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**Personality: Therapies**

WHAT'S THE ANSWER?

It's been 40 years or more since a new large state mental hospital has been built in the United States or Canada. The result is that such facilities are often quite old. *Why is this occurring? Do North American governments no longer care about the treatment of those with abnormal behavior problems?*

*Are the gold stars given to children for good work in school, or as rewards at home toward their weekly allowance, related to any form of therapy?*

"How can it be? I made a deal with my girlfriend. She thought I was gaining too much weight, and I thought she was beginning to look a little plump, too. So we agreed that if I lost ten percent of my body weight and she lost ten percent of her body weight, we'd go to the Senior Ball together. I had to lose 20 pounds, but she had to lose 15."

"So? What's your problem, Jack?"

"Everything was great at first. I love to eat, but I jumped out to an early lead in our race. It was no trouble to keep from eating. But the longer I went with such a strict diet, the tougher it got. And then the dance started drawing closer. She lost more weight, and I really started getting worried. Now the date for the dance is almost here, and I'm really getting nervous. I just can't seem to keep from eating. What's wrong with me?" *What is wrong here? What theory of conflict can best explain what is happening? Is there anything that can be done to help this person achieve his goal?*

At least three possible causes of abnormal behavior can be identified: inherited or biological factors, psychological or learned factors, and cultural factors. There are two major models to explain abnormal behavior: the medical model and the psychological model. A psychotherapist chooses therapy based mainly on which theory of personality he or she endorses.

There are three major forms of psychotherapy. One consists of the physical therapies, which may involve use of shock, drugs, or surgery. A second form is the talking therapies, which are very diverse. Psychoanalysis involves a lengthy study of childhood experiences and of unconscious urges. More recent forms of psychoanalysis have broadened the sources of influence impacting our everyday behavior. Person-centered therapies provide a warm, accepting climate in which the client can examine his or her problems.

The third class of psychotherapies is the most diverse. These are the social learning and behavioral therapies, including systematic desensitization and implosive therapy. Other such behavioral therapies include operant therapies and cognitive therapies. Psychotherapies help people deal with conflict, but one social-learning theory has developed a number of principles for analyzing and controlling conflict situations. Person-centered therapists help people avoid conflict situations.

All psychotherapies share in common the assumption that behavior can be changed and that the therapist and patient/client are interested in a common "problem." Evaluating the success of psychotherapy is difficult because of the problems of defining the basis for evaluation, the differences among various theories, and the difficulty of finding impartial judges of success. Our current definition of "mental health" is undergoing change in the places, the processes, and the personnel assisting in achieving it.

Frustration is one feeling that can cause certain behaviors, including some that can be self-destructive.

Aggression is not an effective response, but channeling the aggression into new compensating activities, and working around the anxiety and the tension can be helpful. Significant personal tension can also be caused by shyness -- like aggression -- a difficult problem to overcome.

## Causes of Abnormal Behavior

We start this section with a problem. We talk in the Theories of Personality chapter about a variety of theories of personality and in the behavioral disorders chapter about the wide range of mental disorders that can occur. Here we review the various treatments or therapies that are being used to "cure" or control the various abnormal behavior patterns and the models of behavioral change on which these theories are based. But it's not that easy, and therein lies our problem.

Abnormal behavior has many different causes. If you have a behavior disorder, the theory of personality selected by your therapist has a direct impact on what he or she will identify as the "cause" of your problem. Likewise, which theory your therapist selects also largely dictates the form of therapy that will be used. Let's go back through that one part at a time to show you the "problems."

One problem is that mental disorders can have multiple causes. There are several inherited or biological factors that influence your behavior. These would include the genetic messages inherited from your parents. One study of genetic factors and schizophrenia reported that among 24 pairs of identical twins, if one twin was diagnosed schizophrenic, 42 percent of the time the other later experienced the same disorder. For 33 pairs of fraternal twins, this happened only 9 percent of the time. Genetic messages also cause differences in our biochemistry. There is indirect evidence that the excessive presence of dopamine in the central nervous system leads to schizophrenic-like behavior. Unusually low levels of the neurotransmitters serotonin, norepinephrine, and dopamine may be involved.

Of course, there are other biochemical factors, including hormones, which can impact our behavior. We saw earlier that certain physiological factors such as nutritional and vitamin deficits can seriously influence our behavior. So can other essentially physiological stresses, such as isolation for long periods of time in solitary confinement.

There are also three major groups of psychological or environmental factors that can affect your behavior. For instance, developmental events may affect you even in the first

year of life -- problems in feeding, or stressful patterns of behavior by your mother. The early childhood years -- according to some theories and research -- are especially critical ones for normal development. And problems you first experience as a child may cause later problems. The worst effects of these early difficulties may not be felt until late adolescence or even full adulthood.

A second set of psychological factors is family pressures and events. You control some of these; others you don't. You don't control the order in which you are born into your family, nor do you control your family's ultimate size. If you're an only child, you gain certain social and interpersonal skills. But what if you are the fourth-born with three older brothers who are four, seven, and ten years old when you arrive? Obviously, your social training would be very different. The patterns of communication developed and used within your family also influence your adult behavior. Suppose one of your parents tells you how much you are loved, but always seems too busy to work or play or learn with you. If you are constantly subjected to "mixed signals," it may have adverse effects on your adult personality.

Third, throughout our adult life we are all constantly subjected to conflicts and stresses over which we may have very little, if any, control. The effect of these stressors upon us depends on our genetic make-up, our childhood successes and failures, and our most recent experiences. A specific event such as a frustration may vary widely in its impact upon us depending upon our current emotional balance.

Finally, there is a third set of factors that influence our likelihood of showing abnormal behavior. These cultural factors are less personal, less controllable, less immediate, and generally more permanent aspects of our environment. Your age is one good example of such a factor. You're probably a late teenager right now. You'll change with age, but very little this week or next. The social class of your parents or your beliefs about religion will not be easily or quickly changed either. Yet, the beliefs and expectations of others about individuals who are teenagers, or males, or females, and so forth will affect your behavior and your mental health.

## **Models for Change**

There are two models of human behavior that are the most widely cited in explaining behavior -- both normal and abnormal: the medical model and the psychological model. Theories of personality are typically anchored in one or the other model.

Let's review the important parts of each model of abnormal behavior.

Suppose you smash your foot against a leg of your desk. Anxiously you look down but see no broken skin; then, suddenly, your second toe HURTS. When you lift your foot, the toe hangs down toward the floor. It hurts even worse if you try to wiggle it. Very simply, you -- and a bit later, your doctor -- assume you've broken your toe.

This is a situation in which an external behavior -- a dependent variable or response, if you will -- is "determined," or explained, by an internal cause. The underlying assumption is a simple (medical) one: If a symptom shows up, then there is an internal cause of that symptom. And therapy is quite simple:

Find that internal cause, fix it, and the symptom will go away because the "cause" has gone away. In this medical model abnormal behavior is viewed as an illness. Professionals who use such a theory as the basis for treating abnormal behaviors refer to people with problems as "patients" -- just as a medical doctor does. Wouldn't Freud's theory of psychoanalysis qualify as being based on a medical model? Of course. But there's another and very different view.

Let's suppose that "abnormal" behavior is learned. Let's continue to suppose that we can learn new responses -- from eyeblinks to word lists. Now extend that logic to offer an explanation for abnormal behavior. In short, let's assume that we learn to behave abnormally. This is a psychological model of abnormal behavior.



This view differs substantially from the medical model. For instance, people believing in this model would feel that there is not an internal cause, but rather that the behavior itself is the abnormality. Change the

behavior and you've solved the problem -- if you have changed the behavior back into the normal, acceptable range. Therapy, then, is very different too. Now our goal is to change the reinforcers so as to reinforce those behaviors we want the client (note the change in terminology?) to exhibit. Treat the symptom(s), and you've treated the problem. If you think back to the theories of personality you've studied, these two models were obvious everywhere.

