

***“Voices, like the roar of a crowd came. I felt like Jesus; I was being crucified. It was dark. I just continued to huddle under the blanket, feeling weak, laid bare defensive in a cruel world I could no longer understand...”***

Stuart, diagnosed with schizophrenia  
(from Emmons & others, 1997)

***“After ten years in therapy, my psychologist told me something very touching, he said, “no hablo ingles.””***

Dennis Wolfberg, Comedian, 1946-1994

---

### ***Notes on Abnormal Psychology and Therapy – Chapters 15 and 16***

#### ***Essential Questions:***

- How do psychologists measure and define abnormal behavior?
- How are the various psychological disorders identified and studied?
- What impact do these psychological disorders have on individuals, families, communities, and society?
- How are the various psychological disorders treated?
- What impact do treatment options have on individuals, families, communities, and society?

#### ***Unit Objectives:***

- Identify the criteria psychologists use to diagnose psychological disorders.
- Differentiate among the different perspectives psychologists take to understand psychological disorders.
- Describe the characteristics of mood disorders.
- Describe the characteristics of anxiety disorders.
- Describe the characteristics of somatoform disorders.
- Describe the characteristics of dissociative disorders.
- Describe the characteristics of schizophrenia.
- Describe the characteristics of personality disorders.
- Describe the characteristics of brain-based disorders.
- Describe the different treatment options for the various types of psychological disorders.

## **I. Dilemmas of Diagnosis**

### **A. Defining mental disorders - abnormal behavior is not the same as mental disorder**

1. Legal definition is based on whether a person is aware of the consequences of his or her actions and can control his or her behavior
2. Violation of cultural standards - depends on the culture and time
3. Maladaptive or harmful behavior
4. Emotional distress
5. Psychological definition of “abnormal behavior”
  - a. *Atypical behavior* – unusual or statistically rare
  - b. *Socially unacceptable* – unacceptable to society as a whole
  - c. *Distressing or disturbing* to the person who exhibits the behavior or to the person’s friends and family (zoophilia – being sexually aroused by animals)
  - d. *Maladaptive* – self-defeating, harmful
  - e. *Results from faulty cognitions*

### **B. Diagnosis: Art or science?**

1. Classifying disorders: The Diagnostic and Statistical Manual of Mental Disorders (“DSM”)
  - a. Standard reference used to diagnose all disorders
  - b. DSM-IV is current issue; contains 300 disorders and is much larger than the original which came out in 1952 and contained nine categories of disorders
  - c. Primary aim - descriptive; to provide criteria of diagnostic categories
  - d. Lists symptoms and associated information for each disorder
  - e. Classifies each disorder according to five axes or dimensions
  - f. DSM has enormous medical, economic, and legal impact

2. Problems with the DSM
  - a. The danger of over diagnosis
  - b. The power of diagnostic labels - can create *self-fulfilling prophecy* and “*labeling effect*” as in *Rosenhan's* famous hospital study
  - c. Confusion of serious mental disorders with normal problems
  - d. The illusion of objectivity
  - e. As times change, so do beliefs about what is “normal”
  - f. Inclusion and exclusion of disorders is not always based on empirical evidence but on pressures and cultural standards
3. Benefits of the DSM
  - a. New studies are improving empirical support for its categories
  - b. Advocates say when used correctly, it improves the accuracy of diagnosis
  - c. Biases in certain diagnosis can be corrected with awareness and better research
4. Perspectives on Abnormality
  - a. Medical-biological approach – organic problems, biochemical imbalances, genetic predispositions cause abnormal behavior
  - b. Psychodynamic or psychoanalytic approach – internal unconscious conflicts cause abnormal behavior
  - c. Humanistic approach – failure to strive toward one’s feelings cause abnormal behavior
  - d. Behavioral approach – reinforcement history and environment cause abnormal behavior
  - e. Cognitive approach – irrational, dysfunctional thoughts or ways of thinking cause abnormal behavior
  - f. Sociocultural approach – dysfunctional society cause abnormal behavior
  - g. Evolutionary approach – natural selection

