Try It Yourself (page 412)

It's common for us to say "I must be crazy" or "You would have to be nuts to do that!" What do we really mean when we say such things? Are we really referring to behaviour that might be classified as mentally disordered? Do you think that the use of such expressions adds to our confusion and sometimes discomfort about mental disorders?

Have you ever encountered a stranger whose behaviour you considered abnormal? What was unusual? How did it make you feel? Do you think other people react in the same way? Ask your friends what comes to their minds when they hear that someone has a mental disorder.

When we say that someone is "nuts", we typically mean that the person has performed actions or expressed thoughts that we find strange or irrational. This usually reflects our lack of understanding or our disagreement with the other person rather than behaviour which might be classified as mentally disordered. A glance at DSM-IV-TR indicates quickly that people's behaviour must show several symptoms over a lengthy period of time to fall within a classification of a true mental disorder. (That's why mental health professionals are far less likely to judge someone as mentally disordered than laypeople are!) Many people, without knowledge of how mental disorders are really diagnosed, assume that some 'abnormal' behaviour must signify a mental disorder when, in fact, all it signifies is a general individual difference among people or perhaps an individual's eccentricity. It is common, however, for us to feel uncomfortable with unexpected, unpredictable behaviour, or behaviour that is not common to our experience. Understanding of what mental disorders really are helps us to become more comfortable and accepting of both people's idiosyncrasies and mental disorders, when they really do exist.

Try It Yourself (page 417)

As Figure 9.1 indicates, various forms of abnormal behaviour are more common than many people think. In addition, there are cases where it can seem difficult for us to draw a line between what constitutes a mental disorder and what is simply a personal idiosyncrasy. Consider, for example, a ‘neat freak’ who cannot abide even a little bit of dust or clutter. Do you think that this might qualify as a diagnosable disorder? What if the person refused to have company because they might make a mess, or would not go outdoors because of the dust in the air? Would that change your opinion? What if the person claimed to be quite happy, and thought that *you* had a problem because of your attitude?

Do you know anyone who suffers from a serious phobia, or has had a mood disorder such as depression? Would you react differently to the person in the two cases? What does this tell you about your own attitudes towards abnormal behaviour?

It can be very difficult to draw a line between a mental disorder and a personal idiosyncrasy. When the behaviour causes personal distress and impairs functioning in day-to-day life over a period of time, it may cross the line into a mental disorder. In the above example, if the ‘neat freak’ finds normal life difficult to cope with (e.g., not being able to go to public places for fear of germs), we tend to become more concerned that a mental disorder is present. In the vast majority of cases, the person showing this impairment in day-to-day life would not be comfortable with the situation and would show significant distress. But if the person did not, it would be difficult to conclude that a mental disorder is present.

In reacting to people with mental disorders, we are often governed by how the disorder affects us. For example, if Keisha has a mood disorder, she might be severely or mildly depressed when we interact with her, depending on her state that day, whether or not she is taking medication, etc. If she is not showing severe symptoms, we might be more comfortable interacting with her than when she shows more severe depression. In this case, it may be that we can even forget that a mental disorder is present since our discomfort level is low. If Keisha has a severe phobia, our reactions to her might depend on what the phobia is. If she has a phobia of snakes, we may have little discomfort in interacting with her on a day-to-day basis, especially if the interactions take place in a setting where snakes are not likely to be present. But if she is the 'neat freak' with a phobia about dirt and germs, we may find that her phobia interferes with our interactions, making us uncomfortable. Our tendency to avoid dealing with severe symptoms of a mental disorder because of our discomfort highlights the isolation that many people with mental disorders experience, and it can only be overcome with more information about the disorder and the acceptance that such knowledge brings.

Try It Yourself (page 428)

Can you think of a situation when you found yourself being self-critical? Do you think your criticisms were realistic or unrealistic? If they were unrealistic, did you recognise it at the time? Ellis (1994) suggests that we can use his technique on our own to avoid unrealistic criticisms of ourselves. He adds a 'D' to his ABC model to help us:

A. *Identify the Antecedent event(s).* For example, if you are feeling down because you have just been turned down for a date, the antecedent event is the other person's refusal.

B. *Identify the Belief.* What are you thinking about this? For example, you may be thinking "Nobody wants to date me" or "I must be a real loser if he/she doesn't want to go out with me."

C. *Identify the Consequence*. The result of your negative thoughts is to make you feel rejected and to lower your self-esteem.

D. *Dispute the unreasonable thoughts* you have and *Develop more reasonable alternatives* to them. So, you might think "Just because one person said no doesn't mean everyone will" or "He/she may have other reasons why they don't want to go out with me that I don't know about." These are more realistic statements than the ones you previously said to yourself, and they will make you feel better.

To stop the irrational thoughts going through your head, you need to say or think "Stop!" to yourself, or even snap a rubber band on your wrist. (Yes, it's supposed to hurt a little! That's what will stop you!) (Hadad & Reed 2007).

Ellis's technique has been demonstrated to be effective for many people in many situations. The problem is that many people try the technique once or twice and then quit. Persistence is the key. After all, it took you a long time to develop irrational or negative self-statements, so it will take a little time to replace them with more realistic and positive statements. In addition, the technique needs to be used on a consistent basis, not just every couple of days!