Resolution? As you might suspect, there is strong disagreement among people endorsing each of these models. What if someone came in to a therapist wanting a cure for the

tendency to bite fingernails? -- his or her own, of course! A medical-model therapist would assume there was an internal problem that was showing up as fingernail biting. That therapist would help the patient look for, identify, and understand the internal stresses.

A therapist endorsing the psychological model would take a very different approach. He or she would be concerned with identifying what reinforcers are maintaining the behavior. Once identified, they could be changed, or more powerful reinforcers could be implemented to increase the frequency of other more desirable behaviors. Using this behavioral approach to alter symptoms directly, the medical-model therapist would be sure the internal cause would simply show up as a different symptom (symptom substitution). The psychological-model therapist would assume the behavior, once cured, was just that -- cured.



**How does Theory Affect Therapy?**

The answer to that question may be obvious. There are two major views as to the actual cause(s) of mental disorders. The therapist's views on this determine how he or she will perform psychotherapy. Moreover, which

theory of personality is endorsed will also affect the choice of psychotherapy. Table 15.1 lists the types of mental health professionals who can offer psychotherapy as well as the types of therapy they are typically best trained to perform.

**Table 15.1**

*Mental Health Professionals: Title, Training, and Task*

<b>TITLE</b>	<b>TRAINING AND TASK</b>
CLINICAL PSYCHOLOGIST	Doctoral degree (Ph.D.) in psychology involving 3-5 years of graduate school followed by a one-year supervised internship (mental hospital or other clinic) involving additional research and/or clinical experience. Uses talking and social learning/behavioral therapies.

COUNSELING PSYCHOLOGIST	Same education as clinical psychologist. One-year internship in counseling situation (e.g., marital or family). Uses same therapies as clinical psychologist.
PSYCHIATRIST	Doctoral (M.D.) degree involving 4 years plus 1 year internship and up to 3 years of residency—the primary source of training in mental disorders. Mainly uses physical therapies.
PSYCHOANALYST training	Doctoral (Ph.D. or M.D.) degree and extensive  in psychoanalytic theory/practice including the psychoanalysis of the therapist him- or herself. Relies on psychoanalysis, often combined with other therapies according to training.
PSYCHIATRIC NURSE	Usually includes a bachelor's (R.N.) degree involving special training with mental patients. Supervised services, often in hospital setting.
(PSYCHIATRIC) SOCIAL WORKER	Master's (M.A. or M.S.W.) degree involving 1-2 years of graduate work, often including some supervised training in social service programs. Usually deals with people in their home.
PSYCHIATRIC AIDE	No formal academic training is necessary beyond high school, although an Associate of Arts (A.A.) degree is now offered by some colleges for general training/experience in mental health. Work limited to supervised direct contact with inpatients.
PARAPROFESSIONAL	Mature and well-adjusted people are now being trained to provide specific services under direct supervision, especially in crisis intervention (e.g., crisis hotline) situations. No formal education necessary.

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Different abnormalities are best treated in different ways. Some therapies are best with milder or anxiety-based disorders. Other therapies -- and sometimes other assumptions about cause -- are more effective in handling more severe forms of mental disorder.

The original forms of psychotherapy (for instance, psychoanalysis) were designed entirely to involve one therapist and one patient. But that can be very expensive. The pressures of expense were among several that aided the development of forms of therapy -- group therapy -- that could treat several people at once. It was cheaper, but it also had some other benefits.

Alcoholics Anonymous is a good example of such a program. It offers group support and understanding. It provides group

pressure to keep the person aware of and trying to exercise control over his or her problem. It provides a nonthreatening environment that encourages each person to share problems, fears, successes, and failures.

One response to the problem a person with a mental/personal problem or disorder faces in choosing personnel has been to develop a team approach. A treatment team might be composed of a clinical psychologist, a neurologist, a psychiatrist, and perhaps a counseling psychologist and a psychiatric nurse. The range of talents and experiences represented by such a team greatly increases the diversity of treatments that can be offered to a client or patient. But it can also be a very expensive approach.

### **Forms of Psychotherapy**

What is psychotherapy? It is basically a helping relationship. Psychotherapy is the use of psychological techniques for the treatment of mental or behavioral disorders. Despite broad agreement on several basic commonalities across all forms of psychotherapy, there are four different primary forms of psychotherapy. First, physical therapies assume there are internal causes of mental disorder and that these causes are often physiological. Thus, these forms of therapy may involve shock, drugs, or even, in extreme cases, surgery. Second, the talking therapies are of two types. Some assume the medical model view of behavior, others assume the psychological model view. These are therapies that stress the correction of mental disorders by talking about them. Third, the social learning and behavioral therapies are based mainly on the psychological model of mental disorder. The latter assumption is also the basis for the final group of therapies, the cognitive therapies.

We have reached the modern approaches to treating mental disorder through a rather wandering path. At the time of the Salem witch trials, in the New England of 1692-3, abnormal behavior was viewed as untreatable. It was thought to be due to outside (evil) forces that somehow took possession of the affected person. The dunking of those convicting of being witches was an attempt to drive these evil possessors from the mind of the possessed. Three events helped to alter that view.

In 1792 Phillippe Pinel, when he was appointed Commissioner of Mental Health in Paris, started an effort to remove the chains from hospitalized mentally deranged patients. He was among the first to treat the mentally ill as sick, not as possessed. It was a major step forward.

More recently, in the 1800's, Dorothea Dix (1802-1887) campaigned nationally for the creation of mental hospitals wherein more humane treatment for the mentally ill could be offered. In 1908, Clifford Beers published a book entitled *A Mind That Found Itself*, in which he described his attempts to recover from the emotional trauma he endured while fighting in the Civil War. His brother was on the opposite side; Beers never knew -- firing into the night -- when he might kill his brother. The book was his story of the three post-war years he spent in a mental hospital and his eventual recovery. The horrors he described were largely responsible for starting the modern mental health movement in North America. The current American Mental Health Association is a direct result of his early work.

Finally, World War II and the Vietnam conflict created a large number of returning veterans who sought -- and were given -- psychological help in readjusting to civilian life. For the first time a federal government recognized emotional and behavioral problems as treatable. The array of problems that could be treated ranges from daydreaming to feelings of inferiority, from extreme forms of psychosis to shyness. It provided the funds with which to achieve that treatment on a national scale. It is to an examination of the forms of that therapy that most of this chapter is dedicated.



### Physical Therapy

Obviously, these forms of therapy assume an internal cause for each disorder. Some of these physical therapies are reserved for use mainly in treatment of the most severe disorders. Primarily psychiatrists tend to use such treatment techniques, since medical procedures -- drugs and operations -- are involved. In the past decade there was a pilot program in which Ph.D.-holding psychologists were given permission to prescribe drugs in a pilot project. Though the effort to open up prescription privileges to psychologists remains a current one, no psychologist is currently able to prescribe drugs as part of therapy. Some forms of physical therapy are quite mild -- for example, use of prescription tranquilizers. The use of mild prescription drugs adds enough to the total list to make the physical therapies -- in their broadest definition -- the most

widely used form of therapy. Let's examine some forms of physical therapy.

Shock Therapy, now rarely used, involves giving the patient's physiological system a moderate to severe "shock." This may lead to convulsions, which are often followed by coma and then a period of recovery. The effects of these shocks are largely unknown. With nothing else being done for them, some patients do seem to improve. For others, the shock is used to render the person more receptive to other forms of therapy.

Several different sources may be used to cause the shock. For instance, Electroconvulsive Shock (ECS) involves a brief, very powerful electric current through the brain. The shock leads to massive neuronal firing and body convulsions. Insulin injection is another, even less frequently used way of producing shock. Such an injection will put a person into insulin shock that, in its more severe forms, also involves convulsions.



You've probably taken aspirin or a similar drug to relieve cold or allergy symptoms or for other problems. That's chemotherapy -- the use of drugs to treat unwanted symptoms. Chemotherapy for psychological problems is similar to the use of drugs to cure physical ills, except the symptoms being "treated" are behavioral or emotional.

