ESSENTIAL PSYCHOLOGY

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2ND EDITION

SAGE
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INTRODUCTION

Have you ever spent time wondering whether you were normal? Or been told that you are ‘not normal’? But then, what is normal? This is a question that has been puzzled over for many years. While many people believe they can recognise abnormal behaviour, psychopathology is a deceptively difficult concept to define. Ultimately, it comes back to answering the question: What is normal? This is not so easy in today’s society, which has so much variety and freedom in how we behave.

Psychopathology is the study of psychological disorders: why they occur (aetiology), what they look or feel like (symptoms) and how they affect people’s lives. Nobody is immune, with all ages, races and differing social groups being shown to be affected by some form of disorder. Alonso et al. (2004) proposed that, throughout our lifetime, 25% of people experience a psychological disorder. This chapter will look at what we mean by psychopathology, the role of culture in its formation, how it is assessed, and take a more detailed look at some of the most prevalent types of the hundreds of psychological disorders detailed in the current diagnostic manuals. First, we would like you to consider the following framing questions before you go on to read about the concept of psychopathology.

FRAMING QUESTIONS

- How does society define normal and what role does culture play in how we define normal?
- How do clinicians (as in psychiatrists and psychologists) define a psychological disorder? Is it possible for them to disagree?
- What is the difference between eccentric and disordered? How has this changed over time?
- How might a psychological disorder change throughout somebody’s lifetime?

THE CONCEPT OF PSYCHOPATHOLOGY

The study of psychological disorders has historically been referred to as abnormal psychology. But over the last decade this has become increasingly referred to as psychopathology or psychological disorder, and both terms are used interchangeably throughout this chapter.

THE CONCEPT OF ABNORMAL

One of the hardest things about looking at psychopathology is trying to define abnormal. When asked to define ‘abnormal’, people may say it is behaviour that is happening infrequently, is dangerous or simply odd or bizarre. Although, these may all be reasonable answers for certain types of abnormal behaviour, none is sufficient in itself; plus, making all of these aspects compulsory in the definition makes it a very specific definition. An early way of defining ‘abnormal’ was through ascertaining whether the behaviour caused impairment in the person’s life. The more the behaviour was seen as hindering daily functioning, the more likely the behaviour was to be classed as abnormal. When several such abnormal behaviours occurred, this was thought to constitute a disorder. More recently, however, there is an increasing view that using the term ‘abnormal’ is unhelpful (Cromby, Harper, & Reavey, 2013: 12) as psychopathology is common, and such terminology could be seen as increasing stigma and marginalising people who experience mental health difficulties.
24.2.2 THE IMPORTANCE OF CULTURE IN PSYCHOPATHOLOGY

Within a society there is often a diverse mix of moral, social, religious and political beliefs. One important question to consider is whether different societies draw the same line between wellbeing and distress or ultimately sanity and madness. The current diagnostic systems rely on agreement being reached about what disorders look like, what to call them and how best to manage and treat them, but what if different societies and cultures view these concepts and behaviours differently? If the variations are too great, does this make a universal model of psychopathology problematic?

An example of how culture can affect psychopathology is illustrated by recent development in China. In the late 1970s China brought in a system for classifying psychological disorders, based on the Western Diagnostic and Statistical Manual (DSM). After it was introduced, the prevalence rates of clinical depression increased dramatically over the following 25 years (Kleinman, 1997). Does this mean the Chinese population were becoming increasingly depressed or was it due to the introduction of Western-influenced assessment and diagnosis systems?

Further evidence for the effects of culture can be seen in disorders that are more prevalent in or even unique to particular cultures. Staying with China, there are diagnoses that are seen much more commonly in China and other Asian cultures, such as Koro or genital reaction syndrome, where the person has an excessive fear of the genitals or of breasts shrinking or drawing back into the body. In the USA, there used to be a diagnosis of drapetomania, which described an irrepresible desire of a slave to escape slavery. Clearly, we would see this as a sign of bravery rather than insanity today. This is due to a shift in cultural attitudes regarding slavery, as opposed to changes in scientific or medical thinking. Culture can therefore also be seen to shape definitions of psychopathology.

Different cultures also make sense of mental illness in differing ways, this having implications for how they assess and treat conditions (Tseng, 2001). Spirit possession, for example, which is common in parts of Africa, Asia and the Middle East, is often associated with particular religious beliefs and in some communities revered as meaning the individual has higher powers. However, in more Western societies, the thoughts and behaviours which may be seen with ‘spirit possession’ may be perceived as a psychiatric or neurological disorder that requires medication. When considering the relationship between culture and psychopathology we must consider particular traditions and customs and how they may play a role in the development of the defining of specific mental health conditions.

KEY STUDY


While debate about the validity and reliability of psychopathology rolls on, there have been few large-scale studies which attempt to quantify its prevalence within the UK. One of the first was this study, which interviewed over 10,000 randomly selected members of the British public screening for a range of psychopathology. After the study, the authors proclaimed that for the first time data could be provided on the prevalence and correlates of psychiatric disorder nationwide.

24.3 DEFINING PSYCHOLOGICAL DISORDERS

Returning to the issue of ‘abnormality’, many definitions have developed over the years, though none is universally accepted (Pierre, 2010). However, there are key features that appear across the board, and these have become known as the *Four Ds*: deviance, distress, dysfunction and danger.
Deviance refers to emotions, thoughts and behaviours that are thought to be abnormal when they vary from a society’s idea about appropriate functioning. A society in which competition and dominance is embraced would see an aggressive personality as normal, whereas a society that values compassion and cooperation may consider aggression not only unacceptable but abnormal.

Distress refers to a personal sense of suffering. For many people with a disorder, one of the most common reasons they access support services is that the disorder causes them distress. This does not have to be physical because psychological disorders primarily result in distressing emotions, thoughts or moods.

Dysfunction refers to the disordered behaviour that often brings with it some level of interference in functioning. To meet the criteria of a disorder, this interference has to be to the level that it affects somebody’s daily life (though not necessarily every day). Disordered individuals will not normally be able to take care of themselves properly, interact appropriately with others or work effectively when unwell.

Danger refers to a potential for harm. Some people with psychological disorders become dangerous to themselves or others, though it is important to highlight that not everybody with a psychopathology presents with risky behaviours at all times. Danger is often cited, especially in the media, as a core feature of psychopathology. However, research indicates it is the exception rather than the rule (Hiday & Burns, 2009).

Using these four constructs, it is clear that the definition of abnormality relies heavily on social norms and values. However, societies still appear to have difficulty distinguishing between an individual who has a psychological disorder and someone who could be labelled eccentric: there is a fine line between madness and eccentricity. We may all know somebody who might be classed as odd or strange (look no further than our staff corridor – Eds), for example, the old woman who lives at the end of the street with two dozen cats yet talks to no one. While her lifestyle may not be your idea of normal, does this make her disordered? The behaviour of such an individual may be classed as different from the norm, but unless it leads to clear distress and dysfunction, most clinicians would judge it to be eccentric rather than abnormal.

EXERCISE: ECCENTRIC OR DISORDERED?

Table 24.1 details a number of real-life cases of people who have displayed eccentric behaviour. But, using the Four Ds model, would they be classed as disordered? It is your turn to play the psychiatrist and decide if you would diagnose them with a disorder or not.

24.4 CLASSIFYING AND DIAGNOSING PSYCHOLOGICAL DISORDER

A symptom is a physical, behavioural or mental feature presented by a person that helps indicate a condition, illness or disorder. So, for example, the symptoms of what is commonly known as hay fever would be itchy, watery eyes or a runny nose. For psychopathology, one of the problems with recognising symptoms is that they are not usually physical but rather in the mind, and are therefore not always obvious to the observer. For example, poor concentration may be a symptom of anxiety or if someone reports they are having visual hallucinations this might or might not indicate schizophrenia. These are both symptoms that, unless expressed by the sufferer, would not be obvious to the clinician. However, when certain symptoms regularly occur together and follow a particular course, clinicians may agree that the grouping makes up a specific disorder. The list of all the disorders that the clinicians might use to diagnose is called a classification system.
In the nineteenth century, Hetty Green was known in the city where she lived as the ‘eccentric’ miser as she was extremely wealthy yet went to great extremes to save money. When her son fell ill she disguised herself and took him to a charity hospital, but when she was recognised, she fled with her son, claiming she would treat him herself. Unfortunately, the son contracted gangrene, which resulted in him having his leg amputated. Hetty Green always wore the same dress and underwear, only purchasing new clothing when she had to throw the other out.

Simeon Ellerton was an eighteenth-century fitness fanatic who loved to walk long distances, often being employed to walk distances as a courier for the locals. On many occasions he would gather stones from the roadside and carry them on his head. His goal was to collect enough stones to enable him to build his own house. Eventually, he reached his goal and built his house, but after carrying the stones for so many years he felt strange without them and for the rest of his life could be seen carrying a large bag of stones upon his head.

Sir George Sitwell was a keen gardener and so annoyed by the wasps in his garden he spent many years devising a pistol to shoot them. Other eccentricities included trying to pay his son’s school fees in carrots (even though he was very wealthy) and having all the cows on his estate stencilled in a blue and white Chinese willow pattern in order to make them ‘more pleasing to the eye’. The sign that hung on the gate to his house stated ‘I must ask anyone entering the house never to contradict me or differ from me in any way, as it interferes with the functioning of my gastric juices and prevents my sleeping at night’.

William Buckland became famous because of his love of animals and food. He claimed to have eaten every species of animal on the planet and would host dinner parties where he would only reveal to his guests what they had eaten after they had eaten it. For interest, he reported that a common garden mole and a bluebottle were the most disgusting things to eat.

David George was a gentleman who, by his own admission, was obsessed with Robin Hood, so much so that he legally adopted the name. He lived in Sherwood Forest, albeit in a semi-detached house, and wore every day a green jumper, trousers and hat and carried a makeshift cross-bow, just not when he was working as a telephone engineer!

The classification system for psychopathologies that is used by most countries throughout the world is the International Classification of Diseases (ICD-10); it is published by the World Health Organisation. ICD is now in its tenth edition with an eleventh edition expected shortly. In the USA, the Diagnostic and Statistical Manual of Mental Disorders (DSM) is published by the American Psychiatric Association (and this is also widely used in the UK and the remainder of Europe). The most recent (fifth) version was published May 2013 and has introduced many changes to the categories, symptoms and criteria, which has caused a great deal of controversy.

When clinicians decide that a person’s symptoms fit the criteria for a particular disorder, they are making a diagnosis. Most clinicians will use the DSM or ICD to help them with this process. Assigning a diagnosis suggests the client’s pattern of dysfunction is the same as the patterns of symptoms displayed by others with the same disorder. Clinicians can then apply what is generally known from the research about the disorder to the individual.

24.4.1 PROBLEMS WITH DIAGNOSIS

Although mental health terms, such as anxiety, depression and schizophrenia, are common in the media, public discourse and daily conversations, accurate diagnoses of psychological disorders are sometimes quite elusive for clinicians. Even with effective assessment techniques and carefully researched classification categories clinicians sometimes arrive at the wrong conclusion (Fernbach, Darlow, & Sloman, 2011). Most famously, in the study by Rosenhan (1973), eight healthy people presented themselves at emergency psychiatric facilities in the USA saying that they were hearing a voice that said the words ‘empty’, ‘hollow’ and ‘thud’. This did not match any known criteria for a recognised mental disorder but bore a resemblance to an existential crisis. Despite this, they were all admitted with the diagnosis of schizophrenia. While in the hospitals all the pseudopatients behaved as they would in normal life, but many of their behaviours were interpreted as signs of their diagnosed mental disorder. They were released after between seven and 52 days and classified not as cured but as having schizophrenia in remission. It appeared that US psychiatrists were not able to distinguish the same from the insane.
Subsequent studies have revealed occasional errors in assessment and diagnosis, particularly in psychiatric hospital (Mitchell & Coyne, 2010). In an often cited study, skilled clinicians were asked to re-evaluate the diagnoses of 131 patients at a mental health hospital (Lipton & Simon, 1985). Whereas 89 of the patients had originally received a diagnosis of schizophrenia, only 16 received it upon re-evaluation, and while 150 patients initially had been given a diagnosis of mood disorder, 50 received the same label on re-evaluation.

