it could also be effective doing any other task that aids the placebo effect—it doesn’t have to be eye movement.
 2. **Light exposure therapy**
 - a. People tend to be depressed in the dark winter months. This is called “seasonal affective disorder” (SAD).
 - b. As a treatment, patients were put under bright lights for a while—they tended to feel better!
 - c. An experiment was done...
 - i. Experimental group A got light in the morning – they had a 50+% success rate.
 - ii. Experimental group B got light in the evening – they had a 33% success rate.
 - iii. The control group got a fake “treatment” (a placebo) – they had a 30% success rate.

- d. The conclusion – morning light helps fight depression.
 - i. The light exposure therapy was as effective as anti-depressant drugs or cognitive-behavioral therapy.
 - ii. Brain scans supported these findings as well.

X. Commonalities among psychotherapies

A. There seem to be some common threads across therapies...

1. Hope for demoralized people.
 - a. Therapy can provide hope to someone who's going through a tough time. The thinking is, "Things are bad now, but I'm getting help, so things should get better."
 - b. If nothing else, even if the treatment isn't really that good, it serves as the placebo and gets the person's self-healing process started.
2. A new perspective.
 - a. Therapy usually gives the patient some type of an explanation. The patient can then perhaps take this reasoning and go forward with a new outlook.
3. A relationship that's trusting and caring.
 - a. The client-therapist relationship is called the "therapeutic alliance" and it's crucial to success.
 - b. The patient often simply needs someone who cares and shows empathy. Sometimes, we just need a friend.

XI. Culture and values in psychotherapy

A. Psychotherapy can differ by culture. For instance...

1. Western cultures, that value individualism, see this reflected in the therapy.
2. Eastern cultures, that value the group, and therefore me-centered therapy seems uncomfortable.

B. Religion is another point to consider. People who are very religious tend to do better with a therapist of the same religion.

C. It's important for a therapist to be culturally-aware of their clients.

D. It's also important for therapists to be open about their beliefs—that way clients can "match up" with someone whom they'll be comfortable.

XII. Drug therapies

A. Since the 1950s, the use of drugs has become the most common psychological treatment by far. **Psychopharmacology** is the study of how drugs affect the mind and behavior.

1. This means far fewer people are now in mental hospitals.
2. It also means many who've been released, yet are unable to care for themselves, wind up homeless.

B. A double-blind study was done to measure the effectiveness of these drugs.

1. Half the people were given drugs, half were given a placebo (neither the patients or staff knew who got what—double-blind).
2. The half getting the drugs wound up considerably better.

C. **Antipsychotic drugs**

1. It was noticed by chance that some drugs had calming effects to people with psychoses (hallucinations or delusions).
2. So, people with schizophrenia tended to respond best to these drugs.
3. The typical antipsychotic drug is chlorpromazine (brand name "Thorazine").
 - a. The molecules of this drug were like the neurotransmitter dopamine. The drug molecules occupy, and thus block, dopamine's receptor sites.
 - b. There can be side-effects like (a) sluggishness, (b) "the shakes" like Parkinson's where too little dopamine is the case, and in long-

term use, (c) **tardive dyskinesia** where facial muscles move involuntarily.

- c. Schizophrenics with apathy or withdrawal usually don't respond to Thorazine. Another drug, clozapine, affects both dopamine AND serotonin receptors. They have some positive effects in these cases.
- d. Newer drugs are trying to achieve the beneficial results without the side-effects.

D. **Antianxiety drugs**

1. Antianxiety drugs depress the central nervous system (as does alcohol). A common drug is Xanax.
2. The good—the drug may aid the effects of exposure therapy and cut down on effects of PTSD and OCD.
3. The bad—the drug can lead to psychological dependence and physiological dependence. Then when the person stops taking it, symptoms can be even worse.

E. **Antidepressant drugs**

1. Antidepressants boost a person's mood by increasing neurotransmitters serotonin or norepinephrine.
2. A typical drug is Prozac (or Paxil or Zoloft).
 - a. The good—Prozac blocks reuptake of the serotonin neurotransmitter molecule so more of them "stay in play" rather than get reabsorbed by the sending axon.
 - b. The bad—side-effects can be dry mouth, weight gain, hypertension, or dizziness.
 - c. Cognitive therapy helps people out of depression too. It helps to get them thinking in a new way.
 - d. Aerobic exercise boosts mood too.
 - e. It usually takes a month for the effects of antidepressants to kick in. But then, the question comes back up, was it just a matter of time and/or placebo?
 - i. A double-blind study showed the "drug's effect" was actually 75% the "placebo effect."
 - ii. The medication was helpful for severely depressed, not so much for moderate depression.