The difficulty with drugs -- and an objection often raised against them -- is that they don't usually solve problems. They may make the problems seem to go away, and they may reduce the anxiety caused by problems, but they don't solve the problems themselves. Some drugs, then, are most frequently used to solve temporary problems such as anxiety associated with approaching final exams or getting married. The danger, of course, is that drug reliance will simply be substituted for whatever problem was previously causing the difficulties.

An associated problem has to do with a "vicious circle" which may be established using drugs -- sometimes also called the revolving door problem. A mentally ill patient is brought into a hospital. Once diagnosed, his or her condition is brought back to a normal range of responsiveness and reactivity through prescription drugs. The patient is released with a prescription. After a period time on the drug(s), the patient feels so well that he or she stops taking the drug(s). The

symptoms return; the patient is hospitalized and the cycle continues.

Are there benefits to using drugs? Yes, as suggested in the Figure and discussed in the Think About It. Such medications can increase a patient's positive reaction and receptivity to other forms of therapy. They aid in reducing the intensity of many symptoms. They have also markedly reduced the number of persons residing in mental institutions.

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**Think About It**

**The question:** We noted at the start of the chapter that large state mental institutions are no longer being built. *Do North American governments no longer care about the treatment of those with abnormal behavior problems?*

**The answer:** No. Rather, the type of treatment that is being offered is now more than just custodial. When mental patients were simply being cared for before tranquilizers were available, it was thought necessary to have large (efficient) treatment facilities. The more modern use of tranquilizers and the emphasis on community mental health centers and preventative mental health measures have markedly reduced the need for large mental institutions. The possibility of keeping those with mental/behavioral disorders in a supportive home environment is also now more feasible and more highly valued than it was before the introduction of tranquilizers. Changes in the nature of therapy itself are responsible for the change in the nature of the institutions being used.



Surgery as a therapy is often the treatment of last choice. Use of surgery in order to create behavioral effects has never been in wide favor. As our knowledge of the brain and its organization improves, our use of surgery may possibly increase. Nowadays

surgery is limited almost entirely to the removal of tumors or blockages that are influencing normal brain functioning. Lobotomy, once used to calm violent patients, involves severing the front portion of the brain from other processing centers. It is occasionally used now in terminal illnesses for people who are suffering unbearable pain.

## Talking Therapies



These are a very diverse lot of psychotherapies, based on a number of differing assumptions. They make different demands on the therapist and client alike, and they offer a variety of techniques. If you were to

agree to undergo one of these kinds of psychotherapy, your personal history (from your own view) would be reviewed. You would usually be made more and more aware of past or present feelings and your reactions to those feelings. During the therapy your psychotherapist does not sit in judgment of you. Rather, he or she simply accepts what you volunteer to tell, showing interest in your problems and taking an understanding, tolerant position.

These therapies are best in handling the anxiety-based disorders, although some will also work with more severe mental disorders. What type of talking therapy would you choose? Let's review some of them.



If you undergo psychoanalysis you can count on its taking from one to several hours a week for as long as a couple of years, if you have a moderately serious problem and successful psychoanalysis. Such time and money demands have led to the development of more efficient techniques in recent times

However, traditional psychoanalysis is still -- though rarely -- offered. In modern times, neoFreudian psychodynamic therapies have evolved from Freud's original psychoanalytic theory. These therapies include the work of theorists such as Carl Jung, Alfred Adler, Karen Horney, and even Anna Freud -- his daughter. Remember, of course, that Freud thought that the main source of psychological difficulties was in the unconscious urges that created anxiety. Psychoanalysis, therefore, involves getting you to recognize and deal with the source of your anxiety.

The key in psychoanalysis is to achieve catharsis, which is the release of emotional tension by working through the sources of your frustration(s). Psychoanalysis assumes that adult emotional difficulties are caused by unconscious traumatic memories from childhood; creating the catharsis involves taking

the individual back to relieve the original source(s) of pleasure or frustration with adult levels of understanding.



Five elements are crucial in this therapy. (1) The least crucial is a couch which serves to relax you and encourage you to talk. (2) Free association (the saying of whatever occurs to you) allows the psychoanalyst to observe

patterns in what you choose to talk about. Are there subjects you stay away from? Are there some you dwell on abnormally? (3) Dream content is often requested in order to gain insight into your motives and what may be causing you to behave as you are.

Freud thought of dreams and slips-of-the-tongue as conscious indicators of unconscious urges. He viewed dreams as the "high road to the unconscious." Manifest dream content is what you experience -- what you describe when telling someone of a dream. Latent dream content was the matter of primary interest to Freud, who maintained the symbolic messages contained in dreams was invaluable in gaining an understanding of the patient's unconscious. Such dream analysis is very different from idle, waking daydreaming. (4) Resistance is identified by what you avoid talking about or obvious conclusions that you are resisting. These offer cues useful in identifying stress points, or areas of repression. If you feel threatened, you may suddenly start missing -- "Oh, I forgot!" -- appointments. Finally, (5) transference occurs as your psychoanalyst gets you closer and closer to realizing the source of your anxieties. In transference you may reenact with your psychoanalyst whatever frustrating relationship you had in your earlier (childhood) life. Successful therapy gets you to resolve successfully the transference reaction. The analyst uses it often to lead you to an understanding of your problem(s).

Most of the current psychotherapeutic techniques trace their beginnings to psychoanalysis. Psychoanalysis lends great importance to early life experiences; it emphasizes the childhood basis of adult anxieties. Your psychoanalyst comes to be viewed as an authority figure. By contrast, the more modern person-centered therapies stress your current individual life situation. This is a very different form of talking therapy with a humanistic emphasis. Therapies of this type really stress that you come to understand your present experiences. In what ways do you wish to grow, and how can you be aided in realizing the greatest part of your total potential as a human?

The therapist is more a competent than a dominating authority. Moreover, it is assumed that you possess the ability to make free and willful choices; you control your own destiny. Finally, such therapies emphasize the unique qualities of being human.

One good example of this type of theory and therapy is Carl Rogers' Person-centered Therapy. It is also known as a non-directive therapy. Why? Because your therapist assumes you can guide the therapy yourself, knowing what you do and what you don't want to talk about, as illustrated in Feature 15.1.

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**FEATURE 15.1**

**CLIENT POWER**

**Dr. Z:** Well, Clarissa, what was it that you wanted to talk with me about?

**C:** Well . . . It's hard to put it in words . . . I guess just the way I've been feeling lately. (pause)

**Dr. Z:** Yes?

**C:** That's it. I've just been feeling so confused . . . I don't know what to do and I feel like I can't do anything. I guess you could say I'm down in the dumps.

**Dr. Z:** You need to decide what to do, but can't make a decision and that makes you feel bad?

**C:** Yeah! It's so confusing . . . You see, I'm just sort of an average student . . . B's all through high school... and well, here I am at the end of my sophomore year, and I need to select a major. I'm running out of time to make that decision!

**Dr. Z:** You don't know what your major should be?

**C:** I want to major in psychology, and I want to major in business . . . and I don't know why I feel either way! I want it to be my decision, but I know my parents want me to select business.

**Dr. Z:** There's some trouble keeping your feelings and your parents' feelings straight.

- C:** Yeah. I guess I'm leaning toward wanting psychology, but in the back of my mind I keep thinking about business. I wonder if I'm not just going along with my Parents wishes.
- Dr. Z:** You want to select based on what's best for you, not for your parents.
- C:** That's it exactly! . . . and the problem is that I don't have a good way of telling which it is.
- Dr. Z:** You really wish there was a good way to make the decision.
- C:** Like if I could list out all the advantages of psychology and of a business major . . . right out there where I could look at them and think about them . . . and weigh them out.
- Dr. Z:** Sounds as if you've hit on a way to get things to make a little more sense.
- C:** You know, I could do just exactly that . . . make out those lists and just weigh the evidence. I think I could be surer that I was deciding for me that way!
- Dr. Z:** The tone of your voice has changed, Clarissa . . . as if you are excited now about making the decision instead of dreading it!