24.4.2 ARGUMENT AGAINST DIAGNOSIS

Simply classifying people can sometimes lead to unfortunate results, with diagnostic labels becoming self-fulfilling prophecies. Once a diagnosis has been made, others may react in ways that actually lead to those diagnosed behaving in more disordered ways, exacerbating the initial problem. Furthermore, our society often attaches a stigma or negative prejudice to mental disorders (Bell et al., 2011; Kavanagh & Banyard, 2014; Rosenberg, 2011). For example, people with such labels may find it hard to get jobs, particularly one with a high level of responsibility. Such a diagnosis would be recorded on medical records and therefore be potentially available to future employees and other interested parties. Some clinicians have argued for doing away with assessment and diagnosis altogether, believing it adds nothing to the process of recovery. If you’d like to read a lively and detailed demolition of the DSM, then pick up Making us crazy by Kutchins and Kirk (2001).

24.4.3 ARGUMENT FOR DIAGNOSIS

There are over 400 psychological disorders within the DSM and as you read through this chapter it will become apparent that there are a number of similarities and crossovers in symptoms. However, it should also become clear

ASIDE

The myth of mental illness

The most common way of looking at psychological distress is to see it as an illness. This means we are assuming that it is a similar experience to a medical illness, such as measles, but is this helpful? In his critique of the medical model, Thomas Szasz (1960) argued that the medical model is unhelpful to our understanding of psychiatric conditions. The medical model suggests that all psychiatric problems will eventually be understood in terms of simple chemical reactions, and that ‘mental illnesses’ are basically no different from other diseases. Szasz argued that there are two errors in this view.

First, a disease of the brain is a neurological defect and not a problem of living. For example, a defect in a person’s vision may be explained by correlating it with certain lesions in the nervous system. On the other hand, a person’s belief, whether this is a belief in Christianity or Communism or that their genitals are retreating into their bodies, cannot be explained by a defect of the nervous system. Some beliefs are perfectly acceptable and some are thought to be a sign of mental disorder, but they are all beliefs.

Second, in medicine, when we speak of physical disturbances we mean either signs (e.g. fever) or symptoms (e.g. pain). When we speak about mental symptoms, however, we refer to how patients describe themselves and the world around them. They might say that they are Napoleon or that they are being persecuted by aliens from another planet. These are symptoms only if the observer believes that the patient is not Napoleon, or not being persecuted by aliens. So to see a statement as a mental symptom we have to make a judgement that involves a comparison of the patient’s ideas and beliefs with those of the observer and of the society in which they live.

Szasz suggests that the idea of mental illness is being used to obscure the difficulties we have in everyday living. In the Middle Ages it was demons and devils who were held responsible for the problems in social living. The belief in mental illness is no more sophisticated than a belief in demonology. Mental illness, according to Szasz, is ‘real’ in exactly the same way as demons were ‘real’.
that each disorder generally needs a different form of treatment to successfully alleviate symptoms or cure the disorder altogether. Some people diagnosed with a disorder also state that they are grateful for the label as it helps them understand symptoms that have previously been unexplained, confusing and even scary. Some clinicians believe, therefore, that classification and diagnosis are essential to understanding and treating disorders and that we should continue to research psychological disorders to improve assessment and diagnostic techniques.

24.5 ASSESSING PSYCHOPATHOLOGY

In order to diagnose, clinicians must fully assess the individual. Clinical assessment is used to precisely identify both the disordered behaviour and the best treatment approach. The clinical assessment tools and techniques that have been developed broadly fall into three categories: clinical interviews, clinical observation and clinical tests. These are detailed below.

24.5.1 CLINICAL INTERVIEWS

Clinical interviews most often happen in a one-to-one setting and they are normally the starting point for most clinicians. They are most useful in eliciting detailed information and give clinicians the opportunity to interact and observe the interviewee fully. Interviews can either be structured (clinicians asking set questions in a certain order) or unstructured (where the clinician will often ask open-ended questions such as ‘why you have come to see me today’).

<table>
<thead>
<tr>
<th>TABLE 24.2</th>
<th>Advantages and disadvantages of clinical interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STRUCTURED INTERVIEWING</strong></td>
<td><strong>UNSTRUCTURED INTERVIEWS</strong></td>
</tr>
<tr>
<td>Advantages</td>
<td>Disadvantages</td>
</tr>
<tr>
<td>Can elicit specific information</td>
<td>Requires more preparation</td>
</tr>
<tr>
<td>Consistency interviewing different individuals</td>
<td>Limits answers of client</td>
</tr>
<tr>
<td>Helps keep to time</td>
<td>Can sometimes feel controlling for client</td>
</tr>
<tr>
<td>Gives interview structure</td>
<td>Led by interviewer therefore can feel intrusive</td>
</tr>
<tr>
<td>Can makes sure all areas of questioning are covered</td>
<td>Limited answers to questions</td>
</tr>
<tr>
<td></td>
<td>Advantages</td>
</tr>
<tr>
<td>Allows interviewer to follow leads</td>
<td>Open more to interpretation</td>
</tr>
<tr>
<td>Can be made client-centred</td>
<td>More open to cultural bias</td>
</tr>
<tr>
<td>Can encourage openness</td>
<td>Requires more skill on part of interviewer</td>
</tr>
<tr>
<td>Less threatening to client</td>
<td>Needs careful management in term of topics and timing</td>
</tr>
<tr>
<td>Needs less preparation</td>
<td>May not elicit required information</td>
</tr>
</tbody>
</table>

24.5.2 CLINICAL OBSERVATION

Another form of assessment of psychological disorders is the clinical observation of behaviour. Observation can be useful in allowing the clinician to observe the individual in their own environment, sometimes allowing for a more thorough understanding of the presenting problem.

This can either be in an artificial setting, such as a therapy office or hospital ward, or a naturalistic environment, where the client is observed in their own home, school or place of work. Observations are normally recorded and can be watched back to give the clinician a clearer picture of the symptoms or behaviours they are assessing. Clinical observations are not without their disadvantages as people may behave differently when they know they are being watched (or assessed) (Lane et al., 2011).

Self-monitoring is a form of clinical observation, but it is where the individual monitors the problematic behaviour or feeling as they occur. In a case of somebody with obsessive compulsive disorder (OCD), this could be recording how many times they wash their hands on a daily basis or how many cigarettes they smoke in a day. Again,
self-report can be highly problematic in relation to changing behaviours. When your doctor asks you how much alcohol you drink or how many cigarettes you smoke a week, are you always honest?

24.5.3 CLINICAL TESTS

Clinical tests are tools that can be used to gather information about a person’s mental functioning. This allows comparisons to be made and conclusions to be drawn about the relevance of a diagnosis or treatment. Such tools can be psychological questionnaires that assess specific domains, such as personality, intelligence or mood, but also encompass neuroimaging, which examines the different structures of the brain. They can be a time- and resource-effective way of gaining the required psychological information and be a more valid and reliable way of assessment than observation and interviews. However, for some tests you need to be a qualified practitioner to administer them, which therefore limits their availability.

24.6 MODELS OF PATHOLOGY

In this section we will look at the differing models used to explain psychopathology. They are used to understand an individual’s disorder and will largely determine the form of treatment recommended. We will explore the medical model, which is more likely to propose medication as the main treatment, and contrast it to models such as cognitive-behavioural and psychodynamic, which advocate more talking therapy approaches. There is more information regarding the differing treatment approaches in Chapter 25.

24.6.1 THE MEDICAL MODEL

Medical practitioners generally view abnormal behaviour as an illness brought about by biochemical or structural malfunction in the brain, chemical imbalances or genetic predispositions (see the Aside above for a challenge to this view). The evidence has largely come from correlational studies which, while showing a relationship between the two areas, have not been clear on whether it is the deficit that causes the disorder or the other way round (Shah & Mountain, 2007). Advocates of this model also link mental disorder to either an excess or deficit of differing neurotransmitters or hormonal activity within the endocrine system, which consequentially inhibits brain functioning (Uher & McGuffin, 2008). Depression, for example, has been linked to insufficient levels of the neurotransmitters noradrenaline and serotonin as well as increased levels of the hormone cortisol (Fava, 2002).

The genetics of psychopathology also come under the medical model. Studies have found that the genes you inherit may play a part in schizophrenia, Alzheimer’s disease, mood disorders, intellectual disability and other mental disorders. Oksenberg and Hauser (2010) state that there is no single gene that has been found to be responsible for a specific disorder, but instead that many genes combined may be attributable to a specific dysfunction.

Viral infection also adds weight to the medical model argument in relation to psychopathology. Research suggests that hallucination symptoms experienced in some individuals with schizophrenia may be related to exposure to certain viruses before, during or after childhood (Fox, 2010). Similar links have been made to anxiety and mood disorders (Fox, 2010).

24.6.2 THE COGNITIVE-BEHAVIOURAL MODEL

The cognitive-behavioural model proposes that psychological disorders result largely from a combination of problematic thinking patterns and learnt behaviours that mutually influence each other. According to this model, people’s particular way
of thinking affects their behaviours, with the behaviours in turn reinforcing thinking, leading to a vicious circle in which people feel trapped. For example, an individual with anxiety may have some physical symptoms of anxiety, such as sweating, palpitations, tightness of chest. These could be related to a range of conditions but, for a student with anxiety and with imminent exams, the first thought (called ‘automatic thoughts’) may be that they are going to fail their exams and therefore they revise all night for a week. The student then falls asleep in the exam and fails, but feels this is down to their lack of revision and thinks that for their next exam s/he needs to revise harder! And so the cycle continues.

Cognitive-behavioural theorists also view emotions as integral to this cycle, with emotions interacting with both the thoughts and behaviours to produce dysfunction. The behaviours and the thinking patterns behind them (the cognitions) are focused on within cognitive behavioural therapy (CBT). Within this theory, thinking patterns are seen as a key factor in both normal and abnormal behaviours and disorders, with research showing that people with psychological disorders often display varying thinking errors and beliefs (Sharf, 2011).

### 24.6.3 Humanistic and Existential Models

Humanists believe that all of us are born with the potential for goodness and growth (Maslow, Frager & Cox, 1970). They feel that this can be achieved if an individual can accept their strengths and weaknesses and live by positive personal values. According to the humanist model, it is when people constantly deceive themselves and create a distorted view of the world that they are likely to experience some degree of psychological disorder.

One of the pioneering humanists was Carl Rogers (1951), who felt that it is when the basic need for unconditional positive regard from others (in particular, parents) isn’t met that psychological disorder may occur. Rogers believed that children who felt they had to meet certain standards in order to gain love were stopped from meeting their full potential, thus creating a distorted view of themselves and others, and leading to differing levels of dysfunction.

Existentialists agree with humanists in that individuals have a good level of self-awareness and need to live purposeful lives in order to be well adjusted and ultimately not disordered. Existentialists believe that, from birth, individuals have the autonomy either to confront life and give meaning to it or to run away from responsibility, resulting in individuals who are empty, anxious, frustrated or depressed (Yalom & Josselson, 2011). The core of these models is human fulfilment, a concept that is fairly hard to define and research. It is only in recent years that controlled studies have been conducted by humanistic and existential researchers, which in turn have demonstrated the potential value of these models to the assessment and diagnosis of psychopathology. These models are referred to as non-empirical views as they currently lack the support or evidence for their use in assessing and diagnosing psychological disorders. They are grouped together here because of their emphasis on the wider dimensions of human life.

### 24.6.4 The Developmental Model

The developmental model is related to the study of how psychological disorders evolve in relation to a person’s genes and early experiences and, importantly, the knock-on effect on later life (Sroufe & Rutter, 1984). Early problematic behaviours are thought to disrupt functioning as people develop into adult life (Cicchetti, 2010). Developmental psychologists believe that the cause of psychopathology can be a mix of genetics, early childhood experiences and environmental influences – so a bit of everything really!