F. **Mood-stabilizing medications**

1. **Lithium is** used to level the emotional roller-coaster of people with bipolar disorder.
2. 7 in 10 people seem to have their moods stabilized.

XIII. Brain stimulation

A. **Electroconvulsive therapy (ECT)** is better known as "shock therapy" or "shock treatment."

1. In the early days (1938), the patient was strapped down then jolted with 100 volts to the brain. Convulsions and unconsciousness followed.
2. Nowadays, the patient is given an anesthetic and muscle relaxant, then 30 to 60 seconds of electricity. They awaken 30 minutes later, remember nothing of the treatment.
3. ECT seems successful.
 - a. 80% of depressed people who did not respond to drug therapy see significant improvement.
 - b. ECT reduces thoughts of suicide.
 - c. Although 4 in 10 return to depression after treatment is over, the results seem very good.
4. Alternative neurostimulation therapies
 - a. Magnetic stimulation

- i. Magnetic energy pulses are sent into the person's brain. They stimulate or dampen certain areas of the brain.
 - ii. This is called **repetitive transcranial magnetic stimulation (rTMS)**.
 - iii. The person remains awake, it's painless, and there's no memory loss or side effects.
 - iv. A double-blind study saw the rTMS group do 50% better than the placebo control group.
 - b. Deep-brain stimulation
 - i. Helen Mayberg has located a spot in the cortex that links the thinking frontal lobes with the limbic system. It's overly active in a depressed person.
 - ii. She implanted electrodes to stimulate these areas.
 - iii. 8 in 12 people that tried this seemed to have positive results.

XIV. **Psychosurgery**

- A. Psychosurgery removes or destroys part of the brain and is therefore irreversible, rare, and usually the last thing tried.
- B. Egas Moniz came up with the most common procedure, the **lobotomy**.
 - 1. The surgery took only 10 minutes and involved shocking the person into a coma, driving "icepicks" through the eye sockets, then wiggling them to cut the connections from the frontal to emotional parts of the brain.
 - 2. The goal was to calm people who were uncontrollably emotional and violent.
 - a. It usually did cut down on the violent emotions.
 - b. It also often left the person lethargic, immature, and uncreative.
- C. Since the 1950s, drugs have replaced lobotomies.
- D. Today, psychosurgery is very rare. It's still used to stop seizures by cutting the nerves that cause them, or in precision MRI-guided surgery to halt extreme OCD.

XV. Therapeutic lifestyle change

- A. A major theme in psychology is that both the mind and body interact with each other.
- B. Stephen Ilardi promotes **therapeutic lifestyle change**. This simply means that to change the way you feel, change the way you live. He says...
 - 1. People seem built for physical exercise, to be engaged with others, to be in the sunlight, and get lots of sleep (think of an Amish community). These people show little depression.
 - 2. But many today live on the couch, alone, in a dark room, and stay up late (think of the "gamer geek").
 - 3. Ilardi suggests...
 - a. *Aerobic exercise* – 30 minutes three times a week.
 - b. *Adequate sleep* – about 7 to 8 hours per night.
 - c. *Light exposure* – about 30 minutes each morning.
 - d. *Social connection* – interact with others at least twice a week.
 - e. *Anti-rumination* – don't dwell on negative thoughts.
 - f. *Nutritional supplements* – including daily fish oil with omega-3 fatty acids.
 - 4. In an experiment, 77% of the people improved from depression; only 19% of control group did.

XVI. Preventing psychological disorders

- A. What's better than treating a psychological disorder is to prevent from getting one.
- B. A person can build **resilience** which is strength to deal with stress and recover from adversity and thus helps fend off psychological disorders.
- C. The idea is to change the root causes of the disorders (rather than try to fix them).

- D. George Albee noted that improving a person's condition helps ward off psychological disorders. This includes *anything* that can help the person: finances, self-esteem, strengthening the family, etc.