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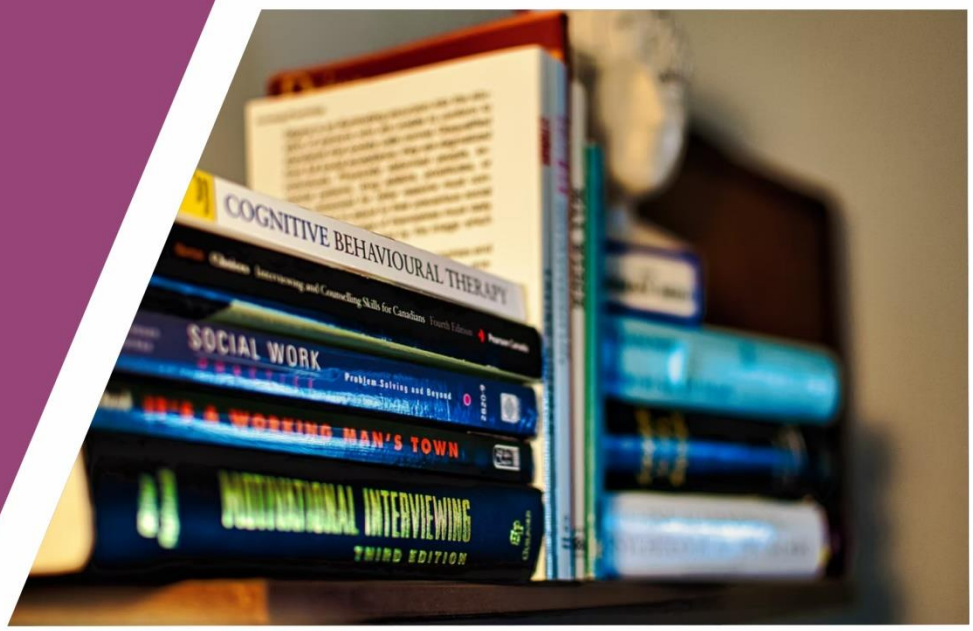

Behaviour Modification

Module 2

EGC 812 Behaviour Modification Module 2

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Module 2

Unit 1 Why do People Seek Therapy?

1.0 Introduction

In module 1, you learnt the concept of behaviour, types of behaviour, development and acquisition of behaviour, the notion of behaviour modification and personality and behaviour. In this unit, you will learn why people seek therapy. The belief that people with psychological problems can change – can learn more adaptive ways of perceiving, evaluating and behaving is the conviction underlying all psychotherapy. Achieving these changes is by no means easy. Sometimes a person's view of the world and his or her self-concept are distorted from pathological early relationships reinforced by years of negative life experiences.

In other instances, environmental factors such as an unsatisfying job, an unhappy marriage, or financial stresses must be a focus of attention in addition to psychotherapy. Because change can be hard, people sometimes find it easier to bear their present problems than to challenge themselves to chart a different life course. Therapy also takes time. Even the highly skilled and experienced therapist cannot undo a person's entire past history and prepare him or her to cope adequately with difficult life situations within a short time. Therapy offers no magical transformations. Nevertheless, it holds promise even for the most severe mental disorders (Carson *et al*., 2011).

2.0 Objective

At the end of this unit, you should be able to:

- explain why people seek therapy.

3.0 Main Content

3.1 Why do People Seek Therapy?

3.1.1 Stressful Current Life Circumstances

People who seek therapy vary widely in their problems and in their motivation to solve them. Perhaps the most obvious candidates for psychological treatment are people experiencing sudden and highly stressful situations such as a divorce or unemployment, people who feel so overwhelmed by a crisis that they cannot manage on their own. These people often feel quite vulnerable and tend to be open to psychological treatment because they are motivated to alter their present intolerable mental states. In such situations, clients may gain considerably, in a brief time, from the perspective provided by their therapists.