Supporters of this model compare abnormal and normal behaviour and attempt to identify the differing developmental issues that have contributed to the negative behaviour. These are called risk factors. This allows the clinician to identify what is likely to be making the disorder worse and the risk factors that can be targeted in treatment. Also important within the developmental model is the concept of protective factors. These are factors that reduce the likelihood of disordered behaviour and help somebody build or maintain resilience to their disorder. Advocates of this model believe it is just as important to understand the strengths of an individual as well as their weaknesses.
24.6.5 THE PSYCHODYNAMIC MODEL

The psychodynamic model was initially developed from the theories of Sigmund Freud, who emphasised the importance of the early parent–child relationship. According to Freud, if a child does not successfully negotiate the different psychosexual stages, psychological disorder will develop. Freud proposed that a child’s environment may prevent the development of these differing parts of the mind or hinder their interaction. He went further by suggesting that if this development does not occur, the child becomes fixated at a specific stage and disordered functioning becomes apparent.

Freud also believed a person’s behaviour is determined by an underlying psychological force that they are not aware of, the unconscious. In relation to abnormal behaviour, Freud and the consequential psychodynamic theorists believe that when conflicts arise between the conscious and unconscious parts of the mind that psychological disorders occur. The psychodynamic model has some ardent supporters and critics, but generally research has failed to support the effectiveness of the model in relation to psychopathology diagnosis and treatment (Prochaska & Norcross, 2013). Like the existential and humanist models, it is therefore classed as a non-empirical approach.

24.7 DISORDERS – SYMPTOMS AND CAUSES

There are over 400 disorders in the DSM-5, and unfortunately not enough space to discuss most of them here. Table 24.3 lists the main psychological disorder subgroups and its equivalent using the ICD-10 framework. The

<table>
<thead>
<tr>
<th>DSM-5 GROUP</th>
<th>CHARACTERISTICS AND EXAMPLES OF DISORDER GROUP</th>
<th>ICD-10 EQUIVALENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurodevelopmental disorders</td>
<td>Disorders seen to emerge before adulthood e.g. intellectual disability</td>
<td>Termed ‘Disorders of psychological developmental’, although mental retardation is in its own separate subgroup</td>
</tr>
<tr>
<td>Schizophrenia spectrum and other psychotic disorders</td>
<td>Marked by deterioration of functioning until state of psychosis is reached e.g. schizophrenia</td>
<td>Termed ‘Schizophrenia, schizotypal and delusional disorders’</td>
</tr>
<tr>
<td>Bipolar and related disorders</td>
<td>Marked by severe disturbance in mood that includes depressed and manic mood states e.g. bipolar disorders</td>
<td>Mostly similar to DSM, although they continue to use the term ‘affect’, with depression also appearing under the category and not as a separate section</td>
</tr>
<tr>
<td>Depressive disorders</td>
<td>Marked by sad, empty or irritable mood that affects functioning e.g. major depressive disorder</td>
<td>Depression is mainly divided into a single episode or is recurrent. Classed alongside bipolar, not as distinct subsection</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>Marked by excessive fear and anxiety e.g. phobias</td>
<td>Termed ‘neurotic, stress-related and somatoform disorders’ Also includes somatoform and dissociative disorders within this group</td>
</tr>
<tr>
<td>Obsessive compulsive and related disorders</td>
<td>Characterised by the presence of obsessions and/or compulsions. e.g. obsessive compulsive disorder</td>
<td>Classified under the group ‘Neurotic, stress-related and somatoform disorders’</td>
</tr>
<tr>
<td>Trauma and stressor-related disorders</td>
<td>Marked by psychological distress following a traumatic event e.g. post-traumatic stress disorder</td>
<td>Classified under anxiety disorders with main remit of post-traumatic stress disorder</td>
</tr>
</tbody>
</table>

(Continued)
### TABLE 24.3 (Continued)

<table>
<thead>
<tr>
<th>DSM-5 GROUP</th>
<th>CHARACTERISTICS AND EXAMPLES OF DISORDER GROUP</th>
<th>ICD-10 EQUIVALENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dissociative disorders</td>
<td>Characterised by a disruption in consciousness, memory, identity, emotion, perception and behaviour that affects a person’s functioning e.g. dissociative identity disorder</td>
<td>Similar versions to disorders listed in DSM-5 but classified under anxiety disorders</td>
</tr>
<tr>
<td>Feeding and eating disorders</td>
<td>Characterised by a persistent disturbance of eating or eating-related behaviours e.g. anorexia nervosa</td>
<td>Groups eating disorders under a wide category of ‘Behavioural syndromes associated with physiological disturbances and physical factors’</td>
</tr>
<tr>
<td>Sexual dysfunctions</td>
<td>Characterised by a significant disturbance in a person’s ability to respond to sexual stimulation e.g. erectile disorder</td>
<td>Classified under the heading ‘Behavioural syndromes associated with physiological disturbances and physical factors’</td>
</tr>
<tr>
<td>Disruptive, impulse-control and conduct disorders</td>
<td>Characterised by violation of the rights of others, and brings a person into direct conflict with the society norms or authority figures e.g. pyromania</td>
<td>Same disorders as listed in the DSM but under a different heading: ‘Disorders of adult personality and behaviour’</td>
</tr>
<tr>
<td>Substance-related and addictive disorders</td>
<td>Marked by a cluster of symptoms indicating that a person continues using the substance despite it impacting on their functioning e.g. alcohol use disorder</td>
<td>Similar disorders as termed in the DSM but classified under the heading ‘Mental and behavioural disorders due to psychoactive substance use’</td>
</tr>
<tr>
<td>Neurocognitive disorders</td>
<td>Marked by a decline in cognitive functioning that has not been present since birth e.g. dementia</td>
<td>Similar listing as to the DSM but are referred to as ‘Organic, including symptomatic mental disorders’</td>
</tr>
<tr>
<td>Personality disorders</td>
<td>10 different disorders that are characterised by an enduring pattern of behaviours that deviate markedly from the expectations of the individual’s culture and environment e.g. borderline personality disorder</td>
<td>These have their own category in DSM but in ICD come under ‘Disorders of adult personality and behaviour’. Obsessive-compulsive PD is referred to as Anankastic, antisocial PD as Dissocial, borderline PD as Emotionally unstable, and avoidant PD as Anxious. ICD does not have entries for schizotypal or narcissistic PD</td>
</tr>
<tr>
<td>Paraphilic disorders</td>
<td>Marked by an intense interest that is causing distress or impairment or causing potential harm to others</td>
<td>Paraphilias come under the heading ‘Disorders of adult personality and behaviour’</td>
</tr>
</tbody>
</table>

**FIGURE 24.2** Diagnoses. There are so many diagnoses possible that they are starting to affect the way we view everyday life

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disorders which are considered to be the most prevalent will be looked at in more detail, exploring the symptoms, the differing views on causes and the usual course of the disorder.

This next section will discuss four of the most prevalent types of psychopathology in the UK (Singleton & Lewis, 2003): depressive disorders, anxiety disorders, schizophrenia spectrum and personality disorders.

24.8 DEPRESSIVE DISORDERS

Everybody’s mood changes from one day to the next. We also react with different moods to different things throughout the day. If something were to happen, such as a bereavement, we would expect to feel sad for a short period of time – in fact, we may become worried if we weren’t sad. However, for people with depressive disorders, the sadness can last a long time or seem to appear for no reason at all. Although depressive disorders have some symptoms in common, they are often different in terms of their prevalence and causes.

24.8.1 SYMPTOMS

One of the most serious in terms of symptoms is major depressive disorder. The primary symptom of this disorder is depressed or excessively low mood that goes further than simply feeling sad. Further symptoms may include the following:

- losing interest or pleasure in experiences that are usually enjoyed;
- changes in appetite that lead to significant weight loss or gain;
- changes in sleeping habit, either not getting enough or sleeping too much;
- low levels of energy, extreme fatigue and/or poor concentration, and little motivation to do activities that were done before;
- reduction in self-esteem, feeling worthless and blaming self for things that aren’t necessarily their fault;
- feeling hopeless about the future.

We all may feel one of these symptoms at one time, but for it to become a disorder the symptoms need to be affecting the ability to function as well as causing distress. It is also important to ascertain whether the change is due to the depression. For example, somebody may already have a poor appetite, not necessarily because of a depressive disorder.

24.8.2 COURSE OF THE DISORDER

Although some people have isolated episodes of depression, most experience recurrent episodes where the disorder often becomes more severe over time (Taube-Schiff & Lau, 2008). Milder forms of depression, in which a few symptoms are experienced rather than more severe episodes, has historically been found to be one of the best predictors of a future, more serious, depressive episode (Pine et al., 2002).

24.9 ANXIETY DISORDERS

Anxiety is a set of symptoms, which may include:

- emotional symptoms, e.g. fear or worry;
- physical symptoms, e.g. fast-beating heart or sweating;
- cognitive symptoms, e.g. fear of dying or losing control.

When these symptoms are experienced together it is commonly called a panic attack. Like a depressed mood, anxiety is a common occurrence for most people with everybody having felt anxiety at some point in their lives, for example, when sitting exams or giving a presentation. In most situations, anxiety prepares the body to respond when it perceives
it is under threat. The anxiety prepares the body to either approach the threat or run in the opposite direction! Anxiety becomes a disorder when, in addition to the impairment in functioning, the fear reaction is caused by something that is not necessarily a threat. Feeling scared and anxious of poisonous snakes is understandable, having the same feelings brought on by fluffy teddy bears, not so much!

### 24.9.1 Anxiety Symptoms

In addition to the symptoms listed above, a diagnosis of an anxiety disorder generally has four things in common:

- There is a specific target that the person is afraid of (e.g. snakes or teddy bears).
- Heightened anxieties (or panic attacks) are experienced in response to the target.
- The target is avoided by the sufferer.
- Anxiety tends to be chronic, that is, it is persistent rather than experienced in episodes.

### 24.9.2 Generalised Anxiety Disorder

Generalised anxiety disorder is a disorder where people experience excessive anxiety that appears unrelated to any specific fear or trigger, appearing to worry instead about most things. Sufferers will typically appear restless, on edge or tense, find it hard to concentrate or sleep, and experience physical symptoms such as muscle tension, headaches and palpitations.

### 24.9.3 Phobias

Phobias are the most common form of anxiety disorders and refer to a persistent and irrational fear of a particular object or situation. Kessler et al. (2010) suggested that 9% of society suffers from at least one phobia. While often caused by a specific anxiety, phobias often only occur in relation to the specific trigger, therefore they are not as generalised as most other anxiety disorders. While most people have a severe dislike of some things (e.g. spiders or flying), to be classed as a phobia there needs to be an extreme level of avoidance and dysfunction. For example, somebody with a fear of flying may lead a very productive life but simply isn’t able to fly. This may affect their work, limiting the jobs they can take, or their family life by not being able to take holidays with relatives.

**ASIDE**

**Is it mad to be happy?**

Have you noticed how a new mental diagnosis seems to appear every week? Once upon a time some children were naughty, now they have conduct disorder, and some people just aren’t very nice but now we diagnose them as having a personality disorder. Perhaps everything we do is odd.

In a gentle parody of psychiatric diagnosis, Richard Bentall (1992) proposed that happiness should be classed as a mental disorder and referred to under the new name of major affective disorder, pleasant type. In his article, he suggested that the relevant literature shows that happiness is statistically abnormal, is made up of a discrete cluster of symptoms, is associated with a range of cognitive abnormalities, and probably reflects the abnormal functioning of the central nervous system. He considered the possible objection that happiness is not thought badly of but he dismissed it as scientifically irrelevant. You would think that an article like this would contribute to the sum of human happiness, but sadly some people took it seriously and it made them sad. Humour is a serious business.
Cognitive behavioural models are seen to provide the best evidence for specific phobias (Gamble, Harvey, & Rapee, 2009). Although similar fears and phobias have been seen to run in families, this is not thought to be a case of genetics, rather a situation in which children are exposed to fears by their parents. For example, a mother who is afraid of dogs will inadvertently teach her child through her own avoidant behaviour that dogs are something to be scared of. Varying research has been indicated that fears can be acquired through this type of modelling (Wilson, 2011).