## II. Anxiety Disorders

### A. Anxiety states

1. When anxiety is associated with fear and apprehension, it is adaptive; when it is not, it can be maladaptive. A diagnosis is made when overwhelming anxiety disrupts social or occupational functioning or produces significant stress. Anxiety is normal when it does not inhibit the ability to maintain normal functioning.
2. Generalized Anxiety Disorder
  - a. Chief characteristics
    1. vague feeling of danger
    2. a fear of the unknown that prevents one from making decisions
    3. difficulty with social relationships
    4. physical symptoms
    5. sleep disturbances
      - (a) May occur without specific anxiety-producing event, but may be related to physiological tendency to experience anxiety, history of uncontrollable or unpredictable life events
3. Posttraumatic Stress Disorder (PTSD)
  - a. When anxiety results from uncontrollable and unpredictable danger such as rape or assault, war or any type of military combat, torture, natural disasters such as tornadoes, floods, or hurricanes or unnatural catastrophes such as a car or plane crashes
  - b. the event that triggers the disorder overwhelms a person’s sense of reality and ability to cope
  - c. learned helplessness on the part of abused children can lead to PTSD in adults
  - d. Symptoms include
    1. Reliving the trauma in thoughts or dreams
    2. "Psychic numbing"
    3. Detachment from others and
    4. Inability to feel happy or loving
    5. Increased physiological arousal
    6. Symptoms may occur immediately after a trauma or after a delay of weeks or months
    7. Episodes may recur long after for some
    8. May be related to hippocampus

4. Panic disorder
  - a. This disorder most likely to develop in people who are hypersensitive to anxiety symptoms
  - b. Recurring attacks of intense fear or panic, with feelings of impending doom or death and feelings of intense almost paralyzing anxiety
  - c. Attacks may be brief or long
  - d. Symptoms include trembling, shaking, dizziness, chest pain, heart palpitations, feeling of unreality, hot and cold flashes, sweating, fear of dying, going crazy, or losing control
  - e. They usually follow stress, but seem to occur out of nowhere
  - f. Differences between those who develop panic disorder and those who don't are how they interpret bodily functions.
5. Phobias
  - a. Exaggerated fear of a specific situation, activity or thing where the severe anxiety is focused on a fear that seems out of proportion to the real dangers involved (such as the fear of spiders)
  - b. Some may have evolutionary basis, some may be acquired through classical conditioning, some related to culture
  - c. *Social phobia* –
    1. fear of situations in which a person will be observed by others
    2. a person with social phobia tends to avoid situations where they have possible exposure to the scrutiny of others and might behave in an embarrassing or humiliating way
  - d. *Agoraphobia* - fear of being alone in a public place from which escape might be difficult or help unavailable
    1. Underlying fear is being away from safe place or person
    2. Usually begins with a panic attack which sets off pattern of avoidance of the situation in which the attack occurred
  - e. *Obsessions and Compulsions*
    1. Obsessive-compulsive disorder
      - (a) *Obsessions* - recurrent, persistent, unwished for thoughts that are frightening or repugnant and reflect maladaptive reasoning and information processing
      - (b) *Compulsions* - repetitive, ritualized behaviors over which people feel a lack of control; if they try to resist, they feel anxiety that is reduced only by the compulsion
      - (c) Many people have trivial compulsions; a disorder exists when this interferes with a person's life
        1. Most common compulsions are hand washing, counting, touching, and checking
        2. Most sufferers know the behavior is senseless and don't enjoy it
        3. PET scans find parts of the brain are hyperactive in people with OCD
6. Causes of Anxiety Disorders
  - a. Conditioning
    1. behavioral researchers have linked general anxiety with classical conditioning (rats and ulcers) especially with stimulus generalization and reinforcement of fears
  - b. Observational learning
    1. through observing others' fear, we might also learn fear
  - c. Natural selection
    1. we as humans are biological programmed to fear things that can kill us such as snakes, spiders, closed spaces, heights
  - d. Genes
    1. some people more than others are genetically predisposed to particular anxiety and fear (although no specific gene has been identified)
  - e. Brain
    1. OCD – hyperactive anterior cingulate cortex
    2. learning can create fear circuits within the amygdala
  - f. Cognitive
    1. irrational thoughts

### III. Somatoform Disorders

- A. Psychological disorders characterized by real physical symptoms that are not under voluntary control and for which no apparent physical cause exists
- B. Somatization Disorder – characterized by recurrent and multiple physical complaints of several year's duration for which medical attention has been ineffective
- C. Conversion Disorder – characterized by the loss or alteration of physical functioning for no apparent physiological reason usually caused by emotional difficulties (Anna O.)
- D. Hypochondriasis – characterized by an inordinate preoccupation with health and illness, coupled with an excessive anxiety about disease