3.1.2 People with Long-Standing Problems

Other people entering therapy have experienced long- term psychological distress and have lengthy histories of maladjustment. They may have had interpersonal problems such as an inability to be comfortable with intimacy, or they may have felt susceptible to low moods that are difficult for them to check. Chronic unhappiness and the inability to feel confident and secure may finally prompt them to seek outside help. These people seek psychological

assistance out of dissatisfaction and despair. They may enter treatment with a high degree of motivation, but as therapy proceeds, their persistent patterns of maladaptive behaviour may generate resistance with which a therapist must contend.

3.1.3 Reluctant Clients

Some people enter therapy by a more indirect route. Perhaps they had consulted a physician for their headaches or stomach pains, only to be told that nothing was physically wrong with them. After they are referred to a therapist, they may at first resist the idea that their symptoms are emotionally based. Motivation to enter treatment differs, widely among psychotherapy clients. Reluctant clients may come from many sources, for example, an alcoholic whose spouse threatens "either therapy or divorce" (Carson et al., 2011). In general, males are more reluctant to enter therapy than females.

3.1.4 People who Seek Personal Growth

A final group of people who enter therapy have problems that would be considered relatively normal. That is, they appear to have achieved success, have financial stability, have generally accepting and loving families, and have accomplished many of their life goals. They enter therapy not out of personal despair or impossible interpersonal involvements, but out of a sense that they have not lived up to their own expectation and realised their own potential. These people, partly because their problems are more manageable than the problems of others, may make substantial gains in personal growth.

Psychotherapy, however, is not just for people who have clearly defined problems, high levels of motivation, and an ability to gain ready insight into their behaviour. Psychotherapeutic interventions have been applied to a wide variety of chronic problems. Even severely disturbed, psychotic client may profit from a therapeutic relationship that takes into account his or her level of functioning and maintains therapeutic sub goals that are within the clients present capabilities (Kendler, 1999 as cited in Carson at al., 2011).

4.0 Conclusion

It should be noted from these brief descriptions that there is no "typical client". Neither is there a "model" therapy. No currently used form of therapy is applicable to all types of clients. Most authorities agree that client variables such as motivation to change and the severity of symptoms are important to the outcome of therapy. Therefore therapist must take into consideration the characteristics of a particular client.

5.0 Summary

In this unit, you have learnt why people seek therapy. They were listed as:

- stressful current life circumstances
- people with long-standing problems
- reluctant clients
- people who seek personal growth.

6.0 Self-Assessment Exercise

Why do people seek therapy?

7.0 References/Further Reading

Carson, et *al.* (2011). *Abnormal Psychology*. (13th ed.). New York: Pearson Education Inc.

Nolen-Hoeksema, S. (2004). *Abnormal Psychology*. (3rd ed.). McGraw-Hill: Higher Education.

Unit 2 Who Provides Psychotherapeutic Services?

1.0 Introduction

In the last unit, you learnt about the reasons for therapy. The reasons given were (i) as a result of stressful life circumstances, people with long standing problems, etc. In this unit, you will learn who provides psychotherapeutic services and the relationship involved.

2.0 Objectives

At the end of this unit, you should be able to:

- state who provides psychotherapeutic services
- discuss the relationship in therapy.

3.0 Main Content

3.1 Who Provides Psychotherapeutic Services?

Members of many different professions have traditionally provided advice and counsel to individuals in emotional distress. Physicians, in addition to caring for their patients' physical problems, often become trusted advisers in emotional matters as well. Many physicians are trained to recognise psychological problems that are beyond their expertise and to refer patients to psychological specialists or to psychiatrists.

Another professional group who deals extensively with emotional problems is the clergy. A minister, priest, or rabbi is frequently the first professional to encounter a person experiencing an emotional crisis. Although some clergy are trained mental health counselors, most limit their counselling to religious matters and spiritual support and do not attempt to provide psychotherapy. Rather, like general-practice physicians, they are trained to recognise problems that require professional management and to refer seriously disturbed people to mental health specialists (Carson, *et al.* 2011). You have learnt about the role of physicians and men of God in psychotherapy. Our focus now will be on trained professionals in the field of psychotherapeutic service – called mental health professionals.