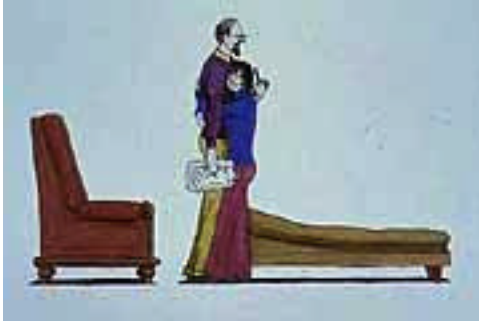
This is person-centered therapy. Notice how Dr. Z. keeps her client focused on the issues. However, she reflects the feelings of the client, not just the specific issue (decision) at hand.

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At core, this type of therapist assumes that you have the potential and ability to make constructive changes in your style of life -- if you wish to do so. More importantly, it is assumed that in a warm and accepting environment you will be able to make the appropriate choices for yourself.

The elements of person-centered therapy are threefold: (1) Unconditional positive regard. Your therapist is going to feel and exude positive feeling for you. You are accepted without question. Any behaviors you describe are accepted nonjudgmentally at face value. (2) Another important element is

empathy. This means that your therapist will identify with you and understand what you are trying to relate to him or her.



Finally. (3) congruence or genuineness refers to the therapist's willingness to be authentic in his or her relationship with the client. As opposed to the "expert" role of any medical model therapy, the person-centered therapist doesn't play a role.

### **USING PSYCHOLOGY: Controlling Daydreaming**

In psychoanalysis Sigmund Freud used the analysis of dreams to gain insight into his patients' unconscious. Though it isn't, a similar topic -- daydreaming -- might seem to be related to dreaming. There are several differences. You are soundly asleep when you dream; you're awake when you daydream. Your EEG shows distinctive shifts in the basic frequency of waves being generated when you sleep; not so when you daydream.

Do you daydream? Daydreaming seems to be a carryover from childhood. What exactly causes it? There are several possibilities. For one, despite your increasing skills, as a young adult you sometimes may not be given responsibilities and challenges that match what you can do. The result is boredom and idle time on your hands. A boring environment, at any age, is likely to encourage daydreaming. In addition, some adolescents may not have had a childhood that led to interpersonal contacts and the development of friendships. Encouraged to play alone, such children come to rely on self-generated activities, conversations, and imagined events.

The effects of daydreaming are fairly obvious. You seem to lose track of ongoing events, and fail to pay attention to your immediate environment. Too much daydreaming may lead you to rely too much on imaginary solutions to everyday problems. Dreams may be entertaining and self-serving, but they are not functional solutions.

What to do? First, reach a specific decision as to how much is an acceptable amount of daydreaming. Second, change the environment that leads to daydreaming. Where do you find yourself daydreaming more than you think you should? In your bedroom? Then study at the library. In school? Then consider changing subjects or rearranging your study schedule. There's

nothing wrong with an active imagination, but excessive daydreaming -- if that becomes a problem -- can be controlled.

### **USING PSYCHOLOGY: Feelings of Inferiority**

Alfred Adler saw each of us as striving to overcome the weaknesses we perceive in ourselves -- an inferiority complex, as he called it. His was an optimistic revision of Freud's psychoanalytic theory. As children learning to talk we gain a certain control over our environment, and this sets a pattern of striving to conquer the feelings of inadequacy we all share. However, if not controlled, this striving may lend too much emphasis to the "problems" or inadequacies being overcome. Such a person then, according to Adler, develops an inferiority complex. Have you ever felt that you suffer from such a complex? It can be caused by excessive expectations of a respected adult (or your boss). It can also result from being relatively immature and identifying with childhood or adolescent skills (or a lack of them) rather than realistically assessing your new late adolescent or young adult (or adult) skills.

A difference in your rate of physical maturation may have caused you to develop much later than your friends. To note some of the advantages of this, you might review the Development: From Adolescence to Old Age chapter. Some feel inferior, however, if their body is not as fully developed as that of the "typical teenager." It's less of a problem for young adults, but it is a problem for adolescents. Finally, your friends and/or a lack of status in your school may encourage -- rightly or wrongly -- feelings of inferiority. As someone has pointed out, thank goodness there is life after adolescence!

The problem of feelings of inferiority is not one to be ignored. It can lead to a self-fulfilling prophecy: I feel inferior, therefore I will act inferior. That leads others to think the one who acts inferior must be inferior. Again, the solution is close at hand. First, and most important, an accurate assessment of your strengths should be undertaken. What are you good at? What do you enjoy doing? List these strong points. You may be pleasantly surprised. Second, identify with positive role models (of which we speak in more detail in the Social Behavior in Group Chapter). That is, choose successful friends to imitate. Finally, try to change not only your mental environment (or attitude), but, as much as possible, your physical environment as well.

## Social Learning/Behavioral Therapies



Social learning therapists assume that by changing the environment it is possible to change undesirable behavior. Since we learn to behave abnormally, we can just as easily learn to behave normally. This assumption is at the heart of one psychologist's suggestion that we should view all "abnormal

behavior" simply as "problems in living." Again, the emphasis is on present events.

Psychiatrist Joseph Wolpe, who developed systematic desensitization, has noted that we cannot make mutually incompatible responses. We can't be happy and sad at the same time, or both relaxed and anxious. So, if a stimulus in your environment makes you anxious, why not learn to relax when experiencing that stimulus?



Let's suppose you have a fear of taking tests. Using this procedure, the psychotherapist would ask you first to list all the things about test-taking that make you anxious. Seeing a test, thinking about one, taking one, saying the word, talking about

tests -- everything that makes you anxious about test-taking is listed. Then in the second phase you're supposed to rank these items from the least-to the most-anxiety-arousing. At this point, in the third phase, the psychotherapist gives you training in how to relax.



In the final portion of this therapy, you go back to the items on your list of test-taking fears from the second phase and start with the least anxiety-causing stimulus. Your therapist will have you continue to think about that stimulus, but if you start feeling tense, you're

instructed to practice relaxing. Eventually what happens is that whatever stimuli -- whatever aspects of test-taking -- made you nervous become counterconditioned (unlearned). These stimuli now cause you to relax. You emit a response that is incompatible with the anxiety that tests once aroused in you. Moreover, your self-concept actually seems to improve. You've mastered a fear!

Implosive therapy also relies on counterconditioning, but it's not a therapy for the "faint of heart." It relies on arousing a tremendous amount of anxiety and then pointing out to the client that neither the worry nor the source of the anxiety had any ill effects -- other than self-generated anxiety.

Operant therapies emphasize the results of behavior -- that is, the reinforcements that can be gained. They rely on positive reinforcers and shaping techniques, as shown in Feature 15.2 and illustrated in the figure.

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### FEATURE 15.2

#### THERAPIST POWER

**Dr. Z:** Well, Clarissa, what was it that you wanted to talk with me about?

**C:** Well...It's hard to put it in words... I guess just the way I've been feeling lately. (pause)

**Dr. Z:** I'm not sure I understand. How have you been feeling?

**C:** Well . . . confused, I guess. And sort of hopeless about selecting a major. I start thinking about whether to choose psychology or business and get so bogged down... (pause)

**Dr. Z:** So you think about it some, and that gets you worrying. What do you do then...once you're worrying about it?

**C:** Well...I do something else to take my mind off it. Like watching TV or calling my boyfriend. Just anything to get it out of my mind.

**Dr. Z:** I guess in the short run that helps you handle it... you can stop yourself from crying about the decision when you think about it. But I wonder if it really helps you in the long run?

- C:** I'd never looked at it that way, but I guess you're right. I can stop myself from worrying when I stop thinking about it, but that way I never think about it enough to make the decision so it's always there to worry some more about later.
- Dr. Z:** That's exactly what I meant. So can you see a way to handle the decision that will involve less worrying?
- C:** I think so...I just need to get it over with... I mean really think it out and decide. I've been avoiding it and that's been keeping me worried.
- Dr. Z:** I think you're right on target.
- C:** But, whew! It's such a big decision! I may not worry as much once I've decided, but I sure am gonna be worrying when I sit down to do it!
- Dr. Z:** Well, it seems to me you need some systematic way of trying to decide, because it is a big decision with lots of different sides to it
- C:** Yeah...some organized way to think it through, but how?
- Dr. Z:** One thing you might try is to simply list out all the pros and cons you can think of for each major. That way you can take everything into consideration, and weigh it out
- C:** That makes sense! I'll give it a try!