### IV. Mood Disorders

- A. When emotions hamper a person's ability to function effectively, cause the person to lose touch with reality, or seriously threaten his or her life
  - 1. many behavioral and cognitive changes accompany depression
  - 2. depression is widespread
  - 3. compared to men, women are nearly twice as vulnerable to major depression
  - 4. most major depressive episodes self-terminate
  - 5. stressful events related to work, marriage, and close relationships often precede depression
  - 6. with each new generation, the rate of depression is increasing and the disorder is striking earlier
  - 7. Major depression –
    - a. a person who spends at least two weeks feeling depressed, sad, anxious, fatigued, and agitated, experiencing a reduced ability to function and interact with others
    - b. depression ranges from mild feelings of uneasiness, sadness, and apathy to intense suicidal despair, not caused by bereavement
    - c. Symptoms - emotional, behavioral, cognitive, physical changes
    - d. Rates among the young have increased rapidly recently
  - 8. Mania is the opposite pole - abnormally high state of exhilaration
    - a. Symptoms - opposite of those in depression; person is full of energy, feels powerful, full of ambition, inflated self-esteem
  - 9. Bipolar disorder –
    - a. sufferers alternate back and forth between the manic phase, experiencing elation, extreme confusion, distractibility, and racing thoughts, to the depressed phase, overcome by feeling of failure, sinfulness, and worthlessness, becoming lethargic and depressed (manic-depression)
  - 10. Seasonal Affective Disorder (SAD) –
    - a. type of major depression involves a reoccurring pattern of winter depressions followed by elevations of mood in the spring and summer (or summer depression followed by elevations of mood in the fall and winter)
    - b. researchers have proposed a possible link between SAD and blood melatonin levels
    - c. treatment options: light therapy
  - 11. Dysthymic Disorder – mild but chronic depression
  - 12. Depression occurs two or three times as often among women
  - 13. Suicide and Depression
    - a. not all people who commit suicide are depressed and not all people who are depressed commit suicide
    - b. many depressed people think about suicide and some go through with it
    - c. reasons: escape pain, end the torment of unacceptable feelings, or punish themselves or someone else
- B. Theories of depression
  - 1. Biological explanations emphasize genetics and brain chemistry
    - a. Possible deficiencies in neurotransmitters norepinephrine and/or serotonin
    - b. Possible genetic component to bipolar disorder and depression
    - c. Less activity level in left frontal lobes of brain which are involved in positive emotions - can't make causal inferences
  - 2. Social explanations emphasize stressful circumstances of people's lives; may explain gender differences in depression rates
    - a. Marriage and work associated with lower rates of depression

- b. Being a mother associated with higher rates of depression
- c. Women who have lower status and higher rates of poverty have higher rates of depression (as well as more likely to have experienced violence).
3. Attachment explanations emphasize problems with close relationships
  - a. Related to disturbed relationships; separations and losses; and history of insecure attachments
  - b. Primary relationship disruption often triggers depressive episode
  - c. Cause and effect is not clear; may differ for husbands and wives
4. Cognitive explanations emphasize habits of thinking and interpreting events
  - a. Involves negative habits of thinking
  - b. Depressed people have a pessimistic explanatory style
  - c. Brooding, more common to women, also associated with depression
5. "Vulnerability-stress" explanations draw on all four previous explanations as an interaction between individual vulnerability and environmental stress
6. Causes of mood disorders
  - a. *Aaron Beck*
    1. "Cognitive triad" – depression results from unreasonably negative ideas that people have about themselves, their future, and their world.
  - b. *Martin Seligman*
    1. Learned Helplessness (cognitive and behavioral) – when one's prior experiences have caused that person to view himself or herself as unable to control aspects of the future that are controllable which results in passivity and depression
  - c. Biological component
    1. a lack of the neurotransmitters, serotonin and norepinephrine, has been linked to unipolar depression
    2. more skin and brain receptors for the neurotransmitter, acetylcholine has been linked to unipolar depression
    3. both major depression and bipolar seem to run in families, a finding that can also be interpreted as an indicative of a genetic component as well