The three types of mental health professionals who most often administer psychological treatment in mental health settings are clinical psychologists, psychiatrists, psychiatric social workers, and guidance and counselling trained personnel. In addition to their providing psychotherapy, the medical training and licensure qualifications of psychiatrists enable them to prescribe psychoactive medications and also to administer other forms of medical treatment such as electroconvulsive therapy. In the United States of America, appropriately supervised psychologists and other clinical specialists may now prescribe medications if they have received additional training. In Nigeria presently, we have not developed to this status. Although every health professional differs to some degree in his or her training and approach to treatment, generally, psychiatrists differ from psychologists in their predilection for treating mental disorders with a biological approach (i.e. medications), whereas psychologists generally treat patients' psychopathology by examining and in some cases changing their patients' behaviours and thoughts patterns (Carson, *et al.,* 2011).

In a clinic or hospital (as opposed to an individual practice), a wide range of treatment approaches may be used. These range from the use of drugs, to individual or group psychotherapy, to home, school, or job visits aimed at modifying adverse condition in a

clients life – for example, helping a teacher become more understanding and supportive to a child – client's needs. Often the latter is as important as treatment directed toward modifying the client's personality, behaviour, or both. The next focus will be the therapeutic relationship.

3.2 The Therapeutic Relationship

The therapeutic relationship evolves out of what both the client and therapists bring to the therapeutic situation. The outcome of psychotherapy normally depends on whether the client and therapist are successful in achieving a productive working alliance. The client's major contribution is his or her motivation. Clients who are pessimistic about their problems and symptoms respond less well to treatment (Mussell *et al.*, 2000 as cited in Carson *et al.*, 2011). Let us now discuss two factors in therapeutic relationship, namely the therapeutic alliance and qualities that enhance therapy.

The therapeutic alliance: the establishment of an effective "working alliance" between client and therapists is seen by most investigators and practitioners as essential to psychotherapeutic gain. In a very real sense, the relationship with the therapist is therapeutic in its own right. There is much evidence that therapists' personal characteristics help determine therapeutic outcome. How well clients do in treatment is related to the strength of the alliance they have with their therapists. However, people who have a lot of problems often have very troubled interpersonal relationships. An important skill for any therapists therefore is the ability to foster good relationships with client who may present some challenges in this regard.

Other factors such as the level of expertise and experience of the therapists are important. Expert therapists have been shown to be better than either experienced or novice therapists in such skills as the ability to provide a clear, coherent, and succinct account of a patient's problems. Although definitions of therapeutic alliance vary, its key elements are (i) a sense of working collaboratively on the problems, (ii) agreement between patient and therapist about the goals and tasks of therapy, and (iii) an affective bond between patient and therapist. Clear communication is also important. This is no doubt facilitated by the degree of shared experience in the backgrounds of client and therapist (Carson *et al.*, 2011).

Qualities that enhance therapy: clients motivation to change is a crucial element in determining the quality of therapeutic alliance and hence the level of success likely be achieved in the therapeutic effort. A wise therapist appropriately cautions about accepting an unmotivated client. Not all prospective clients regardless of their need for treatment are ready for the temporary discomfort that effective therapy may entail. As already pointed in unit 1 of this module, many men, in particular, have trouble accepting the conditions that therapy may impose such as the need to report their innermost feelings. Even the motivation of self-referred clients may dissipate in the face of the painful confrontations with self and past experiences that good therapy may require.

Almost as important as motivation is a client's expectation of receiving help. This expectancy is often sufficient in itself to bring about substantial improvement (Fisher & Greenberg, 1997 as cited in Carson, *et al.* 2011); this may be because patients who expect therapy to be effective engage more in the process. Just as a placebo often lessens pain for someone who believes it will do so, a person who expects to be helped by therapy is likely to be helped, almost regardless of the particular methods used by therapists. The downside of this fact is that if a therapy or therapists fail for whatever reason to inspire client confidence, the effectiveness of treatment is likely to be compromised.

To the art of therapy, a therapist brings a variety of professional skills and methods intended to help people see themselves and their situations more objectively – that is, to gain a different perspective. Besides, helping provide a new perspective, most therapy situations also offer a client safe setting in which he or she is encouraged to practice new ways of feeling and acting, gradually developing both the courage and the ability to take responsibility for acting in more effective and satisfying ways.