This is behavioral therapy. Notice that Dr. Z plays an active role in leading the client from problem to solution. It's more task-oriented than is person-centered therapy. It focuses on the problem at hand, without being so concerned with internal feelings of worry.

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One interesting use of these principles involves contingency contracting. These are the principles influencing any child who "earns" an allowance. A contract exists between family members (or between client and therapist). Conditions to be met are spelled out, as are the reinforcements to be gained for the contracted behavior. For instance, contingency contracting can be used to reduce marital discord by listing the

responsibilities of each partner in areas causing difficulties. Another example of contracting involves an agreement with oneself. Keeping track of your own behavior is called charting, as seen in the Figure. Evaluation of your own performance and reinforcing yourself are both necessary to achieve success with this procedure.

Another system of behavioral therapy involves setting up a token economy. The important element is having a token (for instance, poker chips, stars, points, or something else) that can easily be awarded for proper behavior. These systems rely on the secondary reinforcing qualities of the tokens. The method works best when a parent or therapist has absolute control over the reinforcers so that the rules of the economy system can be enforced. Clients or mental hospital patients must make the link between gaining tokens and being able to turn them in for desired things. Once it's realized that an extra dessert, the opportunity to play with special toys or games, a trip to movies, or the like can be earned, changes in behavior often begin to occur rapidly. Such therapeutic programs have been used in treating a wide range of behaviors, from simple problems in reading to some forms of schizophrenia. Of course, there may be a problem in keeping clients from backsliding once they are no longer earning tokens for their desirable behaviors. This is further discussed in the Think About It. Another group of therapies, called cognitive therapies, deals directly with clients' beliefs, based on the same basic principles of learning on which the social learning and behavioral therapies are based.

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**Think About It**

**The question:** Are the gold stars used in school and at home with children related to any form of therapy?

**The answer:** Most definitely, yes. The gold stars, and the allowance given to children by their parents for household tasks performed or behavior maintained or exhibited under certain circumstances are both "tokens." These are unimportant in themselves except for the fact that they can usually be swapped for desired things -- for higher grades in school, for time with a favorite game, for a trip to a movie, for additional food.

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**Cognitive Therapies**

The most recently developed forms of psychotherapy are called cognitive therapies. Evidence is growing that much human

behavior is voluntarily controlled, and that we do often retain an ability to correct the "problems in living" that we may experience. Whereas behavioral and social learning therapies emphasize direct control of behavior, cognitive therapies give more emphasis to altering the underlying beliefs (cognitions) which influence our behavior. One example of new forms of therapy that emphasize cognitive aspects is Albert Ellis' Rational Emotive Therapy (or RET).

Ellis assumes the client is rational and able to control his or her thoughts and behavior. In RET, three steps are examined: A is the activating experience -- you flunked a test. C is the consequences, emotional and behavioral -- you go to your room, become depressed, and feel your self-esteem drop disastrously. B is your belief about A -- if you loved the subject, you feel depressed for flunking; if you hated the subject, you could even feel relieved. Ellis says A does not cause C. Rather, B causes C; beliefs cause the consequences. As a therapist, Ellis works to convince his client that abnormal behavior results from faulty thinking (cognitive) processes. Correct the thinking and you've corrected the behaviors. This is not a therapy for everyone, and the decision to select a particular type of therapist needs to be based on some level of understanding the nature of the problems you face, as suggested in Feature 15.3.

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### FEATURE 15.1

#### "A SUPERFLUOUS SUPEREGO AND OTHER PROBLEMS IN LEARNING TO LOVE YOUR THERAPIST"

Here's a problem that might not have occurred to you. You're a very aggressive person. In fact, you've decided you're so aggressive that it would be a good idea to visit a psychotherapist. But what kind do you choose?

What if you and your concerns about being aggressive run headlong into a Rational Emotive Therapist -- one who actively tells you in no uncertain terms that your thinking is wrong? Well? Are you going to sit there and take that? No, it's not likely.

The problem here -- and it *is* one -- is a mismatch between client and therapist. It happens. In fact it happens often enough that in the 1970s people began to study the results of different choices. We can now offer tentative advice on what kind of client and behavior problem can best be handled by what kind of psychotherapist.

For instance, person-centered therapy works better with introverted clients than with extraverted clients. The reverse is true for Rational Emotive Therapy. By contrast, systematic desensitization works equally well with both types. In the treatment of anxiety-based disorders, clients tend to improve with both psychodynamic kinds of therapy and behavioral therapies, but in different ways. Psychodynamic therapy is most effective with patients having higher income, more intelligence, and more education, who are younger and married. On the other hand, patients with behavioral abnormalities may be better treated with behavioral therapies. The behavioral therapies seem to work fairly successfully with a much greater variety of clients.

Now, what kind of therapy would you choose?

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Aaron Beck, originally trained as a psychoanalyst, was amazed by the number of his patients who revealed very negative thoughts based on faulty cognitive strategies. The strategies include: (1) overgeneralize -- if you flunk a test, assume you'll flunk the course. (2) view positive events as exceptions to your general incompetence and ability to fail. (3) amplify the importance of negative events -- not only will I flunk this course, it's going to cause me to be dropped by the college! (4) engage in black-or-white, all-or-none thinking -- see above! And (5) generalize these to develop a view of the world as a threatening place organized around aiding your ultimate failure. Beck's logic identifies a sequence similar to the vicious circle established by defense mechanisms. If your interpretation of events is always negative and your thoughts become increasingly negative because of your interpretations, depression seems a most logical result! Depression, in turn, leads to more illogical thinking.

Beck has developed a therapy which seeks to disrupt and alter this progressive deterioration. A rational emotive therapist works actively to disprove his or her client's ideas. In contrast, Beck's cognitive behavioral theory encourages the therapist to work with the client to point out the illogic of his or her thinking. The client is encouraged to set up tests to assess whether the underlying assumptions are correct. "You flunked the test?" "Well, I got a 69 -- passing is 70." "We're nine weeks into the term. What's your score on the other tests?" "All B's, but those tests were easy!" "So, at worst you've got one D and the rest B's. Does your instructor drop test scores?" "Yes." "So, you could drop this test score, and even if you don't, could you view it as a partial success? You

missed a C by only one point." The client has overgeneralized, viewed positive events as exceptions, amplified the impact of the one less-than-desired grade, and engaged in all-or-none thinking. Beck would advise attacking the misguided thought processes and providing more effective means for dealing with occasional failures.

Across the array of therapies available, which one is right? Maybe each type of theory is correct for certain circumstances. Modern theories strike somewhat of a balance between the biologically determined views of a psychoanalyst and the environmentally based views of the traditional learning theorist. The newer theories and therapies recognize the joint impact of both biology and environment. However, they stress that each of us maintains rational control of our own life.

### **Conflict -- A Theoretical Analysis**

Now let's take one common human problem with which we all have to deal. Let's review that problem -- conflict -- in terms of how each theory of personality interprets it. We'll then look at the various therapies that each theory suggests.

Trait theories are easy. Trait theories, such as Sheldon's, don't deal directly with conflict at all. Conflict is neither part of the conceptual basis for such theories themselves, nor do such theories offer specific suggestions for change to conquer conflict.

Conflict is a central part of the psychodynamic theories of personality. In psychoanalysis, the balance struck between the life instincts and the death instincts is rooted in conflict. Therapists deal with conflict in their patients in widely differing ways, as seen in the illustration -- which suggests an approach quite different from what traditional psychoanalysis would advocate. The balance of psychic energy struck among the id, ego, and superego is at heart a conflict. The unconscious works to keep repressed memories repressed and offers substantial resistance -- conflict -- to a therapist's attempt to lead his or her patient to understanding the relevant events of childhood. Freud's whole concept of defense mechanisms is rooted in a conflict-based model of the developing and functioning personality.