**EXERCISE: MATCH THE OBJECT WITH THE PHOBIA**

Table 24.4 lists a number of real-life phobias. Try to match them with their actual triggers!

<table>
<thead>
<tr>
<th>OBJECT</th>
<th>PHOBIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beards</td>
<td>Bibliophobia</td>
</tr>
<tr>
<td>Books</td>
<td>Ommatophobia</td>
</tr>
<tr>
<td>Dolls</td>
<td>Pediophobia</td>
</tr>
<tr>
<td>Eyes</td>
<td>Pogophobia</td>
</tr>
<tr>
<td>Marriage</td>
<td>Phasmophobia</td>
</tr>
<tr>
<td>Ghosts</td>
<td>Eisoptrophobia</td>
</tr>
<tr>
<td>Wasps</td>
<td>Gamophobia</td>
</tr>
<tr>
<td>Snow</td>
<td>Siderodromophobia</td>
</tr>
<tr>
<td>Worms</td>
<td>Theophobia</td>
</tr>
<tr>
<td>Mirrors</td>
<td>Gephyrophobia</td>
</tr>
<tr>
<td>Railways</td>
<td>Chionophobia</td>
</tr>
<tr>
<td>God</td>
<td>Ombrophobia</td>
</tr>
<tr>
<td>Crossing a bridge</td>
<td>Spheksophobia</td>
</tr>
<tr>
<td>Shadows</td>
<td>Hedonophobia</td>
</tr>
<tr>
<td>Rain</td>
<td>Helminthophobia</td>
</tr>
<tr>
<td>Pleasure</td>
<td>Sciophobia</td>
</tr>
</tbody>
</table>

**24.10 SCHIZOPHRENIA SPECTRUM**

Schizophrenia is a mental disorder characterised by a range of symptoms that can be debilitating for those with the disorder. This is reflected in the higher rate of suicide in people with this disorder (Hawton et al., 2005). One of the earliest models applied to schizophrenia was the dopamine hypothesis. A medical theory, this model suggests that the disorder is due to an excess of the neurotransmitter dopamine. While this model is not without its critics, it is still today one of the dominant explanatory models of this disorder. The use of antipsychotic medication (which is discussed more in Chapter 25) provides some evidence for this theory. Research also shows additional neurotransmitters (glutamate and serotonin) may also play a part in schizophrenia (Bach, 2007).

Further research to support the medical model has led to it being generally accepted that people inherit a genetic predisposition to schizophrenia (Akbarian, 2006). Studies have frequently found schizophrenia to be more common among relations of people with the disorder (Conn et al., 2008). The more closely related the existing sufferer, the increased possibility of developing the disorder. However, one factor that needs to be considered is that a close relative
will also have potentially experienced the same environment. Therefore, the role of environment cannot be ruled out altogether. Psychological and socio-cultural factors have been shown to have a precipitating factor and this is known as the diathesis stress model, where a biological predisposition may be triggered by psychological events, personal stress or societal factors. However, many believe that although there may be a biological underpinning for schizophrenia, it needs external stressors for the symptoms to be triggered (Holmes, 2010).

24.10.1 SYMPTOMS

People with schizophrenia can suffer what are called positive symptoms or negative symptoms, or a mixture of both. It can also be characterised by psychosis, which is when an individual behaves in a way that has little to do with reality. Impairments are often experienced in numerous areas of functioning – perception, thought, language, memory, behaviour and emotion.

24.10.2 POSITIVE SYMPTOMS

Positive symptoms are behaviours or thoughts that can appear as bizarre additions to a person’s normal presentation. The most common are detailed below.

- **Delusions** are firmly held elaborate beliefs that do not appear factually correct, there often being evidence to the contrary. Delusions of persecution are the most common form of delusions experienced by people with schizophrenia (Langdon, Ward, & Coltheart, 2010). Sufferers with such beliefs would believe that they are being plotted against, victimised or spied on. For example, a schizophrenic may believe the government is plotting against them or aliens are plotting to kidnap them. **Delusions of grandeur** are also a common symptom of schizophrenia, with a sufferer believing, for example, that they are a member of the royal family or are religious figures.

- **Disorganised thinking and speech** is when somebody has rapid shifts in their thinking and their speech, the sufferer believing that what they are saying makes sense. Using bizarre or odd language may also be a symptom of schizophrenia, sufferers making up their own words (**neologisms**) that only they know and understand.

- **Hallucinations** are sounds, sights and other sensory events that are experienced in the absence of any external sensory stimulation. The most common form of hallucination is auditory, which is where the person hears sounds or voices from either inside or outside their head that are not audible to those around them. It is important to add that hearing voices is very common in people who do not have any form of mental disorder, for example, someone who is recently bereaved can often hear or sense their lost loved one (Dewi Rees, 1971).

- **Inappropriate affect** refers to emotions being displayed that aren’t appropriate to either the situation or the environment. For example, laughing when being told some sad news or being upset in a happy situation. This can be accompanied by inappropriate shifts in mood.
24.10.3 NEGATIVE SYMPTOMS

Negative symptoms are the absence of characteristics or behaviours that effect a person’s ability to function in society. The most common negative symptoms are as follows:

- **Poverty of speech** refers to a general reduction in speech. Some sufferers simply say very little, their interaction with others being minimal.
- **Flat affect** is when people with schizophrenia display little emotion, be it sadness, happiness, joy or any other feeling. This can often be accompanied by poor eye contact and a flat monotone voice.
- **Avolition** refers to a lack of energy or interest in goals or life in general, often serving to distance the sufferer even more from reality and increase isolation.
- **Withdrawal** involves the person moving their interests from issues around them to their own issues, which are often confused with ideas and fantasies.
- **Catatonia** is an extreme form of motionless state. Individuals may stop responding to their environments, remaining motionless and silent for prolonged periods.

### KEY RESEARCHER Theodore Millon

Professor Theodore Millon was an American psychologist known for his influential work on personality disorders, becoming commonly known as the ‘grandfather of personality’. He devised one of the most frequently used psychometric assessments of personality disorder, the Millon Clinical Multiaxial Inventory (MCMI), currently being used in its third revision. In his early career, Professor Millon worked as a mental health professional in a psychiatric hospital, rising through the ranks to the hospital’s board of trustees. He gained notoriety for often allegedly pretending to be an inpatient to enable him to get better insight into his patients’ problems. His clinical experience inspired Professor Millon to study and research the criteria that psychologists use to describe so-called disordered thinking, and the different personality traits that make up a diagnosis. By 1980, as part of a task force gathered by the American Psychiatric Association, he had arranged these traits into 11 standardised categories or ‘subtypes’ (later revised to 14), forming the basis for the third edition of the Diagnostic Statistical Manual of Mental Disorders (DSM-3). Before his death in January 2014, he had set up the Institute for Advanced Studies in Personology and Psychopathology, the website (http://millon.net) also serving as his official web page for his professional and scholarly activities.

24.11 PERSONALITY DISORDERS

The diagnoses of personality disorders are perhaps the most controversial area of psychopathology. For example, the 3:1 ratio of women to men receiving a diagnosis of borderline personality disorder might well reflect society’s judgement on the behaviour of women rather than any underlying psychology disturbance. Despite these concerns, personality disorders are commonly diagnosed in Western countries. Most symptoms first become apparent in adolescence or early adulthood, with recent research predicting that between 9% and 13% of all adults have a diagnosable personality disorder (Paris, 2010).
So what exactly is a personality disorder? According to the DSM-5, a personality disorder is ‘An enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment’ (DSM-5 – American Psychiatric Association, 2013).

The DSM-5 lists 10 distinct personality disorders (ICD-10 has eight but includes other specifications).

**Paranoid personality disorder** is a pattern of distrust and suspiciousness such that others’ motives are interpreted as malevolent.

**Schizoid personality disorder** is a pattern of detachment from social relationships and a restricted range of emotional expression.

**Schizotypal personality disorder** is a pattern of acute discomfort in close relationships, cognitive or perceptual distortions, and eccentricities of behaviour.

**Anti-social personality disorder** is a pattern of disregard for, and violation of, the rights of others.

**Borderline personality disorder** is a pattern of instability in interpersonal relationships, self-image and affects, and marked impulsivity.

**Histrionic personality disorder** is a pattern of excessive emotionality and attention seeking.

**Narcissistic personality disorder** is a pattern of grandiosity, need for admiration and lack of empathy.

**Avoidant personality disorder** is a pattern of social inhibition, feelings of inadequacy and hypersensitivity to negative evaluations.

**Dependant personality disorder** is a pattern of submissive and clinging behaviour related to an excessive need to be taken care of.

**Obsessive compulsive personality disorder** is a pattern of preoccupation with orderliness, perfectionism and control.

Did you recognise any personality traits? I’m sure as you read the list there may be symptoms you recognise in yourself! For example, many people have some obsessive-compulsive traits, whether it be needing to have all your baked beans pointing the right way in the cupboard or not stepping on cracks in the pavements. But does this mean you have a disorder? Absolutely not – revisit the Four Ds model if you want to be sure!

In terms of causes, only two personality disorders have been studied extensively. These are borderline personality disorder and anti-social personality disorder (in ICD-10 they are called emotionally unstable personality disorder and dissocial personality disorder respectively). For anti-social personality disorder, advocates of the behavioural models say the related anti-social behaviour is learnt through modelling (Gaynor & Baird, 2007). Evidence for this theory is the high rate of the disorder among parents and children (Archer & McDaniel, 1995). Advocates of the medical model refer to research which has shown that sufferers have been found to have lower serotonin activity than non-sufferers (Patrick, Fowles & Krueger, 2009). In addition, low serotonin levels have been linked to aggression and impulsivity, which are key characteristics of anti-social personality disorder.

In the case of borderline personality disorder, 2% of the general population are thought to suffer from this (Paris, 2010), with 75% of those diagnosed being women (Gunderson, 2011). There does not appear to be one dominant model of this disorder, although Linehan et al. (1994) developed the bio-social theory, incorporating varying theories for a more holistic approach.

**CHAPTER SUMMARY**

The aim of this chapter has been to provide an understanding of what disorders look like and how they progress, and common suggestions as to possible causes. You have read about some of the diagnosed psychological
disorders – schizophrenia, mood disorders, anxiety and personality disorder. They by no means offer an exhaustive insight into all the disorders.

It should hopefully have become clear that there is still a lot to research about most, if not all, disorders. As more becomes known, it will bring with it changes to the assessment, diagnosis and treatment of psychological disorders. The expectation is that not only will current disorders become better understood, but that new ones may be unearthed and others may disappear completely.

**DISCUSSION QUESTIONS**

How does society measure abnormality? What implications does this have for individuality and cultural variation?

What should be the defining factors in future psychopathology research? Should the field be looking at expanding the range of diagnoses or reducing it?

How important is it to have a diagnosis for people with a reported psychopathology? What are both the positive and negative aspects for the individual?

**SUGGESTIONS FOR FURTHER READING**

Bentall, R.P. (2009). *Doctoring the mind: why psychiatric treatments fail*. Harmondsworth: Penguin. This book takes an in-depth look at mental healthcare in the West, claiming that it is too heavily reliant upon medication and profit. The author argues for a different approach to mental health, which would involve redefining the concept of mental illness and all consequential treatments.