To bring about such changes, an effective psychotherapy must help the client give up old and dysfunctional behaviour patterns and replace them with new functional ones. Because clients will present varying challenges in this regard, the therapist must be flexible enough to use a variety of interactive styles. Effective therapy depends, at least to some extent, on a good match between client and therapist. For this reason, a therapist's own personality is an important factor in determining therapeutic outcomes, quite aside from his or her background and training at the particular formal treatment plan adopted.

4.0 Conclusion

In this unit, you have learnt who provides psychotherapeutic services. You have now known that such services are not provided by lay people but by clinical psychologists, psychiatrists, psychiatric social workers and guidance counselors. It is important that the characteristics of the clients must be noted by the therapist and the aspect of motivation of the clients must also be taken into consideration.

5.0 Summary

You have studied psychotherapeutic services and understood that psychotherapy is provided by:

- general physician
- religious men
- clinical psychologists
- psychiatrist
- psychiatrists social workers, and
- guidance counsellors.

6.0 Self-Assessment Exercise

1. What kind of professional provides help to people in psychological distress?
2. In what kind of setting does treatment occur?
3. What factors are important in determining how well patients do in therapy?

7.0 References/Further Reading

Carson, *et al.* (2011). *Abnormal Psychology*. (13th ed.). New York: Pearson Education Inc.

Nolen-Hoeksema, S. (2004). *Abnormal Psychology*. (3rd ed.). McGraw-Hill: Higher Education.

Unit 3 Measuring Success in Psychotherapy

1.0 Introduction

In the last unit, you studied personnel that provide psychotherapeutic services and the relationship in psychotherapy. In this unit, you will learn about measuring success in psychotherapy, occurrence of changes in therapy and discuss the effects of therapy.

2.0 Objectives

At the end of this unit, you should be able to:

- state how success is measured in psychotherapy
- explain whether therapy can change human behaviour
- determine whether therapy can be harmful.

3.0 Main Content

3.1 Measuring Success in Psychotherapy

According to Carson *et al.* (2011), evaluating treatment success is not always as easy as it might seem. Attempts at estimating client's gains in therapy generally depend on one or more of the following sources of information (i) a therapist's impression of changes that have occurred (ii) a client's reports of change, (iii) reports from client's family or friends (iv) comparison of pretreatment and post-treatment scores on personality tests or on other instruments designed to measure relevant facets of psychological functioning, and (v) measures of change in selected overt behaviours. Unfortunately, each of these sources has its own limitations.

A therapist may not be the best judge of a client's progress, because any therapist is likely to be biased in favour of seeing himself or herself as competent and successful (after all, therapists are only human). In addition, the therapist typically has only a limited observational sample (the client's in-session behaviour) from which to make judgments of overall change. Furthermore, therapists can inflate improvement averages by deliberately or subtly encouraging difficult clients to discontinue therapy. The problem of how to deal with early dropouts from treatment further complicates many studies of therapy outcomes.

Also, a client is not necessarily a reliable source of information on therapeutic outcomes. Not only may clients want to believe for various personal reasons that they are getting better, they may report that they are being helped. In addition, because therapy often requires a considerable investment of time, money, and sometimes emotional distress, the idea that it has been useless is a dissonant one (lack of agreement). Relatives of the client may also be inclined to "see" the improvement they had hoped for, although they often seem to be more realistic than either the therapists or the client in their evaluations of outcome.

Clinical ratings by an outside, independent observer are sometimes used in research on psychotherapy outcomes to evaluate the progress of a client; these ratings may be more objective than ratings by those directly involved in the therapy. Another widely used objective measure of client change is performance on various psychological tests. A client evaluated in this way takes a battery of tests before and after therapy, and the differences in scores are assumed to reflect progress, or lack of progress, or occasionally even

deterioration. However, some of the changes that such tests show may be artificial, as with regression to the mean (Speer, 1992 as cited in Carson et al., 2011), wherein very high (or very low) scores tend on repeated measurement to drift toward the average of their own distributions, yielding a false impression that some real changes has been documented. You have learnt how to measure success in psychotherapy. Now let us find out whether change can occur.

