Additional Try It Yourself Exercises Chapter 9

A true story: MH once taught a class in behaviour modification to graduating students who decided to modify her behaviour. Every time she left the lectern and approached a desk beside it, they smiled and nodded. By the end of the lecture, she was sitting cross-legged on the desk, and the students burst out laughing! But MH had realised what the students were doing all along, and responded that her actions were, in fact, her modification of their attentive behaviour! This mimics the old joke of the rat saying to another rat "I've got him trained: Every time I press the bar, he gives me food!" If the person knows that their behaviour is being modified, the philosophical question arises of who is modifying whom...

Critics have sometimes charged that behaviour modification is manipulative. Assuming that the individual decides which behaviours they want to modify and therefore knows that the modification is taking place, how do you view this criticism? What if the individual doesn't know that the modification is taking place, or is unable to give informed consent (as might be the case with a disorder like schizophrenia)? Are there cases in which behaviour modification is still justified, even though the individual has not given consent to this modification? Parents often engage in informal behaviour modification of their children, which most people might consider reasonable—but is it the same when dealing with an adult, especially if they have an underlying disorder?

These questions trouble many mental health professionals in their attempts to help a person with a mental disorder. The arguments for behaviour modification without informed consent include the desire to provide real help for a person who is experiencing

difficulties in functioning in daily life or who shows distress because of their uncontrolled behaviours. But the nagging thought remains, by what right do we judge what behaviours should be eliminated and what behaviours should be substituted for the eliminated behaviours? This often calls for a judgement on the part of the therapist, a judgement which will reflect the therapist's own biases and values. The issue is less problematical when the behaviours include physical harm to the person or others (e.g., lack of eating which may result in starvation, striking other people); in such cases, the person must be protected from harm or from harming others. But in less overt situations, there is not always a clear answer.

Try It Yourself

We live in a society that seems to demand ‘quick fixes.’ If we have a headache, we take a medication, especially one that is advertised to work quickly; if we have a problem, we try to solve it as quickly as possible. But traditional psychoanalysis typically requires three to five years of therapy several times a week; by contrast, interpersonal psychotherapy typically lasts four months - but note that it focuses on current problems, without really exploring earlier experiences and issues. If you were deciding on a form of psychodynamic therapy, what would matter most to you? The time required? The focus on present vs. past? Other factors, such as the reputation of the therapist? On what basis would you make this decision?

This is a very personal judgment that depends not only on your own preferences, but on the issues you want to deal with in therapy. If your issue is one that involves a problem which needs a quick solution (e.g., "I can't seem to get motivated to study, and if I don't I'm going to fail my exams"), clearly time will be an important factor and IPT might be the therapy of choice. But if the issue is of a more long-standing nature (e.g., "I have no self-confidence and I feel inadequate compared to everybody else"), a more long-term therapy which delves into the origin of your issue might be preferable. In the final analysis, it's your decision, and needs to be based on what kind of therapy and which therapist connects and resonates with you.

Try It Yourself

"Nobody’s staring at you; just do your job!"

"You just sit there - no wonder you feel isolated."

"We all have problems. Stop obsessing and do what I do - crossword puzzles!"

All of these statements reveal expressed emotionality, and these statements (or something like them) are made to many people who have psychological difficulties (not just schizophrenia). Typically, families and friends love the person and want to help. Yet these types of statements imply that psychological problems are within the control of the individual, who seems to be simply unwilling to be mentally 'healthy.' As discussed, though, such direct or implied criticism is not helpful, and is related to higher relapse rates for individuals with schizophrenia. Of course, such statements are often made to people who *don't* have psychological disorders as well. Has anyone made such statements to you? Did they help you or make you feel worse? Under what conditions might such statements be helpful? When would they be unhelpful? Why do you think that people making such statements believe that they will be helpful?

Typically, statements such as these make us feel worse. They seem insensitive to our plight and often we feel isolated and misunderstood. It is hard to think of a situation in which such comments would actually be helpful, yet people making these statements are often trying to guide us on what they believe is the right path or into behaviour that they think is more adaptive. It's worthwhile remembering that we do not walk in anyone else's shoes, and what may seem right or easy for us is not necessarily right or easy for them.

Sometimes, of course, statements such as these are actually acts of aggression - comments disguised as intended to be helpful when they are really designed to hurt. Sometimes the comments have less to do with us and more to do with the speaker: they are used to demonstrate that the speaker is in some way superior to us (more well-adjusted, more competent, etc.).

Does it surprise you that the recovery rates differ across countries? Do you think this supports the view of critics like Thomas Szasz, who argues that mental illnesses like schizophrenia are a ‘myth’ fabricated by societies that are intolerant of individual differences among people?

Given the evidence on the higher relapse rate that occurs in people with schizophrenia who are exposed to expressed emotionality, it should not surprise us that in cultures where there is support and tolerance of mental illness (i.e., less expressed emotionality), recovery rates are lower. Szasz's argument seems unreasonably strong given the physiological correlates of some mental illnesses, but certainly he highlights the fact that we often attribute mental illness to people who are actually only demonstrating the ways they are different from us.