How are we to solve or control these conflicts? Freud suggested the defense mechanisms. The main goal of the defense mechanisms, according to Freud, is to satisfy our id- and superego-driven instincts while reducing -- or, if we're lucky, avoiding -- punishment and guilt. If we express our instinctive urges as desired by our id, we'll often be punished by society

for breaking its laws. If we recognize those instinctive urges and try to act only for the benefit of others -- as urged by the superego -- we feel guilty when we are unable to match all of the superego's urgings.

And the therapy? Psychoanalysts try to get the patient to review earlier moments in life. They attempt to increase his or her understanding of the sources of the urges within. In theory, if this examination leads to catharsis, this will release the psychic energy that was previously devoted to controlling earlier psycho-sexual conflicts. Accepting the important role of conflict in the personality as described by Freud, certain learning theorists have developed by far the most sophisticated theoretical explanation of the basics of conflict.

**Conflict: Views of Social Learning/Behavioral Theorists**

Many theoretical treatments of conflict seem to describe conflict in passing rather than as a central theme. In contrast, the learning-based theory of Dollard and Miller explains the operations of conflict in terms of five basic assumptions, listed in Table 15.2. Using these assumptions, we can identify several common forms of conflict with which we all must deal day by day.

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**Table 13.2**

*Social Learning/Behavioral Theory Assumptions about Conflict*

<b>ASSUMPTION</b>	<b>EXPLANATION</b>
APPROACH GRADIENT	Our tendency to approach a positive goal or stimulus increases as we get nearer to it.
AVOIDANCE GRADIENT	Our tendency to avoid a negative stimulus or goal also increases as we get nearer to it.
RELATIVE INTENSITY	Our tendency to avoid increases faster than our tendency to approach as we get nearer the goal or stimulus.
DRIVE LEVEL	Increasing our drive level (or level of

increase arousal) associated with a goal will the overall tendencies to approach and/or avoid the goal. Such an increase will also increase the intensity of any conflict which is experienced.

CONFLICT When conflict exists between two response tendencies (either to approach or to avoid), the stronger of the two tendencies will occur.



(1) Approach-approach. Suppose you've just dropped your coins into a soft drink machine. You can't decide between a Coke and a Sprite. That's really conflict in name only. There's no reason to avoid either one, as seen in the Figure. As soon as you start leaning toward

(preferring) one or the other, the approach gradient for that goal will take over, and you will approach (select) whichever you desire at the moment.

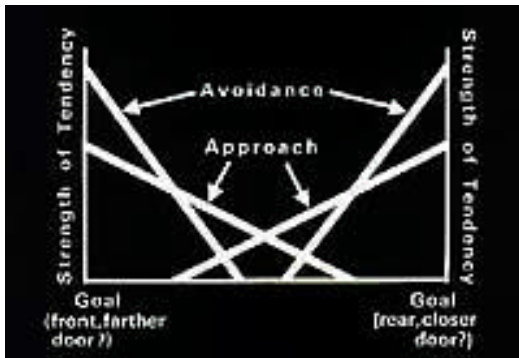


(2) Approach-avoidance. You've been gaining weight recently, so you decide to go on a diet. So far, so good, but the thing that made you gain was your love of eating. If you've been on your diet just a week, you will still be faced with an approach-avoidance conflict when you sit

down to eat. As diagrammed in the Figure, the approach tendency is to eat; the avoidance tendency is to cut down on the food you're eating. You will experience the point of maximum conflict when the tendency to approach is exactly countered by an equal tendency to avoid. At that point you will show indecision and vacillation ... Should I eat? Or should I not eat? I want it! I shouldn't!

What course of therapy would the graphed analysis suggest be used in this situation? In addition to aiding a client in

understanding the sources of his or her conflict, a behavioral therapist would attempt to reduce the drive level or desire expressed in a conflict between the two choices. Would it be better to elevate the positive aspects of dieting (the avoidance gradient), or would it be better to try to reduce the positive aspects of eating (the approach gradient)?



Assuming the client does want to continue dieting, the graph suggests it's better to cut the positive aspects of eating, rather than emphasizing its negative aspects. Why? By cutting the positive aspects you are (1) moving the site of conflict further from the goal, and (2) reducing the total

drive level (strength of tendencies) associated with the conflict. Once the avoidance gradient dominates: No conflict!. Although the conflict may still be experienced, it wouldn't be so intense. Another example of this is contained in the Think About It.

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**Think About It**

**The question:** We described someone who had made a bet with a good friend about losing weight. As time went on the person found it harder and harder to continue losing weight, and the more he tried the jumpier he got. *How can this be explained? Can anything be done to get back on the track toward losing weight?*

**The answer:** The behavioral theories seem to offer the most direct explanation for what's occurring here. Obviously, for the person described there is an approach-avoidance conflict situation. Eating has long been a favorite activity, so food is an attractive goal for him. Yet, losing the body weight is also an attractive goal. The thought of not being able to go to the dance with his girlfriend is boosting his motivation to try to achieve his half of the bargain. Thus, his drive level is steadily increasing.

The best favor he could do for himself would be to reduce his anxiety. He should tell his girlfriend that the bet is off. That will reduce the intensity of the approach-avoidance conflict he's experiencing, and let him concentrate more on the more important task of losing weight.

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(3) Avoidance-avoidance. Suppose you had to study for both a psychology and an English exam, as seen in the Figure. If you were doing poorly in both courses, then you might want to avoid

both of them. In this conflict you'd tend to remain about halfway between the two decisions. Here we often see a response called "leaving the field." Are you having tests in both psychology and English? Do you need to study for both? Well, let's go to a movie!. . . . It's called "caught 'twixt the devil and the deep blue sea"!

(4) Multiple approach-avoidance. This is a very frequent type of conflict in human experience. Suppose you want to buy a car. You have two choices, and each has strengths and weaknesses. One car is cheap to run but looks terrible; the other is expensive but good-looking. If you choose one of them, you lose the other -- a common problem when faced with a double approach-avoidance problem.

In contrast to this behavioral analysis based on learning and drive level, conflict plays an unusual role in Carl Rogers' person-centered theory. You may perceive your self as being happy and carefree. Conflict-called incongruence by Rogers-may be encountered when you notice through your experiences that you are really feeling sad, and that your perception of being carefree is only a way of protecting yourself from hurt.

Rogers' theory describes a search for authenticity as an attempt to resolve any such conflict. For Rogers, therapy is a place where it is safe to explore our genuine feelings and experience them appropriately. When our experience is consistent with our feelings, and we are able to communicate those feelings, "congruence" has been achieved.

## **Common Factors Across Therapies**

The major underlying element common to all therapeutic techniques is the recognition that human behavior can be changed. The means for changing behavior may vary, but not the most basic assumption that the task is achievable. Another similarity is that client and therapist are seeking information about the source of a problem and/or how best to change abnormal behavior. From this knowledge, ways to alter behavior are developed.

The following factors occur widely enough to be viewed as common to all forms of therapy you are likely to encounter:

(1) The psychotherapist accepts you (or, the client) as a human. The client is valued as a person and is provided assistance in solving a behavioral problem. The primary exception to this is the Rational Emotive therapist, who accepts the client as a person but actively rejects the client's faulty beliefs.

(2) The therapist in seeking the source of the difficulties and/or changing the abnormal or troublesome behavior offers you guidance.

(3) The psychotherapist maintains encouraging, supportive detachment. The therapist is accepting of you as a person, nonjudgmental of your actions, fears, dreams, and behaviors. The therapist is not emotionally involved in your despair or your concern with your problem. Again, the possible exception is the Rational Emotive therapist, who may be disagreeing violently with some of your beliefs.

(4) Your psychotherapist is ethically bound to maintain a proper social distance from you. The client-therapist relationship is a professional one. In fact, the relationship between client and psychotherapist is governed by ethical and legal restrictions very similar to those that exist between patient and medical doctor.

(5) Finally, all of the psychotherapies are based on the assumption that psychotherapy is a cognitive activity. With the possible exception of certain operant-conditioning procedures, all therapies involve talking, thinking, verbal skills, and analysis. Despite these major sources of agreement, analyzing the relative effectiveness of various forms of therapy has proven to be a very difficult task.