3.2 Changes Occurrence in Therapy

One important question to find answer to is; what happens to disturbed people who do not obtain formal treatment? In view of the many ways in which people can help each other, it is not surprising that improvement often occurs without professional intervention. Relevant here is the observation that treatment offered by therapists has not always been clearly demonstrated to be superior in outcome to non-professionally administered therapies (Christensen & Jacobson, 1994 as cited in Carson et al., 2011). Moreover, some forms of psychopathology such as depressive episodes or brief psychotic disorder sometimes run a fairly short course without treatment. In other instances, disturbed people improve over time for reasons that are not apparent (Carson et al., 2011).

Even if many emotionally disturbed persons tend to improve without psychotherapy, psychotherapy can often accelerate improvement or bring about desired behaviour change that might not otherwise occur. Most researchers today would agree that psychotherapy is more effective than no treatment, and indeed the pertinent evidence, widely cited throughout the entire researches, confirms this strongly. The chances of an average client benefitting significantly from psychological treatment are overall, impressive. Research suggests that about 50 percent of patients show clinically significant change after 21 therapy sessions. After 40 sessions, about 75 percent of patients have improved (Lambert *et al*., 2011 as cited in Carson *et al*., 2011).

3.3 Can Therapy be Harmful?

The outcome of psychotherapy is not invariably either neutral (no effect) or positive. Some clients are actually harmed by their encounters with psychotherapists. According to one estimate, somewhere between 5 and 10 percent of clients deteriorate during treatment (Lambert & Ogles, 2004 as cited in Carson *et al*., 2011). Patients suffering borderline personality disorder and from obsessive compulsive disorder typically have higher rates of negative treatment outcomes than patients with other problems.

Obvious ruptures of the therapeutic alliance – what Binder and Strupp (1997 as cited in Carson, *et al*., 2011) refer to as "negative process" in which client and therapist become embroiled in a mutually antagonistic and downwardly spiraling course – account for only a portion of the failures. In other instances an idiosyncratic array of factors operate together (for example, the mismatch of therapist and client personality characteristics) to produce deteriorating outcomes. It should be noted that certain therapists, probably for reasons of personality, just do not do well with certain types of client problems. In the light of these intangible factors, it is ethically required that all therapists (i) to monitor their work with various types of clients to discover any such deficiencies, and (ii) to refer to other therapists those clients with whom they may be ill-equipped to work (APA, 2002).

A special case of therapeutic harm is the problem of sex between therapist and client, typically seduction of a client (or former client) by a therapist. This is highly unethical conduct. Given the frequently intense and intimate quality of therapeutic relationships, it is

not surprising that sexual attraction arises. A prospective client seeking therapy needs to be sufficiently wary to determine that the therapist chosen is one of the large majorities who are committed to high ethical and professional standards.

4.0 Conclusion

In this unit, it can be concluded that psychotherapy success is measurable. For a valid and reliable measurement, clinical ratings by independent observer and the use of tests are most appropriate. Therapy can be harmful if there is a soiled relationship between the therapist and client. It is therefore advisable for client to seek therapy from a professional who has high regard for ethical values.

5.0 Summary

In this unit, you learnt about the following:

- in measuring success in therapy, the role of the therapist, the client, family or friends are important
- changes in behaviour occur during therapy
- therapy can be harmful as a result of the characteristics of the therapist and the client.

6.0 Self-Assessment Exercise

1. What approaches can be used to evaluate treatment success?
2. Do people who receive psychological treatment always show a clinical benefit?

7.0 References/Further Reading

American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders.* (4th ed.). Washington, D. C: American Psychiatric Association.

Carson, *et al.* (2011). *Abnormal Psychology* (13th ed.). New York: Pearson Education Inc.

Unit 4 Therapeutic Approaches–An Overview

1.0 Introduction

In the last unit, you studied measuring success in psychotherapy, changes occurrence in therapy and the effect of therapy in human behaviour. In this unit, you will briefly learn about the different approaches in therapy. The aim is to prepare you for the last module in this course, where each of the approaches will be discussed elaborately.

2.0 Objectives

At the end of this unit, you should be able to:

- explain psychodynamic therapies
- discuss humanistic therapy
- examine behaviour therapy, and
- analyse cognitive therapies
- discuss social approaches.