## V. Personality Disorders

- A. Definition - rigid, maladaptive traits that cause great distress or inability to establish and maintain meaningful social relationships or adapt to their social environment
- B. Problem Personalities
  1. *Paranoid Personality Disorder* - pervasive unfounded suspiciousness and mistrust
  2. *Narcissistic Personality Disorder* - exaggerated sense of self-importance
  3. *Histrionic Personality Disorder* – Individuals seek attention by exaggerating situations in their lives, have stormy personal relationships, are excessively emotional, and demand constant praise and reassurance.
  4. *Borderline Personality Disorder* – trouble with relationships because of fear of abandonment, and self-image. They sometime sabotage or undermine themselves just before a success.
  5. *Schizoid Personality Disorder* – aloof and distant from others, with shallow or blunted emotions
  6. *Avoidant Personality Disorder* – pattern of avoiding social relationships out of fear of rejection
  7. *Dependent Personality Disorder* – pattern of excessive dependence on others and difficulty making independent decisions
  8. *Obsessive-Compulsive Personality Disorder* – excessive needs for orderliness and attention to detail, perfectionism, and rigid ways of relating to others
  9. *Antisocial Personality Disorder*
    - a. Individuals who show a pattern of disregard and violation of others' rights with no feelings of remorse, treating people as objects, intolerant of everyday frustrations, and living for the moment. They lack connection to anyone so they can cheat, con, and kill without any problem; used to be called psychopaths or sociopath
    - b. Symptoms include: repeated law breaking, using deception, using aliases and lies to con others, acting impulsively, fighting, disregarding safety, irresponsibility, lacking remorse; some are sadistic
    - c. Antisocial personalities begin with problem behaviors in childhood
    - d. More common in males
    - e. Not all those with APD are violent, not all violent criminals have APD

- f. Can be encouraged or discouraged by the values of the culture
- g. Causes of APD
  1. Don't respond to punishments so they may be unable to feel the anxiety necessary for learning about negative consequences
  2. Inability to feel emotional arousal - empathy, guilt, fear of punishment, anxiety- suggests brain and central nervous system abnormality
  3. One theory centers around problems with impulse control - an inherited characteristic shared by those who are antisocial, hyperactive, addicted or impulsive
  4. May have suffered brain damage from physical abuse
  5. Vulnerability-stress model - biological vulnerability (genes) is combined with environmental stresses (abuse, neglect)
  6. One study found a combination of birth complications and maternal rejection accounted for disproportionately high number of cases

## VI. Dissociative Disorders

- A. Definition - disorders in which consciousness, behavior and identity are split off
  1. Dissociative states are intense and seem out of one's control
  2. Often are in response to shocking events
- B. Amnesia and Fugue
  1. *Amnesia* - inability to remember important personal information, usually of a traumatic nature, that cannot be explained by ordinary forgetfulness
  2. When organic condition not responsible, called dissociative or psychogenic
  3. *Dissociative Fugue* - person forgets identity entirely and wanders far away and often takes on new identity and life
  4. These disorders are controversial among psychologists who disagree about the mind's ability to "cut off" or "repress" traumatic memories
- C. Dissociative Identity Disorder (Multiple personality)
  1. The appearance of two or more identities within one person
  2. The DID controversy - two views among mental health professionals
    - a. A real disorder, common but often under diagnosed or misdiagnosed, which develops in childhood as a response to trauma
    - b. A creation of mental health clinicians who believe in it
  3. Research on DID - evidence in support of the diagnosis is questionable
  4. The research that says DID patients show different physiological responses for different personalities is flawed
  5. Pressure and suggestion by clinicians may be creating multiple personalities
  6. The media played a major role in fostering the DID

## VII. Schizophrenia

- A. Schizophrenia - a psychosis or condition involving distorted perceptions of reality and an inability to function in most aspects of life
- B. Symptoms of schizophrenia
  1. Active or positive symptoms - distortions of normal thinking processes and behavior
    - a. delusions - false beliefs, paranoia, persecutory, thought broadcasting, thought insertion, grandeur
    - b. perceptual distortions - hallucinations and heightened sensory awareness (usually auditory, but can be tactile and visual; seem intensely real), breakdown of cognitive filter/selective attention
    - c. disorganized, incoherent speech - illogical jumble of ideas, word salad
    - d. disorganized thinking – form of thought disturbances, loosening of associations, blocking, clanging (rhyming or alliteration), neologisms (newly coined expression or made up words)
    - e. Grossly disorganized and inappropriate behavior like catatonia
  2. Negative symptoms - loss of former abilities; often persist after active ones are in remission
    - a. loss of motivation - inability to pursue goals
    - b. poverty of speech - empty replies reflecting diminished thought
    - c. disturbance in emotional or affect - flatness, general unresponsiveness, ambivalence, inappropriate
    - d. psychomotor disturbances – catatonic stupor, rigidity, posturing, waxy flexibility (bizarre motor behavior)