Still want more? For links to online resources relevant to this chapter and a quiz to test your understanding, visit the companion website at edge.sagepub.com/banyard2e
25 Psychological Interventions

Lead authors: Karen Slade, Laura Hamilton and Claire Thompson

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25.1 INTRODUCTION
The mind is complex and it can play tricks on us and things can go wrong, and we can think differently, feel bad or behave differently from other people. In the previous chapter, we introduced you to ideas of psychological abnormality and psychopathology. Now we will look at how we can change ourselves and introduce the most widely used psychological interventions available for the treatment of psychological abnormalities and difficulties. The interventions are drawn from a wide range of theories and all have different ways of doing things. We will look at how the interventions operate and how they work. All these interventions can be delivered by an applied psychologist or other trained professionals, although in some cases a psychiatrist or specialist doctor may also need to be involved. Psychological interventions have changed over time with different methods coming in and out of use, and so we will look at some of the history of psychological interventions. No one psychological intervention is suitable for everyone and this chapter will outline the different approaches and who they might be used with.

FRAMING QUESTIONS
- What are psychological interventions and how do they work? Which ones work best for which kind of issue?
- Are there different interventions for different issues, and how and why were they developed?
- What does an intervention look like? And what are the main aims and methods that they use?
- Do psychological interventions even work? And, if so, who do they work for best?

25.2 WHAT IS A PSYCHOLOGICAL INTERVENTION?
Psychological interventions have been present in our history probably since humans first realised that some people were a bit different. The definition of psychopathology has changed dramatically over the last 1000 years and so have interventions, which have ranged from the inspired to the bizarre. Some early explanations of mental disorders focused on biological explanations, asserting that there was some sort of disease of the brain, and other explanations focused on the supernatural, such as demons or possession (see Figure 25.1).

The exact nature and purpose of psychological interventions has been continuously debated and interventions have fallen in and out of fashion. The approaches change depending on the underlying theoretical model, although all should be based on accepted psychological methods and are ‘broadly based on the use of the interaction between therapist and service user to elicit changes in the service user’s behaviour (for example, drug use), as well as other related factors, including cognition and emotion’ (National Institute of Clinical Excellence (NICE), 2008). In the literature, the term ‘psychosocial intervention’ is also widely used. This is a broader term than psychological intervention and is defined as any intervention that emphasises psychological or social factors rather than biological factors (Ruddy & House, 2005). It therefore includes psychological interventions, but also includes educational programmes and social assistance, for example, parenting classes.

25.2.1 DELIVERING PSYCHOLOGICAL INTERVENTION
Psychological interventions are broad in scope and are used in a huge range of psychopathologies, difficulties and behaviours. There are many different types of clients of psychological interventions and they come from a range of
Supernatural approach in early civilisations (6000–2000 B.C.)
- **Bleeding a patient**
- **Trepanation**: removing a section of the skull was widely used to release demons and thousands of skulls have been found with this (Finger, 1994).
- **Homeopathic magic** is based on similarity: doing things to models of a person to effect change.
- **Contagious magic**: based on contiguity: using items which belonged to someone so the ‘therapist’ might hold an item and mimic symptoms and then effect change.

Biological approach
4th century B.C. to 2nd century A.D.
- Around 4th century B.C. up to around 2nd century there was a move to ‘naturalistic’ approach using fresh air and baths to ‘balancing the four humors of the body’ (Hippocrates, c. 460–377 B.C.).

Humane treatment
17th century A.D. onwards
- After this, moves to provide humane treatment was pioneered by radicals like Philippe Pinel (1745–1826) and Dorothea Dix (1802–1887) and included hypnotism and magnetism treatment.
- **Demon possession** based on religious beliefs. Exorcisms were performed to rid person of demon. Accusations of witchcraft and having sex with demons led to the execution of over 100,000 people in Europe, with around 80% being women (Clark, 1997), or being locked up in ‘asylums’. This activity peaked in 16th century.

**ASIDE**
What is a ‘therapy’?
- ‘Therapies have been developed by physicians, priests, psychiatric and psychological specialists, interested layman, charlatans and quacks; the therapies vary accordingly’ (Maher & Maher, 1985, p. 266).

**SCHIZOPHRENIA**
Schizophrenia is not a single condition but is best described as a syndrome. The typical symptoms include difficulties in organising behaviour (including speech) as well as detachment from reality which may involve delusion and/or hallucinations. Schizophrenia is often misrepresented in the popular media as a case of split or multiple personalities.

Some are diagnosed with a psychopathology (e.g. depression or **schizophrenia**) by a doctor who refers them to therapy. But psychologists also work with people who have decided to seek help for an issue with how they think or behave, or have been referred because their behaviour is harmful to themselves or others (e.g. deliberate self-harm and criminal behaviour). It has been suggested that up to 15% of people in the USA will access psychological interventions in the course of any one year (National Institute of Mental Health (NIMH), 2010).
Given the broad range of clients for psychological intervention, the interventions themselves take place in a wide range of locations, and with different methods. Serious, long-term disorders were often only treated in long-term institutions but this had other negative effects on the clients, so inpatient treatment is now used for only a few people (Craig & Power, 2010). Although inpatient treatment can be voluntary, it can also be involuntary (e.g. in the UK many of these inpatients will be sent to them by the courts in a process commonly called ‘sectioning’, which refers to the sections of the UK’s Mental Health Act (1983 amended in 2007), under which they are detained). These decisions are reviewed regularly and people remain as an inpatient for as short a time as possible in the least restrictive conditions possible, therefore so the stay is now often weeks rather than months or years. The majority of interventions occur in an outpatient or community setting.

There are a broad range of professions who deliver psychological interventions, although the most common are applied psychologists, counsellors and psychotherapists. The training and qualifications for these practitioners have similarities and they are all trained and supervised in the delivery of one or more types of psychological intervention, depending on the therapy most suitable to their client group. Psychologists in the UK must meet the requirements of the Health and Care Professions Council (HCPC) in order to practise and most will also ensure they meet the competence standards of the British Psychological Society (BPS) to attain chartered psychologist status, and psychotherapists and counsellors generally meet the requirements of the British Association of Counselling and Psychotherapy (BACP).

25.2.2 OUTLINING THE TREATMENT MODELS

This chapter will focus on five approaches to psychological interventions that are widely used across the world:

1. psychodynamic therapy, drawn from the early work of Freud, but brought right up to date;
2. cognitive-behavioural therapy (changing what we think and what we do);
3. person-centred or humanistic therapy to help the client to find their own solution;
4. motivational interviewing to develop the client’s motivation to change;
5. biological (including pharmacological) treatment.

For each of the interventions we will be:

- outlining the theory behind each intervention;
- exploring the purpose of treatment and the methods used;
- considering which psychological interventions are most effective for different psychopathologies or people.

To illustrate how each of the interventions might be used, we will follow the path of John as he undertakes each treatment to consider where and how it might be used. We will then explore some current controversies and ethical issues.
Psychodynamic therapy dates back to the nineteenth century and is one of the oldest therapies still available today. It was first suggested by Sigmund Freud, and since then has been developing with psychologists such as Carl Jung, Alfred Adler and, more recently, the influential British psychologist, Melanie Klein. The terms ‘psychodynamic’ and ‘psychoanalytic’ are often used to describe the therapy. However, this chapter will use the term ‘psychodynamic’ as it includes a broader range of treatment approaches.

The underlying idea of psychodynamic theory is that people have an individual internal world which they are not always consciously aware of. The theory suggests that symptoms of distress and psychopathology (e.g. anxiety) are the external demonstration of a conflict between unconscious ‘needs’. In addition, we have developed defences to defend these needs, but when these defences are inappropriately used or conflicts are strong, they come to the conscious ‘surface’.

Freud’s original model included three forces which interact and conflict. The first of these forces is the id, which is the force which generates all pleasure-seeking, selfish and hedonistic impulses, seeking immediate satisfaction and being oblivious of consequences. The second force is the superego, which establishes the rules and prohibitions, telling us what is the right thing to do and using guilt to override our id impulses. Essentially, Freud suggested that the superego is developed through childhood as we internalise the rules of authority figures, like our parents. The third force is the ego, which is the negotiator and makes compromises between the wishes of the id and the superego. Over time, the ego develops a range of approaches to manage these conflicts and these are called ‘defence mechanisms’ (see Table 25.1).

The primary goal of psychodynamic therapy is to make the unconscious world conscious by helping clients to become aware of thoughts, feelings and other mental activities. This process has been termed ‘insight’, so psychodynamic therapy can also be called an ‘insight-oriented’ therapy. By bringing our thoughts, feelings, defences and the conflict fully into conscious awareness, we can make efforts to control them and develop more effective strategies to deal with them.

There are five key concepts which underlie psychodynamic therapy.
A key pathway to change in psychodynamic therapy is the way in which painful feelings are dealt with through the therapeutic relationship. The key characteristics of this relationship are: (1) unconditional acceptance (implicit value as a human being); (2) neutrality (the therapist remains a blank slate/screen and does not provide any personal information); (3) containment (providing a safe environment where the client can express anything without rejection). Boundaries are also key to psychodynamic therapy, with the conditions or limits which are placed on the therapy providing consistency and predictability plus a safe place to share any feelings. They also provide points for discussion when boundaries are broken. These boundaries can be grouped into four aspects: Place (where sessions take place and positions within room); Time (timing and length of sessions); Conduct (conduct required within sessions); and Relationship (therapist maintains confidentiality and honesty but also their neutrality).

Transference and countertransference are terms related to the dynamic between the therapist and client. Transference broadly refers to the feelings that the client has about the therapist. Psychodynamic theory would suggest that (due to neutrality of the therapist) these feelings have been projected from other relationships and are often outside consciousness. This means that the person’s relationships outside are mirrored in therapy, which allows an understanding of the client’s internal world and interpersonal relationships. Countertransference broadly refers to the feelings felt by the therapist towards the client. However, these feelings originate with the client and can be seen as unconscious communication. So it may be that the therapist is feeling emotions which the client is really feeling – feelings the client is having difficulty in expressing or even feelings that others may have towards the client. These feelings can provide information on the true feelings in interpersonal relationships of the client.

Interpretations are the final key aspect in psychodynamic therapy. The interpretations of the therapist help the client to gain insight between their behaviour and their unconscious feelings. Interpretations are making the links between the unconscious and conscious world of the client.

### 25.3.2 ASSESSING THE UNCONSCIOUS WORLD

In order for the client to achieve insight and for the therapist to interpret, it is important to examine the unconscious. Psychodynamic therapists use a number of ways to infer an understanding of the client’s unconscious world and hypothesise what is happening.

Free association is a strategy whereby therapists ask the clients to say whatever comes into their mind without stopping themselves. The therapist can gain an understanding of the unconscious world through the words which come to the surface.

Ever heard of Freudian slips? One of the most widely known methods in psychodynamic therapy is the exploration of these ‘slips’. This method rests on the idea that no behaviour is random or accidental and if there is no conscious reason for the behaviour then it must be an indicator of our unconscious wishes coming to the surface. Most Freudian slips are verbal, but they can be behavioural as well. Freud also suggested that the raw thoughts and

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**TABLE 25.1** Common defence mechanisms in psychodynamic therapy (adapted from Pomerantz, 2011)

<table>
<thead>
<tr>
<th>Defence Mechanism</th>
</tr>
</thead>
<tbody>
<tr>
<td>The ego represses the impulse of the id that is rejected by the superego. This means the ego sweeps the impulse ‘under the rug’ and pretends it’s not there. This is called <strong>Repression</strong>.</td>
</tr>
<tr>
<td>The ego projects an id impulse onto other people, entitled <strong>Projection</strong> – trying to convince ourselves that the unacceptable thing belongs to someone else and not ourselves, e.g. wanting to smoke a cigarette and instead seeing everyone else who smokes as unacceptable.</td>
</tr>
<tr>
<td>The ego can form a reaction against the id impulse and do the exact opposite (‘<strong>Reaction Formation</strong>’), e.g. when the id wants to do something for itself, the reaction is to do something for someone else.</td>
</tr>
<tr>
<td>The Displacement of the impulse by the ego towards a safer target can be used as a defence mechanism, e.g. kicking the dog rather than kicking your friend.</td>
</tr>
<tr>
<td>The ego redirects the impulse in such a way that the behaviour actually benefits others, e.g. stealing from the rich but giving it to the poor. This defence is called ‘<strong>Sublimation</strong>’.</td>
</tr>
</tbody>
</table>

---

*Some common defence mechanisms which occur when the id has an impulse but this is rejected by the superego include when:*
feelings of the unconscious are developed into the specific content that we remember in our dreams and this unconscious world can be drawn out through Dream Analysis. The content of our dreams may be heavily disguised and distorted, but interpretation can be made through gaining insight from the perspective of the client (e.g. what does the dog represent in your dream?).