3.0 Main Content

3.1 Psychodynamic Therapies

Psychodynamic therapies focus on uncovering and resolving unconscious conflicts that drive psychological symptoms. The goal is to help clients recognise the maladaptive ways in which they have been trying to cope and the sources of their unconscious conflicts. These insights free clients from the grip of the past and give them a sense of agency in making changes in the present. (Vakoch & Strupp, 2000). Another goal is to help clients integrate aspect of their personality that have been split off or denied into a unified sense of self.

Sigmund Freud is the original founder of psychodynamic therapy. Psychoanalysis was his therapeutic technique. Freud believed the patient's free associations, resistance, dreams, and transferences and the therapist's interpretations of them released previously repressed feelings, allowing the patient to gain self-insight. You will learn more about it in the last module.

3.2 Humanistic Therapy

The goal of humanistic therapy, often referred to as person-centered therapy, is to help the client discover his or her potentialities and place in the world and to accomplish self-actualisation through self-exploration. Person – centered therapies are unique in the extent to which they emphasise the self-healing capacities of the person (Bohart, 1995). The job of the therapist in person centered therapy is not to act as an authority or expert who provides healing to the client. Rather, the therapist's job is to provide the optimal conditions for the client to heal him or herself. This therapy rests on the assumptions that the natural tendency for human is toward growth. Person centered therapists do not push clients to uncover pressed painful memories or unconscious conflicts. Instead, they believe that, when clients are supported and empowered to grow and self-actualise, they will eventually face their past when it is necessary for their further development (Bohart, 1995). The best known of these therapies is Carl Rogers' client – centered therapy (CCT).

3.3 Behaviour Therapy

Just as behaviour theories of psychopathology are radically different from psychodynamic and humanistic theories, behaviour therapy would seem to be the polar opposite of these other therapies. Whereas psychodynamic therapies focus on uncovering unconscious conflicts and relational issues that develop during childhood and humanistic therapies focus on helping the client discover the inner self, behaviour therapies focus only on changing a person's specific behaviour in the present day.

The foundation for behaviour therapy is the behaviour assessment of the client's problem. The therapist works with the client to identify the specific circumstances that seem to elicit the client negative behaviour or emotional responses. What situations seem to trigger anxiety symptoms? When is the client most likely to begin heavy drinking? What types of interactions with other people make the client feel most distressed? The behaviour therapies are based on the theories classical conditioning of Ivan Pavlov and Operant conditioning of B. F. Skinner. You will learn more about it in the last module.

3.4 Cognitive Therapies

Cognitive therapies focus on challenging people's maladaptive interpretations of events or ways of thinking and replacing them with more adaptive ways of thinking. Cognitive therapists also help clients learn more effective problem solving techniques to deal with the concrete problems in their lives.

One of the most widely used forms of cognitive therapy was developed by Aaron Beck (1976). Techniques in cognitive can be condensed into three main goals. The first goal is to assist clients in identifying their irrational and maladaptive thoughts and to consider alternative ways of thinking. The third question or set of questions the cognitive therapist might happen?" and "what could you do if the worst get the client to face his or her worst fears about a situation and recognise ways the client could cope with even his or her fears. The next focus in this unit is the social approaches.

3.5 Social Approaches

Biologically based treatments focus on changing physical symptom. This will be discussed in unit 5 of this module. Psychological therapies focus primarily on changing the ways people think and behave. The social approaches to therapy view the individual as a part of the larger system of relationships, influenced by social forces and culture, and view that this larger system must be addressed in therapy. Under the social approaches we have interpersonal therapy, family system therapy and group therapy. You will learn more about them.

4.0 Conclusion

In this unit, you have been introduced to different therapeutic approaches. This is done to prepare your mind towards comprehending the different approaches involved in therapies. It is also important to state that just as we have different psychological perspectives in the study of psychopathology, personality assessment, so also we have different therapeutic approaches.

5.0 Summary

This unit has introduced you to different therapeutic approaches in treating maladaptive behaviours. The psychodynamic therapy of Sigmund Freud, humanistic theory of Carl Rogers, behavioural theory, cognitive therapies and the social approaches were briefly explained.