3. Severity and duration of symptoms vary; onset can be abrupt (better prognosis) or gradual (prognosis is more uncertain)
- C. Unraveling the mysteries of schizophrenia - many variations and symptoms
1. Same core signs appear in cultures around the world
  2. Biological findings
    - a. *Genetic predispositions* -
      1. exist though no specific genes identified
      2. studies find that schizophrenia runs in families and there is a genetic link between parents and children
      3. twin studies show higher concordance rates for identical twins [MZ] than fraternal twins [DZ]
      4. adoptive studies show that individuals are more at risk if the biological parents exhibits schizophrenia than if their adoptive parent exhibits schizophrenia
    - b. *Structural brain abnormalities* –
      1. some found, but meaning is unclear because anti-psychotic medications can affect the brain (enlarged ventricles of the brain)
    - c. *Dopamine Hypothesis* –
      1. several neurotransmitters such as GABA and dopamine believed involved in schizophrenia (“dopamine over-activity”)
      2. studies have linked schizophrenia to excessive levels of dopamine
      3. drugs that block dopamine decrease symptoms of schizophrenia
      4. drug that increase dopamine increase symptoms of schizophrenia
      5. dopamine overactivity is related to positive symptoms
    - d. Prenatal abnormalities possibly related to exposure to malnutrition or a virus like the flu
    - e. Diathesis vulnerability/vulnerability-stress model – physiology and environment interact
  3. Different factors may predominate in different kinds of schizophrenia
- D. Types of schizophrenia
1. *Disorganized* – frequent incoherence; disorganized behavior; blunted, inappropriate or silly affect
  2. *Paranoid* – delusions and hallucinations of persecution or grandeur (or both) and sometimes irrational jealousy
  3. *Catatonic* – stupor in which there is a negative attitude and marked decrease in reactivity to the environment, or an excited phase in which there is agitated motor activity not influenced by external stimuli that may appear and disappear suddenly
  4. *Residual* – history of a least one previous episode of schizophrenia with prominent psychotic symptoms but at present a clinical picture without any prominent psychic symptoms; continuing evidence of the illness, such as inappropriate affect, illogical thinking, social withdrawal, or eccentric behavior
  5. *Undifferentiated* – prominent delusions, hallucinations, incoherence, or grossly disorganized behavior, which do not meet the criteria for any other types or which meet the criteria for more than one type

### VIII. Other Disorders

- A. Paraphilias – are marked by a sexual attraction to an object, person, or activity not usually seen as sexual
1. Zoophilia – sexual attraction to animals
  2. Pedophilia – sexual attraction to children
  3. Fetishism – sexual arousal to objects such as shoes
  4. Voyeur – sexual arousal to watching others engage in some kind of sexual behavior
  5. Masochist – sexual arousal to inflicting pain on them
  6. Sadist – sexual arousal to having pain inflicted on others
- B. Eating Disorders
1. Anorexia nervosa –
    - a. loss of 15% or more average body weight
    - b. fear of fat and food
    - c. distorted body image
  2. Bulimia nervosa –
    - a. Shares similar features with anorexia
    - b. Commonly involves a bingeing and purging cycle

C. Childhood disorders

1. Autism –
  - a. deviation from typical social development
  - b. seek out less social and emotional contact
  - c. slow to develop language skills and seek out parental support when distressed
2. ADHD
  - a. Difficulty paying attention or sitting still
  - b. Critics say that this behavior is not unusual especially in young boys

## IX. Therapy

### A. Psychoanalysis

1. Aims – psychoanalysis assumes that many psychological problems are fueled by childhood’s residue of supposedly repressed impulses and conflicts. Psychoanalysts try to bring the repressed feelings into conscious awareness where the patient can deal with them.
2. *Insight Therapy* – discover the relationship between unconscious motivations and current abnormal behavior
  - a. *Latent content* – hidden content of dreams or the unconscious
  - b. *Manifest content* – direct or known content of dreams or the conscious
3. Methods –
  - a. *Free Association* – the analyst invites the patient to relax (probably on a couch) and focus on a childhood memory, dream, or recent experience.
  - b. *Hypnosis*- a technique used to get into the unconscious
  - c. *Interpretations* – analyst’s suggestions of underlying wishes, feelings, and conflicts (to provide insight).
  - d. *Resistance* – the patient blocking from the conscious anxiety-laden material
  - e. *Transference* –
    1. the process of a client feeling toward a therapist the way he or she feels toward some other important person
    2. the transference allows the patient to experience their true feelings toward that person
    3. the act of the patient transferring their strongest feelings onto the therapist that can expose long repressed feelings.
  - f. *Countertransference* – the tendency for therapists to relate to clients in ways that mirror their relationships with important figures in their lives
  - g. *Symptom substitution* - an unconscious psychological process by which a repressed impulse is indirectly manifested through a particular symptom, e.g., anxiety, compulsion, depression, hallucination, obsession.
  - h. *Dream analysis* – helps the therapist identify unconscious thoughts, feelings, and motives ( some therapists use latent content of dreams to identify unconscious thoughts)