### **Problems in Evaluating Psychotherapy**

In spite some shared assumptions about human behavior, one of the continuing problems in evaluating the effectiveness of various forms of psychotherapy is an inability to identify a basis for evaluation with which differing psychotherapists will agree. Should we judge by a client's own reports of improvement? Disappearance of symptoms? The efficiency of various therapeutic techniques? The client's family -- who are often paying the bills?

Another problem involves theoretical differences. A behavioral therapist would be satisfied to show the removal or blockage of a symptom, whereas a psychoanalyst would feel that without the patient's gaining insight, the symptom must reappear -- even in some other form.

A third problem is finding objective judges. Who can best judge the effectiveness of a therapy? The client may unconsciously want rapid or delayed recovery. No therapist would devote his or her life to a therapeutic technique and then acknowledge it doesn't work. How about asking the patient/client's family? They may be the best judges because

they will continue to live with the person and thus be able to detect a return to normal behavior.

Is psychotherapy effective? Essentially, yes. After very pessimistic reports in the early 1960s about the apparent lack of effectiveness of traditional forms of psychotherapy, the results in the past decade have been much more encouraging. A statistical technique called meta-analysis permits effective, controlled comparisons of therapy and non-therapy groups.

How effective is psychotherapy? First, as one psychologist has suggested, psychotherapy in almost any form is more effective than unplanned help or no help. Second, no particular technique seems consistently best in treating disorders; however, other psychologists would argue that more intense forms of therapy are most likely to lead to permanent improvements. Third, clients who show early improvement tend to retain that improvement. Finally, the personal characteristics of the client and the therapist and the nature of their interaction are more important than the form of psychotherapy. Most effective is an eclectic approach in which these personal factors are all considered in choosing a form of therapy.

### Mental Health

Even though we spend almost three chapters talking about mental disorders from theory to therapy, these problems affect only a minority of people. It seems fitting to take a moment to mention mental health, which concerns all of us, and what we can do to maintain it. Day to day, the problems with which we must deal cover a wide range -- from how to handle the frustrations of everyday life to the anxieties generated by neurosis, from dangers of schizophrenia to those milder problems associated even with a common problem such as shyness.

What is mental health? What are the things a professional psychologist might look for in deciding if you are mentally healthy? There are at least seven factors that can be identified. These are listed with a brief description in the Table 15.3.

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**Table 15.3**

*To Be Mentally Healthy is To Be . . .*

<b>CHARACTERISTIC</b>	<b>HOW TO IDENTIFY IT</b>
EFFECTIVE	Behavior is goal-directed, intended to reduce problem

	sources by direct attack. Attempts are made to overcome sources of tension and fear.
EFFICIENT	No time is wasted in meeting one's responsibilities. Undue effort is not spent on hopeless tasks. This leads to a savings of energy and effort used otherwise in erecting defenses to justify an inability to achieve what couldn't be achieved anyway. Use of energy thus becomes efficient.
APPROPRIATE	Thoughts, feelings, and actions are adjusted to situations and include a recognition of the age, level of maturity, and skills of another person. Fear, worry, and tension are experienced, but don't become the focus of all an individual's efforts.
FLEXIBLE	Adaptation is a key to mental health. When facing conflict or frustration, the person recognizes the problems and deals with them by seeking alternate routes or means to the goal.
ABLE TO LEARN	The mentally healthy person continually adjusts to his or her environment and profits from each experience. There is no intent to commit the same mistake over and over again, but rather to adjust behavior in light of past experience.
INTERPERSONALLY EFFECTIVE	Can deal successfully with other people. Such a person strikes an appropriate balance between give and take -- yielding neither to personal greed nor the whims of others.
SELF-SECURE	Has a firm sense of self and of security based on realistic assessment of strengths and weaknesses.

(Adapted from Coleman, 1975, pp. 48-49.)

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Today we are seeing more focussed attention on mental health and on efforts designed to prevent emotional breakdowns. More emphasis is being given to psychology in high schools, and to education about mental health in the home, the school, and the community -- preventive therapy, if you want to think of it that way. On college campuses it is now common to find depression screenings offered campus-wide a couple of times a year. In outreach efforts college and community counseling centers often offer a wide range of readily available low cost or free seminars on dealing with parents -- or dealing with children! -- test-taking anxiety, math anxiety, dealing with sexual issues, dealing with drugs. . .

Psychology is now among the most popular subjects offered in college, and substantial numbers of people take graduate training in psychology. These students, as they complete their

work, are moving out into the community and increasing the breadth and depth of available psychological services. In addition -- parallel with efforts in medicine -- paraprofessionals are being used in supervised roles in counseling, in telephone advice services as described in the illustration, and in a widening range of public outlets. Depending on the nature and severity of the problem you are experiencing, you might -- in a professional counseling situation -- find yourself dealing with a wide range of helping personnel. These could range from a paraprofessional with less than a complete undergraduate degree (for instance, on a drug-crisis hotline) or someone with a Master's degree hired by a supervising psychologist to conduct interviews and/or administer tests, to a doctoral-level psychologist.

### **How Should you Handle Frustration?**

Even with relatively good mental health many of us behave in certain ways that don't really do us much good. At times these behaviors can even be self-destructive. One feeling that often provokes unusual behavior in ordinary situations is that of frustration.

There are many different forms of frustration with which we must deal. The "frustration" may actually be something beyond our control. Sometimes we simply feel frustrated internally, but at other times we act frustrated -- angry, withdrawn, stressed. What is our most likely response? Unless we're prepared for the frustration, we are inclined to fight back, to be aggressive. However, there are several better responses we could make. Following are some suggestions as to how you can handle the problem of frustration when you face it.

(1) Channel the aggression. Aggression isn't a very effective response to frustration. Rather, the energy being spent on aggression should be redirected. Seek additional help. For instance, if you have a big job to be done and a fast-approaching deadline, then contact some friends and get the extra help you need to get the task finished. Sometimes frustration comes because we're "too close" to the problem. The old saying of "not being able to see the forest for the trees" applies here. If someone insults you, it's quite "natural" to want to lash back, but pause for a moment first and ask yourself what led that person to insult you. "Counting to ten before screaming" has much the same effect. It allows you a moment to consider a more rational plan of action.

(2) Work around anxiety. Defense mechanisms are usually bad, especially if they encourage you to continue your day-to-

day activities without assessing the cause of your problem. However, as a means of dealing with occasional frustrations, the defense mechanisms have something to recommend them. For instance, rationalization involves justifying your actions somehow in such a way that you don't feel guilty about the way you're behaving. If such behavior is not at the expense of others, then rationalizing what you are doing to keep from being frustrated may yield mental health, without qualifying you as mildly disordered.

The same logic also applies to compensation. In certain situations, when we realize our shortcomings -- and those usually are frustrating -- it may cause us to try all the harder to achieve and excel in another activity. In that sense, if frustration leads to compensating activity in another arena, no damage is done and considerable progress can result.

(3) Withdrawal with a difference. A third way to respond to frustration is to back away. Flexibility in achieving one's goals may often yield far greater returns than rigid adherence to what may later prove to be the wrong set of intentions. Finally, if it is true that your progress toward a legitimate goal has been blocked, then frustration might be the logical response. But it may be a lot wiser to look for alternative paths by which to achieve the desired goal. Are your parents discouraging marriage right now? Consider enrolling in the same college as your boy- or girlfriend, or one nearby. It'll get you educated, keep you together, and allow you to share a lot more experiences with which to demonstrate to parents -- and self alike -- that the love is genuine. Make a short-term sacrifice for a long-range gain. We're probably the only organism in existence that really understands that concept -- and benefits from it!

### **USING PSYCHOLOGY: Can You Cure Shyness?**

In this chapter we examine frustration, a problem that most of us experience many times in our lives. Here we'll discuss an area of mental health that is often of special concern to adolescents late adolescents, and even adults -- though the source of the problem often stretches well back into childhood.