6.0 Self-Assessment Exercise

List and explain five therapeutic approaches in treating maladaptive behaviour.

7.0 References/Further Reading

Beck, A. T. (1976). *Cognitive Therapy and the Emotional Disorders.* New York: International Universities Press.

Bohart, A. C. (1995). "The Person-Centered Psychotherapies." In: A. S. German (Ed.). *Essential Psychotherapies: Theory and Practice* (pp. 55-84). New York: Guilford Press.

Vakoch, D. A. & Strupp, H. H. (2000). "Psychodynamic Approaches to Psychotherapy: Philosophical and Theoretical Foundations of Effective Practice." In: C. R. Snyder & R. E. Ingram (Eds). *Handbook of Psychological Change: Psycho-Therapy Processes and Practices for the 21st Century* (pp.200 -216). New York: Wiley.

Unit 5 Biological Approaches

1.0 Introduction

In the last unit, you learnt different therapeutic approaches in treating of maladaptive behaviours in human organisms. In this unit, you will learn about biological approaches in treating mental disorders. This unit will provide you with some important facts that will assist you to function as a competent and professionally trained guidance counsellor.

2.0 Objectives

At the end of this unit, you should be able to:

- discuss drug therapies in treating maladaptive behaviours
- explain the use of electroconvulsive therapy
- state the importance of psychosurgery.

3.0 Main Content

3.1 Drug Therapies

Under drug therapies, the major classes of medications that are now routinely used to help patients with a variety of mental disorders, as well as some additional treatment approaches (such as electroconvulsive therapy) will be discussed. The drug therapies under discussion are (i) antipsychotic drugs (ii) antidepressant drugs, and (iii) anti-anxiety drugs.

Antipsychotic drugs

As their names suggests, antipsychotic drugs are used to treat psychotic disorders such as schizophrenia and psychotic mood disorders in abnormal psychology. The key therapeutic benefit of antipsychotics derives from their ability to alleviate or reduce the intensity of delusions or hallucinations. They do this by blocking dopamine receptors.

Antipsychotic medications are usually administered daily by mouth. However, some patients, particularly those with chronic schizophrenia, are often not able to remember to take their medication each day. In such cases, depot neuroleptics can be very helpful. These are neuroleptics that can be administered in a long acting, inject able form. The clinical benefits of one injection can last for up to four weeks. We are not interested in learning about the names of these antipsychotics drugs because it is not the responsibility of a counselor to prescribe them for patients.

Antidepressant drugs

Antidepressant drugs lift people up from a state of depression. Most antidepressants work by increasing the availability of the neurotransmitters nor-epinephrine or serotonin, which elevate arousal and mood and appear scarce during depression. Consider fluozetine, which 38 million users worldwide have known as Prozac (Goode, 2000). Prozac and other serotonin – enhancing drugs have been prescribed not only to patients with depression but also to those with obsessive compulsive disorder (OCD).

Prozac partially blocks the reabsorption and removal of serotonin from synapses. Because they slow the synaptic vacuuming up of serotonin, Prozac, and its cousins Zoloft and Paxil,

are therefore called "selective serotonin – reuptake – inhibitor drugs (SSRIs). Other antidepressants work by blocking the reabsorption of both nor-epinephrine and serotonin or by inhibiting an enzyme that breaks down neurotransmitters such as serotonin. These drugs, though no less effective, have more potential side effects, such as dry mouth, weight gain, and hypertension or dizzy spells (Anderson, 2000; Mulrow, 1999). Myers (2004) remarked that one side effect of SSRI drugs can be decreased sexual appetite, which has led to their occasional prescription to control sexual behaviour (Slater, 2000 as cited by Myers, 2004).

Anti-anxiety drugs

Like alcohol, anti-anxiety agents such as Xanax or Valium, depress central nervous system activity (and so should not be used in combination with alcohol). Used in combination with other therapy, an anti-anxiety drug can help a person learn to cope with frightening situations and fear triggering stimuli. These drugs appear to reduce the symptoms of anxiety without interfering substantially with an individual's ability to function in daily life. The most frequent use of benzo-diazepines, accurately referred to as minor tranquilisers, is as sleeping pills. Unfortunately, these drugs are highly addictive, and up to 80 percent of the people who take them for six weeks or more show withdrawal symptoms, including heart rate acceleration, irritability, and profuse sweating (Nolen – Hoeksema, 2004). The next focus now is electroconvulsive therapy.