### B. Humanistic

1. Aim – to boost self-esteem by helping people grow in self-awareness and self-acceptance as well as make the client responsible for his or her own change. They focus on the following;
  - a. Present and future not the past
  - b. Conscious rather than unconscious
  - c. Taking responsibility for their feelings and actions
  - d. Promoting inner growth
  - e. Self-actualization
2. Methods –
  - a. Rogers’ “*Client-Centered Therapy*”
    1. focuses on the patient’s self-perceptions rather than the interpretations of the therapist
    2. Therapist exhibits genuineness, acceptance, and empathy
    3. “Unconditional positive regard” – blanket acceptance and support of the person regardless of what a person says or does
    4. Empathy and genuineness
    5. Does not tell client what to do but is “non-directive” or helps the client seek a course of action for themselves
  - b. *Active Listening* – echoing, restating, and seeking clarification of what the person expresses and acknowledging the expressed feeling (paraphrase, invite clarification, reflect feelings).
  - c. *Essential Therapies* – helping clients achieve a subjectively meaningful perception of their lives because of a lack of sense of purpose to their lives

### C. Behavior

1. Aim – applies learning principles to eliminate unwanted behavior or abnormal behaviors and acquire desirable behaviors in their place
  - a. *Contingency management* – the therapist and client decide what old, undesirable behaviors need to be eliminated and what new, desirable behaviors need to appear. Desirable behaviors are reinforced, while undesirable behaviors are not

2. Methods –

a. *Classical Conditioning* –

1. Counterconditioning – pairs the trigger stimulus with a new response that is incompatible with fear.
  - (a) A process of reconditioning in which a person is taught a new, more adaptive response to familiar stimulus
  - (b) If a therapist can condition a patient to respond to a stimulus with something other than anxiety a real breakthrough can be achieved
2. Systematic Desensitization –
  - (a) a type of counterconditioning that associates a pleasant relaxed state with gradually increasing anxiety-triggering stimuli that is commonly used to treat phobias by extinguishing the fear response. (relaxation is paired with the feared stimuli)
  - (b) a three-stage procedure in which people are taught to relax when confronting stimuli that formerly elicited anxiety (flying)
  - (c) Steps
    1. Relaxation
    2. Visualization of anxiety provoking stimulus
    3. Gradual step by step exposed to the source of the anxiety
    4. The client learns to relax instead of having a fear or anxiety response
  - (d) In vivo desensitization – sometimes imagining the feared stimuli is not enough so the patient needs to confront the actual items on the anxiety hierarchy (also referred to as exposure therapy)
  - (e) virtual reality exposure therapy – within the confines of a room, virtual reality technology exposes people to vivid simulations of fearful stimuli such as spiders crawling around and on you
3. Adverse Conditioning –
  - (a) associates adverse, noxious, or negative stimuli when paired with a stimulus that elicits an undesirable behavior so that the person will cease responding to the familiar stimulus with the undesirable behavior (alcohol and nausea)
  - (b) the therapist tries to replace a positive response to a harmful stimulus (such as alcohol) with a negative (adverse) response.
4. Implosive Therapy – have the patient imagine the most frightening scenario first and if the patient can face their fears they will soon realize that their fear is irrational
5. Flooding – experiencing the feared stimuli until the fear has been extinguished

b. *Operant Conditioning* –

1. Token Economy – a system set up to reward desired behavior. A patient exchanges a token of some sort such as a plastic coin earned for exhibiting a desired behavior such as getting out of bed. Patients may turn in accumulated tokens for privileges or treats.
2. Behavior Modification - a system set up to use the theories of Skinner and “shaping” with the use of both positive reinforcement and punishment so that an undesirable behavior will change
3. Extinction – if reinforcers are withheld then extinction or ending the behavior will happen
4. Time-Out – a person typically removed from the sources of reinforcement to decrease the occurrence of undesired behavior
  - (a) the time in the time-out depends on the age of the child – the younger the child the less time is necessary in the time out

c. *Modeling* – (Bandura)

1. Learning a new behavior or a more productive behavior by watching and imitating other people
2. Best therapy for
  - (a) teaching a new behavior
  - (b) helping eliminate fears, especially phobias
  - (c) enhancing already existing behavior

D. Gestalt Therapy (Fritz Perls)

1. Aim –

- a. combines the psychoanalytic emphasis on bringing unconscious feelings to awareness and the humanistic emphasis on getting “in touch with oneself”
- b. to help people become more aware and able to express their feelings, and to take responsibility for their feelings and actions