During therapy clients may indicate that ‘they don’t want to go there’ either directly or indirectly (e.g. changing topic), and this suggests that certain unconscious thoughts or feelings have come to the surface too quickly or too strongly, creating anxiety. These topics are therefore indicative of a key area to be explored later in therapy, and identifying and exploring these topics is a method known as Interpreting Resistance.

Earlier on we explored the defence mechanisms for the unconscious world and so, in therapy, by Identifying the Defence Mechanisms, the client becomes more aware of them in their conscious world and can therefore begin to change them.

25.3.3 WHO IS IT FOR?

Psychodynamic therapy is often the longest type of therapy, with some clients being in treatment for years, although much shorter versions have been developed in more recent years. It is considered to be most beneficial for clients for whom interpersonal emotional issues are most prominent, where there are problems in the development of a sense of ‘self’ or where intrapsychic (in the mind) conflict is present.

Psychodynamic therapy has become less popular as a sole choice of therapy, but its concepts can be seen in other integrative approaches to treatment. In particular, the concepts of transference and countertransference are used in a range of treatment counselling situations.

25.3.4 PRACTICE APPLICATIONS AND EVALUATION

The nature of psychodynamic theory and its basic concepts makes evaluation difficult in an empirical manner so its critics suggest that it is not able to be fully tested. However, psychodynamic therapists would suggest that, given the powerful force of the unconscious, it is necessary to understand and control the unconscious to treat psychopathology. There have been a number of outcome studies completed for psychodynamic therapy, although the quality and volume of studies is considered to be somewhat less than therapies such as cognitive behavioural therapy (CBT) (Pomerantz, 2011). Large-scale reviews of psychodynamic therapy show that it can help clients improve significantly in conditions such as depression, bulimia, anxiety, anorexia and serious offending, although it is often inferior to other types of therapy (Galatzer-Levy et al., 2000; Leichsenring, 2009; Prochaska & Norcross, 2010).

25.4 COGNITIVE BEHAVIOURAL THERAPY

Cognitive behavioural therapy (CBT) is a model which integrates aspects from two models: largely, the cognitive model and, partially, the behavioural model. CBT is built around the concept that behaviour and feelings are both dependent on the way in which we interpret situations and the thoughts (cognitions) we have about
them. The underlying rationale is that our cognitions affect our behaviour. It is drawn from the cognitive model (Beck, 1963; Ellis, 1962), with the main aim of CBT being the development of rational thinking. With CBT, our behaviours are also important, and to change behaviour we need to develop and practise new behaviours. This aspect is drawn from the behavioural tradition (starting with Wolpe in 1958). The CBT model is one of the most widely used around the world for a range of psychological concerns, and it is increasing in popularity (Norcross, Karpia, & Santoro, 2005).

Cognitive behavioural interventions begin by analysing the problem behaviour and understanding the thoughts and emotions behind it. The intervention is then tailored to the problematic behaviour, with a focus on the cognitions and emotions. Due to its direct approach, CBT is a much shorter intervention than psychodynamic approaches and can be just a few sessions long. To understand CBT we will start by exploring the theory and methods from the cognitive and the behavioural models which make up CBT.

### 25.4.1 The cognitive model – what are you thinking?

The cognitive model came from the work of Aaron Beck and his Cognitive Therapy (Beck, 1963; Beck et al., 1979) and Albert Ellis and his Rational Emotive Behaviour Therapy (Ellis, 1962). The cognitive approach to therapy arose from a disillusionment with the psychoanalytic method and a desire to address clients’ symptoms more directly. It therefore focuses on current behaviour, thoughts and emotions and not on unconscious or childhood experiences. It is drawn from the idea that the majority of emotional issues (including emotive behaviour) are due to irrational thinking. Ellis says these beliefs are illogical, damaging and self-sabotaging, and that irrational thinking does not lead to helpful emotions. For example, a man is made redundant from his job. To him it means that he was terrible at his job, his co-workers are much better and that no one will give him another job, and so he feels worthless and does not bother applying for any jobs. According to Ellis, people and things do not upset us, but we upset ourselves by believing that they can.

The cognitive model states that there are three different levels of beliefs which affect the way we interpret the world. These are:

#### Automatic thoughts

These are the first thing we think and are the thoughts we have every day (e.g. ‘She’s so rude!’). These thoughts directly influence our behaviour and mood, and represent how we think about the world. They are linked to deeper conditional or core beliefs.

#### Conditional beliefs

These are also called ‘rules for living’ and are the next level down. They are generally in our awareness. They involve assumptions (e.g. ‘If she ignores me, it means she doesn’t love me’) or rules for life in the form of ‘should, must or oughts’ (e.g. others shouldn’t push in the queue).
Core beliefs: These are the deepest level beliefs and are sometimes called ‘schema’. These beliefs are basic but extreme, developed early in life and are reinforced through experience. They can be functional, but some might cause us problems in some situations (e.g. ‘I am worthless’). These are very resistant to change but are the basis of how we interpret everything.

Core beliefs are part of the ‘cognitive triad’ (see Figure 25.3), which affects the more accessible conditional beliefs and automatic thoughts. This triad involves beliefs about self, others and the world, and it is theorised that when all three are negative, depression will result (Alford & Beck, 1997).

25.4.2 Socratic questioning

Socratic questioning is a form of dialogue that helps a person to discover and attend to previously overlooked information, and to ‘guide discovery’ of the individual rather than interpretation from the therapist. It should draw the client’s attention to information that is relevant but outside the client’s current focus, and move the focus away from the concrete to the more abstract so the client can re-evaluate their conclusions or develop new ideas, for example, by asking ‘What might you advise a friend who told you something similar?’. (For more detail, see Padesky, 1993.)

25.4.3 Formulation

CBT formulation is a way to understand the client’s problem from all directions and how they link to each other. A formulation shows how dysfunctional thoughts and/or behaviours started, are maintained and made worse. It then can identify ways in which the situation might be changed through changing one part. One common way to do formulation is to use the ‘five systems’ model (Greenberger & Padesky, 1995), which outlines the Environment, Thoughts, Feelings/mood, Behaviour and Physical aspects/physiology of the client’s issue (see Figure 25.4).

25.4.4 Cognitive techniques – changing your thinking

There are two longstanding methods from cognitive therapy which are used in CBT to understand and adapt thinking. These are (1) identifying cognitive distortions and (2) using the ABCDE model to understand and adapt them to make thinking more logical.
To help to identify dysfunctional thoughts or ‘thinking errors’, Beck and his colleagues developed a list of common thought distortions (e.g. Beck, 2002; Beck et al., 1979) that can be used to train clients to identify and monitor their own dysfunctional thoughts. Common thought distortions include:

**All-or-nothing thinking**: Only seeing the extremes and not seeing any of the ‘grey’ in a situation. Clients often use words such as ‘always’ or ‘never’, without seeing any of the middle ground or exceptions.

**Catastrophising**: Only seeing the worst in a situation or the future when, in fact, it is not that extreme. This is like all-or-nothing thinking but is focused on only seeing the extreme negative.

**Magnification/minimisation**: For events, either ‘making a mountain out of a molehill’ or playing down the importance, so giving more weight than is proportional to a particular aspect or exaggerating the importance of one incident.

**Personalisation**: Taking things too personally or assuming excessive personal responsibility for a situation.

**Overgeneralisation**: Applying rules too far where they don’t really fit anymore.

**Mental filtering**: Only seeing some information and ignoring other contradictory information.

**Mind reading**: Thinking you know what others are thinking or feeling when in fact you do not.

### 25.4.5 THE ABCDE MODEL

The ABCDE model was developed by Albert Ellis (Ellis, 1962), although Beck also had a similar system known as the dysfunctional thought record. In Ellis’s model, there are five stages to understanding and correcting unhelpful beliefs.
By identifying dysfunctional thoughts and then placing them in the ABCDE model, it is possible to re-train the mind so the client perceives their life and the world differently, changing emotion and behaviour.

**EXERCISE: WHICH THOUGHT DISTORTIONS ARE THESE?**

1. **That idiot should be locked up for pushing in front of me like that!**
2. **I must get As at college or else I won’t get a good job.**
3. **I just know she is going to dump me because she hasn’t texted today.**
4. **This will never get better and will always be like this, even though I do have good days now.**

Think of the last time you became really angry. Which thought distortions were you having?


**TABLE 25.2** Description and example of ABCDE model in cognitive therapy

<table>
<thead>
<tr>
<th>Activating event</th>
<th>The event which started unhelpful thoughts</th>
<th>Girlfriend said she can’t come out this evening</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Belief</strong></td>
<td>Thoughts and the underlying conditional beliefs which are triggered</td>
<td>Automatic: She doesn’t like me anymore  Conditional: If she doesn’t like me then I feel awful and I can’t stand feeling like this  Core: I am unlovable</td>
</tr>
<tr>
<td><strong>Consequence (emotional)</strong></td>
<td>Emotion felt as a result</td>
<td>Sad and anxious</td>
</tr>
<tr>
<td><strong>Dispute</strong></td>
<td>Challenges of the assumptions in the beliefs and thoughts</td>
<td>What other reasons might there be?  Can I really not stand this feeling?</td>
</tr>
<tr>
<td><strong>Effective new belief</strong></td>
<td>New helpful beliefs and rules for the situation which reduce emotion</td>
<td>I can cope with one night on my own  She still likes me and might be busy with homework</td>
</tr>
</tbody>
</table>

**25.4.6 BEHAVIOURAL THERAPY**

The founding of behaviourism by pioneers such as Watson and Skinner is outlined in Chapter 2. Watson and Skinner realised the importance of reinforcement and practice in behaviour change. The behavioural strategies used in CBT are about encouraging or reinforcing behaviour change, supporting cognitive change.

There are a number of behavioural techniques. These include Activity Monitoring, which highlights the triggers and patterns of behaviour that are helpful and unhelpful, and Activity Scheduling, which is used to target the client’s key problems by scheduling the client to increase helpful activities and reduce unhelpful ones. Linked to activity scheduling is Behavioural Activation, whereby the client schedules in activities which they are avoiding in order to develop the chance to construct new “rules” and cognitions.

Some of the most used techniques are linked to **classical conditioning**. They use Desensitisation and Exposure, where clients are gradually exposed to problematic situations in order to extinguish irrational fears. They are often used for anxiety and phobias, for example, having a fear of spiders. Treatment may start with a picture of a spider, gradually increasing exposure to handling a spider. Connected to conditioning, **operant conditioning** techniques use
reinforcement and punishment to modify behaviour. This can be external (e.g. the therapist giving gold stars to a child for good behaviour) or internal (e.g. giving yourself praise when you have finished a task).

Other techniques include Modelling, which involves watching and learning from other people how you can act differently. The therapist may show the client a different way of behaving and encourages the client to do the same and to complete Skills Practice in order to develop new ways of behaving. Relapse Prevention can be the final stage of behaviourist approaches. It includes preparing plans for difficult situations and practising them in therapy before undertaking the new skills and behaviour in real life. Relapse prevention interventions often include skills practice where the client learns and practises new skills to develop new patterns of behaviour and links between thoughts and behaviour.

**KEY STUDY**


Are psychological interventions only for the common psychopathologies? No, far from it. They can work for all kinds of feelings and behaviours which can be disruptive to life and happiness. Kimberly Young showed that people who spend excessive time on the internet can be helped through CBT therapy. She showed that clients reported better motivation to reduce internet time, their online time management improved, they reduced their social isolation and even showed improvement for sexual dysfunction.