Shyness is a common problem that many of us must learn to handle. In a survey of almost 2,500 American college-age students, one researcher found 73 percent -- almost three-quarters -- felt that at some point in their life they had been shy. In fact, at the time they were surveyed (around the age of 20), 44 percent of the men and 39 percent of the women still labeled themselves as shy.

What, exactly, is shyness? It's not easy to identify since it takes many different forms. There are several different behaviors that seem to shout "I'M SHY!": not speaking up in groups; looking down; standing or sitting at the back of a group out of the focus of attention, to name a few.

Perspiring and blushing are physical signs of anxiety that are detectable by anyone paying attention to the shy person. Butterflies in the stomach, pounding heart are internal symptoms similar to what happens any time any of us experiences a general arousal. If you are shy, you know the sense of self-consciousness that accompanies the condition. Am I sweating? Do my trembling hands show? Is it obvious I'm standing here in the corner?

Reducing or overcoming shyness is not easy. However, it can be achieved if a person starts with a commitment and a willingness to make several major changes in his or her style of living.

The factors that have influenced anyone to learn to be shy can just as well be unlearned. Activities that you control can be used to change your self-image, your behavior, and the way other people think about your shyness. In one sense, the attitude you have toward your shyness is the most important aspect. For example, if you are going to a dance, then where do you sit (or stand)? If you behaved in your usual way, of course, you'd sit in a remote location. That would ease your embarrassment, and reduce the amount of contact you have with others at the dance. However, sitting in an out-of-the-way place would also make it difficult for anyone even to ask you to dance, and create in others the impression that you really don't feel like dancing. Thus, to get rid of your shyness you must deliberately take steps to change (1) the way you think about yourself and (2) the way you behave. This will help people change the way they think about you and make it easier for you to be less shy next time. Shyness is a problem that is learned. Positive steps can be taken to reduce it.

## REVIEW

### CAUSES OF ABNORMAL BEHAVIOR

1. Name some of the possible causes of abnormal behavior and provide examples.
2. Compare and contrast the two major views or models of abnormal behavior. Describe the approaches each recommends.
3. Why is personality theory important in treatment?

4. Describe some of the varying formats in which therapy may be given.

5. What are some of the advantages of a team approach to treatment?

#### FORMS OF PSYCHOTHERAPY

1. How have public attitudes toward abnormal behavior changed over the

past several hundred years?

2. Describe the advantages and disadvantages of the different physical therapies.

3. What is involved in psychoanalysis?

4. Describe three important qualities of person-centered therapists.

What influences do these qualities have on the progress of a client

in therapy?

5. Name and explain the types of social learning or behavioral therapy

that are based on classical conditioning.

6. What techniques in therapy are based on operant conditioning?

7. Name a type of cognitive therapy and describe the view its

proponents take on how abnormal behavior develops.

#### CONFLICT -- A THEORETICAL ANALYSIS

1. Describe how the different personality theories view conflict.

2. Name and explain the types of conflict described by social learning

(behavioral) theorists.

#### COMMON FACTORS AND PROBLEMS IN EVALUATING PSYCHOTHERAPY

1. What assumptions do all the therapies described in this chapter have

in common?

2. Name four or five typical characteristics of therapists in their

client-therapist relationships.

3. What are some of the difficulties in evaluating the effectiveness of

psychotherapy?

4. Is there any "best" therapy? Why or why not?

#### MENTAL HEALTH

1. How is our concept of mental health changing?
2. Describe some constructive ways to handle frustration.
3. Describe some constructive ways to reduce shyness.

### **ACTIVITIES**

1. Many times when people tell us about problems they are having, we have been trained (often without our awareness) to play down the problem. Someone says she feels terrible because she did poorly on a test. The reply you often hear is, "Oh, don't worry about it." A more supportive response would be, "You seem worried . . ." Keep a record for a week of conversations you overhear or take part in where a problem is mentioned and immediately glossed over or minimized. Identify examples where a more supportive comment might have been more appropriate. What do you find? Do people tend to respond to one another only socially, without really helping to solve one another's problems?

2. There are many different groups to help people who have a behavioral problem. Examples include Alcoholics Anonymous, Weight Watchers, Gamblers Anonymous, Al-Anon (for the families of alcoholics), Parents Anonymous (for those with problems involving child abuse or parenting), Barriers for Free Living (for those who are partially disabled), and Lighthouse for the Blind. Contact a representative from such a group to learn about the kinds of problems-in-living the group is intended to handle, and what treatment or therapeutic strategies it suggests.

3. Systematic desensitization involves learning how to relax. This is done first by learning how to sense when you are tense, and then practicing strategies for relaxing. Pick a muscle group (such as your jaw muscles) and clench them as tightly as you can. Continue to do so until your muscles ache, really ache. Then relax your jaw, and let your mouth hang down on your chest. Concentrate on what you do in order to relax those muscles; learn relaxation as a new response. Repeat this process with every muscle group you can think of, starting from your head and moving toward your feet. It may take an hour or more to do all of them. Tense, create the pain, and then relax, concentrating on what you do in order to relax -- your main goal. Then, the next time you feel yourself getting tense -- as you start an exam, perhaps -- practice your new relaxation skills. It should help your performance, and certainly your endurance.

4. Try taking a poll of your family, your friends, or fellow students who are not in your psychology class. Ask them to define what they consider to be normal, healthy behavior. Record their definition and list each behavior they mention.

5. Join the volunteer program of a local mental hospital conducting work, physical, or play therapy programs. Talk with a staff member about the limits imposed by the patient's right to privacy, and about how those rights are respected. Write a summary of your experiences. Consider: What impact did your visit have on the patients? What examples did you see of the application of psychological principles in the wards? Do you think the environment of the mental hospital itself causes people to behave abnormally? If you found yourself in a mental hospital, how would you try to behave in order to be released?

### **INTERESTED IN MORE?**

BANDURA, A. (1969). *Principles of Behavior Modification*. Holt, Rinehart & Winston. Discusses how to change behavior, from a social-learning point of view. Stresses the roles of observation and self-regulation.

COLEMAN, J. C. & GAROS, A. G. (1983). *Contemporary Psychology and Effective Behavior*, 5th ed. Scott, Foresman. Examining social and personal environments, these authors suggest ways to achieve maximum personal growth and effectiveness.

COREY, G. (1977). *Theory and Practice of Counseling and Psychotherapy*. Brooks/Cole. An excellent source describing how various theories can be applied to a specific behavior problem. Shows how various psychotherapies derive from personality theories.

LAZARUS, R. S. (1976). *Patterns of Adjustment*, 3rd ed. McGraw-Hill. Includes a discussion of successful adjustment to stress. Reviews various models of success and failure of adjustment and gives a brief analysis of failure.

MARKS, J. (1976). *Help-A Guide to Counseling and Theory Without a Hassle*. Messner. Writing for students, the author describes forms of psychotherapy and tells how to go about getting help.

MARTIN, G. & PEAR, J. (1978). Behavior Modification: What It Is And How To Do It. Upper Saddle River, NJ: Prentice-Hall. Presents the principles of behavior modification, from basic concepts to their application to complex problems. Includes discussion of observation skills.

PERVIN, L. (1978). Current Controversies and Issues in Personality. New York, NY: John Wiley and Sons. A short, challenging book that discusses a wide range of problems, from caring for the mentally ill to analyzing why people don't offer help. To guide the reader, a series of questions opens each chapter.

PRICE, R. H. & DENNER, B., eds. (1973). The Making of a Mental Patient. Holt, Rinehart & Winston. Traces the stages of mental illness from first detection to hospital commitment. Gives strategies for survival.

SCHULTZ, D. (1977). Growth Psychology: Models of the Healthy Personality. D. Van Nostrand. This short book picks up on Maslow's concept of a healthy personality. Covers various theories about how a person can develop one.

SZASZ, T., ed. (1973). The Age of Madness. Anchor Books. Szasz suggests that society decides what is "normal" to protect itself and fails to recognize the needs of the involuntarily committed "mentally ill." He uses literature and personal stories to support his position. Interesting reading.

VISCOTT, D. S. (1972). The Making of a Psychiatrist. Arbor House. Light reading on a heavy subject. Presents an overview of one psychologist's training and experience.