2. Method -
  - a. Incomplete Gestalt – unfinished business or unresolved conflicts that affect behavior. People become aware of these by becoming sensitive to tension and repression
  - b. Change the way a client talks– this allows a client to get passed things that may be blocking them (a person with trouble being assertive may be asked to speak assertively to the group)
  - c. Have clients do the opposite than they would do – by completing this exercise clients are able to have immediate context for consideration and reflection
- E. Cognitive
  1. Aim – focuses on changing a client’s behavior by changing his or her thoughts and perceptions through a combination of substituting healthy thoughts for negative thoughts and beliefs and changing disruptive behaviors in favor of healthy behaviors
  2. Methods –
    - a. *Rational-Emotive Behavior Therapy(REBT)* (Ellis) –
      1. emphasizes the importance of logical, rational thought process
      2. psychological disturbance is a result of events in a person’s life which give way to irrational beliefs leading to negative emotions and behaviors
      3. Ellis’ 10 Irrational Assumptions (included in cognitive distortions) – based on an individual’s needs to be liked, to be competent, to be loved, and to feel secure
      4. therapy is confrontational and the therapist vigorously challenges people’s illogical, self-defeating attitudes and assumptions
      5. *goal of therapy* – help people examine past events that have produced irrational beliefs
      6. *role play* – allows people to see how their beliefs affect their relationships
      7. *modeling* – demonstrates other ways of thinking and acting
      8. *humor* – can point out the absurdity of beliefs
      9. *homework* – assignments and simple persuasion can challenge people to act more responsibly
    - b. *Beck’s Approach* –
      1. depression is caused by people’s distorted thoughts about reality which lead to negative views of the world, themselves, and the future (based on generalizations)
      2. therapists use persuasion and logic to change existing beliefs and encourage clients to engage in actual tests of their own beliefs
      3. goal of therapy – is to help individuals develop realistic appraisals of situations and then solve problems
      4. the therapist acts as trainer and co-investigator in helping determine and understand how cognitions influence behavior
      5. four stages – awareness of thought, recognize thoughts that are awry, substitute accurate for inaccurate judgments, then give feedback as to if these changes are correct
      6. has been very successful in treating depression
    - c. *Meichenbaum’s Approach* –
      1. what people say to themselves determines what people do
      2. goal of therapy – change the things people say to themselves
      3. self-instruction – private monologues in which they work out adaptive ways of coping with situations
    - d. *Cognitive Distortions* –
      1. All or Nothing Thinking –
        - (a) Viewing events in black and white terms, either all good or all bad
        - (b) Viewing a relationship that ended a total failure
      2. Misplaced Blame –
        - (a) Tendency to blame and criticize yourself for disappointments or setbacks while ignoring external circumstances
        - (b) When something does not go the way it is supposed to you blame yourself
      3. Misfortune Telling
        - (a) Tendency to think that one disappointment will inevitably lead to another
        - (b) One rejection letter from a job will mean that other applications will meet the same fate

4. Negative Focusing –
    - (a) Focusing attention only on the negative aspects of your experiences
    - (b) With a job evaluation, you only focus on the negative criticisms and not the praise
  5. Dismissing the Positives –
    - (a) Trivializing or denying accomplishments, minimizing your strengths or assets
    - (b) When given a compliment, you respond “no big deal”
  6. Jumping to Conclusions –
    - (a) Drawing a conclusion that is not supported by the facts at hand
    - (b) Always expecting the worst will happen
  7. Catastrophizing –
    - (a) Exaggerating the importance of negative events or personal flaws
    - (b) Reacting to a bad grade on a test as if your whole life is ruined
  8. Emotion-Based Reasoning –
    - (a) Reasoning based on emotions rather than clear headed evaluation of the evidence
    - (b) Feeling things are hopeless because that is how it feels
  9. Shouldism –
    - (a) Placing unrealistic goals on your self that you should or must accomplish certain tasks or reach certain goals
    - (b) You should be farther along in your life than you are now
  10. Name Calling –
    - (a) Attaching a negative label to yourself or others as a way of explaining your own behavior or others’ behavior
    - (b) Label yourself as stupid or lazy
  11. Mistaken Responsibility –
    - (a) Assuming that you are the cause of other people’s problems
    - (b) A person automatically assumes that their friend or spouse is depressed because of something that they did
- F. Eclectic Therapy – uses a variety of methods to help each client achieve their goals
- G. Group and Family Therapy
1. Aim – group members can be useful models of behavior for one another and can provide mutual reinforcement and support
  2. Methods –
    - a. Group Therapy –
      1. 6 to 12 clients meet regularly for 6 months or more which allow people to help one another work through problem they have in common
      2. split the cost of therapy
      3. act as support for issues (substance abuse [AA or NA], death, etc)
    - b. Family Therapy –
      1. helps families who are dealing with communication or family structure issues by treating the family as a system
      2. views the individual’s unwanted behaviors as influenced by or directed at other family members
      3. encourages family members toward positive relationships and improved communication
- H. Biologically Based Therapies
1. Psychosurgery –
    - a. Brain surgery used to alleviate symptoms of serious mental disorders (reduces aggressiveness and violent behaviors in people)
    - b. Prefrontal lobotomy – involves destroying a front portion of the brain
      1. still used today in extreme cases that have not responded to any other forms of treatment
      2. controversial – because it cannot be reversed
    - c. Trephining – drilling holes in the skull to release evil spirits
  2. Electroconvulsive Therapy (ECT) –
    - a. A treatment for severe mental illness (bipolar and severe depression) in which an electric current is briefly applied to the head in order to produce a generalized seizure or convulsion; also known as shock treatment