**See how it is done**

British Medical Journal video guide to CBT in obsessive compulsive disorder (OCD): www.youtube.com/watch?v=d3wHk-wiuCo.

**25.4.7 PRACTICE APPLICATIONS AND EVALUATION**

CBT is used as a treatment in most emotional or behavioural psychological disorders and even in helping people adjust to situations. You can even use it if you are feeling a bit weird! Many applied psychologists will deliver CBT in some form and it is the first option of treatment for most disorders where psychological intervention is indicated. CBT has been shown to be as effective as pharmacological treatments for many disorders and it is often used in tandem with

**KEY RESEARCHER Marsha Linehan**

Marsha Linehan is a Professor of Psychology and of Psychiatry and Behavioral Sciences at the University of Washington and is Director of the Behavioral Research and Therapy Clinics. She is the developer of Dialectical Behavior Therapy (DBT), a skills-based treatment that is effective in reducing suicidal behaviour as well as other mental disorders. Currently, many consider it to be the gold-standard treatment for borderline personality disorder.
drug treatments to gain maximum long-term sustained improvement (Hollon, Haman, & Brown, 2002). This means that clients for whom medications may not be suitable may still benefit from CBT. In contrast to psychodynamic therapy, the concepts and methods making up CBT are easier to test, so CBT has a very large body of supporting research behind it, with hundreds of studies supporting its effectiveness with a large number of issues, including depression, anxiety disorders and post-traumatic stress disorder (PTSD) (Holman et al., 2002; Prochaska & Norcross, 2010). It has been suggested that CBT may not be as suitable for clients with poor memory or verbal skills since it relies on an analysis of thoughts and can be intellectually challenging (Whisman, 1993).

25.5 HUMANISTIC/PERSON-CENTRED THERAPY

Person-centred or humanistic therapy was initially developed by Carl Rogers in the 1940s. Carl Rogers believed that humans were inherently ‘good’ and that they would, if given the space to do so, do the best they could with the knowledge and skills they have. Person-centred therapy (PCT) assumes the client as the expert in their own situation and so the method is non-directive, meaning that the therapist does not guide the client to an answer, and only facilitates the client’s thinking, trusting that the client will find their own understanding and the best solution.

25.5.1 MODEL AND THEORY

The aim of PCT is to increase the person’s awareness of their deepest feelings, true thoughts and inner resources. The core principle is that humans are good and they drive towards being the best they can be. This drive towards becoming the best person they can be is called the ‘self-actualising tendency’. This drive can be affected by negative influences and limitations on the resources available, so, for example, children who have suffered from neglect or abuse may have fewer resources to draw upon. However, PCT comes from the position that with the right support and circumstances the person can still flourish.

Within PCT there are a number of ‘conditions’ of therapy which interlink to create flourishing or non-flourishing people. These are (1) the organismic valuing processes, (2) the effects of others and the environment, (3) the conditions of worth, and (4) the locus of evaluation.

Organismic valuing processes: Everyone has an internal valuing system on which they rate everything. For example, you might rate skydiving as something highly likeable and exciting. Someone else may rate it as low on likeable and high on fearful.

The effects of others and the environment: The surrounding conditions of a child will impact on the resources available to flourish and may support or inhibit their self-actualising tendency. The parental or caregiver response to the child will affect the view the child has of themselves and the child will begin to understand themselves through others’ responses and develop a perception of themselves (self-concept).

Conditions of worth: For fully functioning adults, three factors must have been present from parents (Rogers, 1961):

- unconditional acceptance (accepted the way you are);
- unconditional positive regard (you are loved whatever you do);
- unconditional approval (you will always be supported).

The locus of evaluation: This is whether the person searches for the answers and guidance in themselves (internal) or from outside and from other people (external). PCT wants the reference point to be the client themselves and finding their own answers from their ‘real self’; not to have disturbance in their life, where trying to meet an ‘ideal
self, including gaining approval from others, means they deny their own real wishes (e.g. thinking ‘I ought to behave this way’).

PCT therapy aims to support people to become fully functioning adults who see the value in themselves and are able to flourish. It also seeks to help people to be able to experience without feeling threatened, to have confidence in making decisions which are congruent with their own values, and to lead the best life they can.

25.5.2 CORE APPROACH

The therapeutic relationship is the key factor in PCT. It aims to re-create aspects of the client’s childhood to redefine their self-concept, as a lack of self-concept is a barrier to the self-actualising tendency. The therapist should therefore create an environment where unconditional acceptance, regard and approval are present. Core approaches of the PCT therapist are:

1. to be genuine and honest, but not an ‘expert’;
2. to offer unconditional positive regard and total acceptance;
3. to feel and communicate a deep empathic understanding.

By reflecting back to the client what the therapist hears and sees, it is possible to let the client ‘hear themselves’ and connect to their ‘real self’. By reducing the incongruence between the real and ideal self, clients can find emotional congruence and their self-actualising tendency is supported – and able to find the best solution for them.

25.5.3 PRACTICE APPLICATIONS AND EVALUATION

PCT, by the nature of its aims, lends itself to problems of interpersonal discord and intrapersonal distress where there is a tension between the ideal and real self which needs to be resolved. Person-centred therapy has been part of the intervention tradition in the USA and Europe for many decades and although it is less widely used as a single approach than in earlier decades, some of its principles are still widely integrated in interventions. For example, the conditions for effective therapy have been integrated by most therapists. The role of the therapeutic relationship has been confirmed on many occasions as being the key factor in enhancing change and recovery in all forms of therapy (Martin, Garske,
& Davis, 2000). Thus, Rogers and PCT have made a valuable contribution to almost all psychological interventions. In evaluations of PCT, it has been shown to be effective in depression (Gibbard & Hanley, 2008). In random controlled trials on depression, PCT has also been shown to be able to hold its own against other psychological interventions with similar outcome results (e.g. Bower et al., 2000).

25.6 MOTIVATIONAL INTERVIEWING

Motivational interviewing (MI) is a client-centred therapy style that is directed at a particular outcome, that is, it develops internal motivation to change behaviour and lifestyle. It is often used for life-long health changes (e.g. eating habits) and substance misuse. MI was developed by Steve Rollnick and Bill Miller in 1983 and it is increasingly widely used across health services. They describe it as being about ‘arranging conversations so that people talk themselves into change’ (Miller & Rollnick, 2013).

25.6.1 THEORY

The MI model has links to Prochaska and DiClemente’s Stages of Change model (Prochaska, DiClemente & Norcross, 1993), with the idea being that people may be ambivalent about change. The model suggests that by helping resolve this ambivalence towards making a change, the person is likely to make those changes. ‘MI is a collaborative conversation style for strengthening a person’s own motivation and commitment to change’ (Miller & Rollnick, 2013). MI tries to encourage the client to develop an understanding of what is important to them, to weigh up the reasons for change against the reasons to stay the same to help make a firm decision, and also to develop confidence that they can make the change.

MI is underpinned by different skills and philosophies which together make up MI in practice. MI is not just about techniques. It embraces the idea of the relationship between therapist and client and that MI is a way of ‘being’ with the client which is as effective as the methods that might be used. MI focuses its therapy around an idea entitled the MI ‘Spirit’, which includes four key aspects:

1. Partnership: A collaborative relationship where client and therapist work together (Quote: MI is done ‘for’ and ‘with’ a person) (Miller & Rollnick, 2013, p. 15).
2. Acceptance: This does not mean approving a client’s behaviour but accepting the person as having inherent worth, accepting that they can solve their own issues, being empathic to their situation and acknowledging the strengths of the person.
3. Compassion: The therapist actively promotes the client’s welfare and gives priority to their needs.
4. Evocation: The therapist helps to call forth the answer from the client – the answers do not come from the therapist.

25.6.2 METHODS

There are four processes which form MI: Engaging (establishing the relationship); Focusing (directing the conversation on the key topic); Evoking (bringing out the client’s reasons for change); and Planning (developing a plan for change). These steps can be seen as sequential, but also acknowledge that people will step backwards in their motivation. The therapist must therefore also be prepared to return to an earlier step.

25.6.3 THE CORE SKILLS OF MOTIVATIONAL INTERVIEWING

In order to move a client, MI uses a number of skills, many of which have been integrated into other forms of therapy. In order to gain the client’s perspective and the full picture, it is important to ask open questions (e.g. ‘What are some of the problems you are facing?’) and not closed ones (e.g. ‘Are you facing a debt problem?’). Affirmation is offering praise but without judging the person as good or bad. It emphasises the strengths of the client (e.g. ‘You have shown you can pick yourself up when you need to’). A further fundamental skill in MI is reflective listening. The purpose of reflective listening is to let the client hear back what they are saying – sometimes with a twist! The therapist will therefore say back
what they have heard (e.g. ‘You say that things are bad for you right now, but that there is no problem with your drinking’), but this may include highlighting the discrepancies between what the client is saying or doing, thus ‘developing discrepancy’. Finally, MI therapists will use *summarising* to bring together a collection of all the important things they have heard – to make sure they understand what the client is saying and also so the client can hear what they are saying.

**CASE STUDY CONTINUED: JOHN AND MOTIVATIONAL INTERVIEWING**

John is reluctant to consider giving up drugs but is aware that it is causing him difficulties. He sees an MI therapist for one session to think about what he wants to do about his drug use. MI was devised for substance use and he quickly finds himself thinking about his reasons for change and the reasons why he wants to stay the same. He realises that he is not really happy and that what he really wants is his old friends back – and that to do this he needs to give up the drugs. He decides that he will accept the therapist’s offers of help to give up all the drugs.

**25.6.4 WHEN THE CLIENT IS NOT TOO SURE HE/SHE WANTS TO CHANGE**

MI makes certain assumptions about change. These assumptions may include the fact that not everyone is geared up and ready to change, and that even when someone starts thinking about change they may not be totally convinced. Although the purpose of MI is to develop change, it also includes techniques to help the client when they express lots of reasons to stay where they are (termed ‘sustain talk’) or when there is active resistance. MI is known for the phrase ‘rolling with resistance’, where the therapist does not need to challenge this natural process of being concerned about change, but ‘rolls with it’, using reflections to allow the client to find their own path.

**25.6.5 PRACTICE APPLICATIONS AND EVALUATION**

MI has been evaluated for use in many different settings with some of the best methods available, including random controlled trials, and has shown impressive results in meetings its aims. It is widely utilised and supported for use in substance-related disorders, smoking cessation, and a wide range of health issues where lifestyle changes are recommended (e.g. diabetes) (Burke, Arkowitz, & Mechola, 2003). MI is shown to be most effective when given in combination with other therapies. It can be a good precursor in developing motivation prior to more content-based therapies for change, such as CBT (McKee et al., 2007; Moyers & Houck, 2011).

**KEY STUDY**


Did you know that psychological interventions have been used widely with people perpetrating all types of criminal behaviour? Knowing which interventions work is important because it impacts on whether people might hurt someone and end up on *Crimewatch*! Lösel and Schmucker also wanted to know what treatments worked to reduce offending. They completed a meta-analysis of 69 studies on sexual offenders, looking at a wide range of different interventions. They showed that biological treatments (e.g. drug treatment) and cognitive behavioural treatments are both effective in reducing the likelihood of crime, reducing sexual offending by up to 37% (compared to sexual offenders who did not receive any intervention). A massive improvement on the crime rate!
Biological and pharmacological treatment

There is a broad range of biological psychological interventions with many different outcomes. They are largely defined as therapies which use biochemical and physical methods to help overcome psychological problems (Comer, 2013). Unlike the other interventions, biological treatments are often delivered by those with medical training, such as doctors, psychiatrists and nurse prescribers. We will look briefly at two types of biological intervention, psychopharmacological (drug) therapy and electro-convulsive therapy.

All biological interventions come from the tradition of the medical model of abnormality. This medical model suggests that abnormal psychology comes from a dysfunction in the brain and its connections. It sees patients as sick (as though they have an ear infection and need to be treated with antibiotics). Therefore, biological treatments suggest that they can be effective by addressing this dysfunction, either through medication or through other means which affect the person’s physical body. The difficulties with defining people with the medical model were discussed in Chapter 24, but there are conditions which respond well to biological treatments and there is evidence that for some conditions biological treatments aid recovery and give symptom relief.