3.2 Electroconvulsive therapy

An alternative to drug therapies in the treatment of some disorders is electroconvulsive therapy, or ECT. ECT was introduced in the early twentieth century, originally as a treatment for schizophrenia. Italian physicians Ugo Cerletti and Lucio Bini decided to experiment with the use of ECT to treat schizophrenia, reasoning that ECT can calm people with schizophrenia much as experiencing epileptic seizures would calm and sedate people with epilepsy. Eventually, clinicians found that ECT is not effective for schizophrenia, but it is effective for depression (Nolen – Hoeksema, 2004).

ECT consists of a series of treatments in which a brain seizure is induced by passing electrical current through the patient's brain. Patients are first anesthetised and given muscle relaxants, so that they are not conscious when they have seizure and so that their muscles do not jerk violently during the seizure. Metal electrodes are taped to the head and a current of 70 to 150 volts is passed through one side of the brain for about one-half of a second. Patients with typical condition will last about one minute. The full series of treatments consists of 6 to 12 sessions.

Although many mental-health professionals believe that ECT can be useful, it remains a controversial treatment. The idea of passing electrical current through the brain of a person to relieve psychiatric symptoms seems somewhat bizarre (Nolen-Hoeksema, 2004). And some critics argue that ECT still results in significant and permanent cognitive damage, even when done according to modern guidelines (Breggin, 1997). For some seriously depressed people who do not respond to medications, however, ECT may be the only effective alternative. The last important thing to learn in this unit is psychosurgery.

3.3 Psychosurgery

In the study of abnormal psychology, you learnt about the theories that prehistoric people performed crude brain surgery, called trephining, on people with mental disorders in order to release the evil spirits causing the mental disorders. In modern times, brain surgery did

not really become a mode of treatment of mental disorders until early twentieth century. A Portuguese neurologists named Antonio de Egas Moniz introduced the procedure in 1935 in which the frontal lobes of the brain are severed from the lower centres of the brain of people suffering from psychosis. This procedure eventually developed into the procedure known as prefrontal lobotomy. Although Moniz won the Nobel Prize for his work, prefrontal lobotomies were eventually criticised as a cruel and ineffective means of treating psychosis (Valenstein, 1986). Patients would suffer severe permanent side effects, including either an inability to control impulses or a loss of the ability to initiate activity, extreme listlessness or loss of emotions, seizures, and sometimes even death (Nolen – Hoeksema, 2004).

By the 1950s, the use of psychosurgery had declined. These days, psychosurgery is used rarely, and only with people who have severe disorders that do not respond to other forms of treatment. Modern neurological assessment and surgical techniques make psychosurgery more precise and safe than it formerly was, although it remains highly controversial, even among professionals.

4.0 Conclusion

In this unit, you have seen that drug therapies such as antipsychotics, antidepressants and anti-anxiety drugs can help in the treatment of different mental disorders. You have also seen that electroconvulsive and psychosurgery are important approaches in the treatment of maladaptive behaviours. As guidance counselors, you may not be competent to prescribe drugs because you do not have the professional competence to do so. But your knowledge of biological approach is an imperative. It will help you to make adequate referral when your psychological approaches fail.

5.0 Summary

This unit has extensively examined drug therapies. Antipsychotic drugs were described as drugs used in treating psychotic disorders such as schizophrenia. Antidepressant drugs lift people from state of depression and anti-anxiety drugs help to calm the central nervous system. Electroconvulsive therapy is alternative to disorders that defy medical treatment. Psychosurgery that started in a crude form in the ancient times is still being used today in a modernised way.

6.0 Self-Assessment Exercise

1. What kind of disorders can be treated with antipsychotic drugs? How do these drugs help patients? What are their drawbacks?
2. Do the clinical advantages of ECT outweigh its disadvantages?

7.0 References/Further Reading

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