3. Drug Therapy – assumes that there is an underlying physical reason for disturbed behavior and they only treat the symptoms of the disorder not the actual causes of the disorder

Effect Group	Acts on lowering or raising	Chemical Group	Risks/Side Effects	Generic Name/Trade Name
Antianxiety	Neurotransmitter GABA	Benzodiazpines Nonbenzodiazpines	<ul style="list-style-type: none"> <li>• nausea</li> <li>• headaches</li> <li>• dizziness</li> <li>• drowsiness</li> <li>• upset stomach</li> <li>• constipation</li> <li>• diarrhea</li> <li>• dry mouth</li> </ul>	Xanax, Ativan Buspar, Valium, Klonopin, Restoril, Halcion Some SSRIs will also be used for anxiety & depression
Antidepressant	Neurotransmitters norepinephrine and serotonin	Tricyclics MAO Inhibitors Serotonin Reuptake Inhibitors	<ul style="list-style-type: none"> <li>• emotional symptoms (crying spells, irritability)</li> <li>• sensory disturbances</li> <li>• flu-like symptoms</li> <li>• gastrointestinal symptoms</li> <li>• movement and balance irregularities</li> <li>• sleep disturbances</li> <li>• weight gain</li> <li>• sexual problems</li> <li>• increased thoughts of suicide</li> <li>• sexual dysfunctions</li> </ul>	Tofranil, Anafranil Nardil, Parnate  Prozac, Zoloft, Paxil, Luvox, Lexapro, Celexa  Cymbalta, Wellbutrin, Effexor
Antimanic	Neurotransmitter dopamine	Lithium Carbonate	<ul style="list-style-type: none"> <li>• nausea</li> <li>• headaches</li> <li>• dizziness</li> <li>• drowsiness</li> <li>• upset stomach</li> <li>• constipation</li> <li>• diarrhea</li> <li>• dry mouth</li> <li>• increased thoughts of suicide</li> <li>• tremors</li> <li>• weight gain</li> </ul>	Lithium/lithium carbonate, Valproic acid, Topamax
Antipsychotic	Neurotransmitter dopamine	Phenothazines  Atypical Antipsychotics	<ul style="list-style-type: none"> <li>• Side Effects: tardive dyskinesia (damage to the basal ganglia which elicits rhythmic or writhing movements of the tongue, jaw, fingers, or hands), symptoms like Parkinson's, tremors or seizures, restlessness, weight gain. loss of white blood cells, damage to immune system, slow mental functioning, blurred vision, losing sense of self, depression/suicide, low blood pressure, &amp; reduced appetite</li> <li>• potential for overdose</li> <li>• usually have to take medication to counter side effects</li> <li>• social discrimination</li> <li>• potential drug interaction</li> <li>• noncompliance</li> <li>• may not receive other treatments</li> </ul>	Thorazine, Prolixin, Mellaril  Clozaril, Risperdal

Notes based on information from the following sources:

- Lefton, Lester. *Psychology* - seventh edition. Allyn and Bacon. Boston. 2000
- Myers, David. *Psychology* – seventh edition. Worth Publishing. Michigan. 2004
- Nevid, Jeffery. *Psychology: Concepts and Applications*. Houghton Mifflin Company. Boston. 2003
- Pettijohn, Terry. *Psychology: A ConnecText*. McGraw-Hill. Ohio. 1998.
- Passer, Michael and Smith, Ronald. *Psychology: The Science of Mind and Behavior*. McGraw-Hill. Boston. 2004