25.7.1 Psychopharmacology (drug) treatments

There are a range of psychotropic drugs (medications which work directly on the brain) available for many different conditions. Chapter 10, section 10.5.2, has examples of the biological mechanisms of some of these drugs. Broadly, these all fit into five categories (taken from Gelder, Mayou, & Geddes, 1999):

Anxiolytics drugs: These are also called antianxiety drugs and are used to help reduce anxiety or tension. One of best-known anxiolytic drugs is diazepam (commonly called Valium).

Antidepressant drugs: These medications are largely used to improve mood and depression, although they can also help anxiety. There are three sub-categories: (1) monoamine oxidase inhibitors (MAOIs), which were widely used in the 1950s but are less used now; (2) tricyclic medications, which have three carbon rings and are widely used to block the reuptake of certain chemicals like dopamine, noradrenaline and serotonin. Amitriptyline is one of the most widely used tricyclic drugs; (3) the next generation of antidepressants, specific serotonin reuptake inhibitors (SSRIs), which selectively block the reuptake of serotonin into presynaptic neurons, making serotonin more available to the brain. Paroxetine and Fluoxetine (commonly known as Prozac) are two widely used SSRIs.

Mood-stabilising drugs: These are used to prevent affective (emotional) disorders. An example is lithium carbonate used to treat bipolar disorder.

Antipsychotics: These have been used since the 1950s and are also sometimes called ‘major tranquillisers’. They help to reduce symptoms of psychotic disorders (such as schizophrenia). They manage the ‘positive’ (additional) symptoms, such as confusion, hallucinations and delusions, but do not work on ‘negative’ symptoms (e.g. emotional blunting, slow movement, social withdrawal). An example of an antipsychotic is Chlorpromazine (largactil). Newer antipsychotic drugs (e.g. Clozapine), which have less serious side-effects compared to earlier antipsychotic drugs, are now available, but these may impact upon the negative symptoms, as well as the positive symptoms, of schizophrenia. (There is an interesting key study in Chapter 10 on the discovery of antipsychotics.)

Detoxification: These are medications provided for people who are substance-dependent but who wish to reduce or stop taking substances. There are short- and long-term detoxification drugs, which initially support symptom relief, and long-term medications to prevent the return to drug use. Methadone is an example of a short- and long-term medication used for heroin withdrawal.
25.7.2 PRACTICE APPLICATIONS AND EVALUATION

Drug interventions are widely used and have been shown to have a modest effect on many conditions and symptoms. They are mainly used for treating psychopathology symptoms that are linked to a diagnosis (e.g., depression, schizophrenia, substance abuse) and a range of specialist drugs have been developed to target symptoms for these disorders.

The benefits of pharmacology on many disorders is relatively well established, and specific drugs have been developed and are widely used for specific disorders. Most drugs treatments have been found to be effective when compared to a placebo (dummy drugs) (e.g., Quitkin et al., 2000). There are concerns over the high relapse rate (return of symptoms) once drug treatment terminates and that to maintain effectiveness clients must continue to take drugs for long periods of time (Maj et al., 1992). For this reason, there is a growing trend to combine drugs treatments with other ‘talking’ psychological interventions to support the management of symptoms in the long term without drugs.

25.7.3 ELECTROCONVULSIVE THERAPY (ECT)

Electroconvulsive therapy (ECT) was first utilised in Italy in 1938 in an attempt to treat schizophrenia and was popular as a treatment in the USA in the 1940s; however, growing evidence suggests that it may be more effective for conditions other than schizophrenia. Although only evident in a handful of places in the UK and the USA, and rarely used outside these countries, it may be a useful treatment for patients who do not respond to conventional treatments.

In ECT, the patient is given an anaesthetic and muscle relaxant and electrodes are attached to the patient’s forehead. Then they receive a short dose of electricity through the brain (commonly around 225 volts and 0.8 amps), which is enough to induce a seizure. This seizure or convulsion can last a few minutes, although it is often of a shorter duration. The procedure is repeated two to three times a week for an average of eight sessions. There have been concerns over its use, including that treatment can lead to memory disruption (Rami-Gonzalez, 2001), so ECT is often administered only to one side of the brain (the non-dominant hemisphere) to reduce this side-effect. You will not be surprised to hear that this is a very controversial treatment.

ASIDE

Hemingway and ECT

The great US author, Ernest Hemingway, underwent 20 gruelling sessions of ECT to treat him for depression. One of the side-effects of ECT is memory loss and he is reported to have said: ‘Well, what is the sense of ruining my head and erasing my memory, which is my capital, and putting me out of business? It was a brilliant cure but we lost the patient.’ Shortly after this he took his own life.

(The Economist, 2005)

25.7.4 PRACTICE APPLICATIONS AND EVALUATION

There is limited evidence of the global effectiveness of ECT, but there are some benefits. Many studies have concluded that there is a relapse of symptom rate of around 80% (Sackeim et al., 2001). However, in recent years, the National Institute of Clinical Excellence (2009) has considered evidence from over 119 randomised-controlled trials. NICE concluded that ECT may have some benefits for severe depression and schizophrenia, but that other treatments are better. According to NICE, ECT should only be used as a treatment of choice for resistant catatonia (a state of apparent unresponsiveness to external stimuli in a person who is apparently awake) and severe mania (abnormally excessive elevated mood disorder).
25.8 OTHER ISSUES

25.8.1 FORMAT OF INTERVENTIONS

There are many different ways in which interventions can be undertaken and the approaches covered in this chapter have often been adapted to meet new demands for treatment which is more effective, reduces cost and allow for access by less accessible populations.

*Individual therapy* is the most commonly known format, where there is one client and one therapist – which takes us back to the image of the psychiatrist’s couch. All of the psychological interventions in this chapter can be delivered in this individual format.

In *group therapy*, one or two therapists will facilitate a number of clients at once in a single room to deal with similar problems. This is a more cost-effective way of delivering interventions as it allows for one therapist to treat several clients at once, and it has been found that around one-third of clinical psychologists practise in group settings to some degree (Norcross et al., 2005). This is widely used for CBT forms of therapy and is utilised for a diverse range of disorders, from depression to violent and/or sexual offending.

*Self-help groups* are a common form of group therapy, where people with similar problems will meet and support each other. This approach differs from other forms of intervention as there is no leadership from a therapist. One of the best known examples of self-help groups is Alcoholics Anonymous, which operates a 12-step illness-model (alcoholism as an illness) approach to start and maintain abstinence from alcohol. Mentors from within the group support and guide other members.

A new and growing area for psychological intervention is *computerised and e-therapy*. The availability of the internet and computers in most homes allows people to access support and intervention at a time convenient for them. It allows treatment to be delivered with or without a therapist, where the client works through a computer-generated self-help ‘workbook’, or through online chats with trained therapists.

25.8.2 WHAT WORKS? EVALUATING TREATMENT APPROACHES

**SO DOES IT MATTER WHICH THERAPY I GET?**

Yes, it does, but only to a point. Some key meta-analysts in the 1970s considered the question as to whether psychological interventions were effective and which therapy was best. Singer and Luborsky (1975) and Smith and Glass (1977) completed a meta-analysis of the research and concluded that all the therapies were effective and generally equally effective! More recent studies (e.g. Elkin et al., 1989; Westen & Morrison, 2001) also found that therapies for depression fared evenly in outcome, but when followed up after two years, most of the clients had relapsed and only 26% of clients who entered treatment stayed well in the long term. However, in even more recent studies, there has been some differentiation in the outcome studies and now some therapies are seen to be better for certain conditions. Cognitive behavioural therapy, for instance, has been shown to be very helpful for depression, anxiety and panic disorders (Craske, 2010), and drug therapy is the single most helpful treatment for schizophrenia and bipolar disorder.

**CASE STUDY CONTINUED: JOHN AND BIOLOGICAL TREATMENTS**

John is ready to come off the drugs, but he is dependent on them and he doesn’t like the sound of all the side-effects of ‘cold turkey’. So, the doctor prescribes Methadone, which John will need to pick up from the pharmacy each day, but he must stay off the heroin! The doctor also prescribes an anxiolytic to help John with his anxiety, which sometimes leads him to take drugs.
HOW CAN WE KNOW IF AN INTERVENTION WORKS?

Agreement on how to measure the effectiveness of different psychological interventions has been hard to develop. In 1952, Eysenck published an influential paper in which he stated that although it was difficult to use the scientific method to show that psychoanalysis was effective, it did not mean that it was ineffective. However, by 1960 he was arguing that behaviourism was the only therapy worth considering. Hmmm …

The difficulty in evaluating research is the number of questions that need to be answered. So, how do you decide what the outcome should be when clients are so different? How much improvement is enough? How do you measure the outcome? How do you prove that it was the therapy that made the difference?

Some psychological interventions lend themselves to the scientific method more easily, for example, behaviourist approaches, where the frequency of problem behaviour can be used as a measure of change. However, some psychological interventions involve more complex or less measurable changes, including emotional and cognitive aspects which must be less directly measured and may require self-reported assessment of change (e.g. feelings of depression or level of motivation to change).

There has been much debate over the best method of evaluation for interventions, with some authors suggesting that only those therapies that have been shown to be effective using high-quality random controlled trials (RCTs) should be available (e.g. Seligman, 1995). These are termed ‘efficacy’ studies. This approach is the one taken in medical trials where one group is given a drug and the other a placebo. Other authors have argued that RCTs have two major issues in applied practice. First, RCTs require clients to receive structured and identical treatment (sometimes from a strict manual) and so the therapy is not able to be flexible to the client, which is important to gain the full benefit. These authors argue that studies which evaluate whether the therapy was effective for the patient (with its flexibility) are also valid. These are called ‘effectiveness’ studies. Second, questions are raised regarding the ethics of RCTs as a group of clients would not receive the psychological intervention that another group does, and therefore one group may have to continue with the psychological issue which may be distressing or dangerous.

CHAPTER SUMMARY

A psychological intervention is an interaction between therapist and patient to elicit changes in the patient’s behaviour, cognition or emotion. This chapter has explored some of the widely used psychological interventions, specifically psychodynamic, cognitive-behavioural, person-centred, motivational interviewing, and biological and pharmacological approaches. We spent time looking at the theory behind each intervention, what they aim to do and how they work. We have also looked at the methods used by each intervention and whether they are effective and with whom.

There is a broad selection of psychological interventions which come from different perspectives and use different methods. All of these psychological interventions have been shown to be effective in relieving issues and they are pretty similar in how effective they are. Some interventions have been shown to be better than others for specific issues, with CBT used for depression and anxiety disorders, motivational interviewing for substance misuse and biological (drug) treatments for schizophrenia. Many interventions now integrate aspects from other approaches to maximise their effectiveness, with therapeutic alliance (from person-centred therapy), transference and countertransference (from psychodynamic therapy) and ‘rolling with resistance’ (from motivational interviewing) often seen in counselling sessions.

DISCUSSION QUESTIONS

How should you choose the best psychological intervention for a particular issue or person? The evidence is mixed for many of the issues that are taken to therapy, and which therapy is best depends a lot on the client and which therapy style they will respond to and which one meets their underlying issues. It has been argued that the best therapy is the one in which the client can develop a good therapeutic relationship with his/her therapist. So does this mean that we should leave the client to choose? What if the client chooses one and it doesn’t work? Does this mean the client isn’t trying hard enough, that the therapy doesn’t work or that really it is not the best therapy for the presenting issue?

Some interventions are more easily evaluated and therefore lots of researchers study it because it is easy. Does this mean that only this intervention should be used? What does this mean for therapies that are tapping into unconscious thoughts or memories set down at a young age and are not conscious?
Suggestions for further reading


Still want more? For links to online resources relevant to this chapter and a quiz to test your understanding, visit the companion website at edge.sagepub.com/banyard2e