Try It Yourself (page 433)

A Rogerian therapist strives to be genuine, empathic and accepting. He or she tries to provide an atmosphere of unconditional positive regard. To some, this sounds like a wonderful friend or even parent; but that doesn't guarantee the relationship is positive--even friends and parents can exert a powerful influence, and someone seeking help from a therapist (no matter how kindly) is potentially vulnerable. What do you think? Is client-centred therapy a kind of manipulation? Or is it a normal, day-to-day use of social influence in a caring relationship? How do you think it compares to behaviour modification, where the therapist can use reinforcement to change the individual's behaviour? What makes therapy 'manipulative' or not? And which type would *you* choose?

While it is true that a Rogerian therapist seeks to provide unconditional positive regard, empathy, and openness to the client, the goal is to allow the client to understand himself or herself more fully and to make his or her own decisions based on realistic self-perceptions and perceptions of the situation. The unconditional positive regard that is given to the client may be considered positive reinforcement for desired responses by some behaviourists, but Rogerians contend that it is not since it is given unconditionally, not as the consequence of a particular response. Of course, it would be hard for any therapist not to indicate approval when a client makes statements that are positive, self-affirming, and realistic, but whether this constitutes manipulation or not is debatable. Unlike a parent or friend, the Rogerian therapist is a more objective observer whose life is not interwoven with that of the client. The client's decisions and actions may have an impact on the lives of family and friends, but generally not on that of the therapist. This means that the therapist has little motivation to manipulate the client. That the therapist has a certain degree of power in the relationship is a natural outcome of the roles that the client and therapist play, and this power can be abused by therapists who are not continually aware of their ethical obligations. But can this not be said for therapists in other orientations as well? Therapists who use behaviour modification say no, since behavioural techniques and goals are clearly defined for the client. This may be somewhat idealistic however. It is not inconceivable that even behaviour modification techniques can be abused. Perhaps most social interactions contain an element of 'manipulation' insofar as we all try to influence our environment, including the people in it, even if our influence is totally benign (e.g., trying to comfort someone). The need for ethical guidelines and monitoring becomes more and more apparent.

Try It Yourself (page 437)

The risks of eclectic styles of therapy are illustrated by an old puzzle: which is more accurate, a watch which doesn't work, or one which loses five minutes per day? (The answer: the broken watch, because at least it will be right twice a day, while the one which loses time may *never* be correct!) Suppose that you had a problem such as severe depression. What type of therapist would you go to? Why? What questions would you want to ask them before beginning therapy? Would you go to the same therapist if your problem were low self-esteem? Why or why not? Do you think that finding the right therapist for you depends on the approach the therapist uses or the personal characteristics of the therapist? Ask a friend what he or she would look for in an ideal therapist. Do you and your friend agree or disagree?

There is some evidence that good therapists of all orientations possess much the same characteristics: they indicate caring and respect for the client and they reveal a commitment to the client and to the therapeutic process, thus giving the client support and hope. In this sense, the orientation of the therapist may be of secondary importance. Yet it seems clear that the most wonderful therapist in the world may not always have the right 'style' or skills for every problem their wide variety of clients may have. Certainly, since it appears that cognitive behaviour therapy is effective with depression, it might be wise to go to a therapist who is skilled in giving this type of therapy if you are depressed. Similarly, since behavioural techniques have been found to be more efficacious in treating phobias than psychoanalysis, a behaviourist might be the therapist of choice if the problem is a phobia. Therapists who call themselves 'eclectic' may or may not have skills in each type of therapy that are comparable to those of a therapist who specialises in one type of therapy (that would be asking a great deal of the therapist!), so it is important to recognise that the client has the right (and responsibility to himself/herself) to try another therapist if the style and technique used by one doesn't seem to fit well with the client's needs.

Try It Yourself (page 439)

Elijah is a 48-year-old man who wears a straw hat, a bulky sweater, plaid shorts and army boots every day, rain or shine, as he stands on a busy street corner. Sometimes he seems to be having arguments with people who are not there; sometimes he laughs uproariously for no apparent reason; sometimes he is completely unresponsive when people attempt to speak to him. If someone tries to take him to a homeless shelter, he angrily rejects their overtures, insisting that they should mind their own business.

Elijah has many of the symptoms associated with schizophrenia. Can you identify them? Is the presence of these symptoms enough to make you conclude that he has this disorder? Is there other information you might want before you made this judgment? Are there circumstances where these behaviours might *not* reflect schizophrenia?

It appears that Elijah is having hallucinations in his arguments with people who are not there and in his seemingly unprovoked laughter. He also seems to be showing delusional thinking in his angry reactions to people who are trying to help him. But this is hardly enough information to conclude that Elijah has schizophrenia. We would also need to have information about his previous experiences (e.g., might he have a different disorder, such as post traumatic stress disorder, that is causing uncontrolled anger and hostility towards others?). We would need to know if he has been taking any prescribed or non-prescribed drugs (e.g., could his behaviour be the result of excessive use of amphetamines?). An additional piece of necessary information would be how long he has been showing these behaviours—a brief trauma-induced break with reality would not necessarily lead us to a diagnosis of schizophrenia. And perhaps (remote as it may seem) Elijah may be a psychologist deliberately enacting a role to see how the public will react!

Try It Yourself (page 443)

Do you find the medical model interpretation of schizophrenia convincing? Why or why not? If you were in charge of administering funding for research into the causes of schizophrenia, how would you allocate the money? (Surprisingly, although schizophrenia affects about one in a hundred people world-wide, it receives relatively little research funding.) Suppose one of your parents or grandparents had schizophrenia; would this affect your desire to have children?

The medical model of schizophrenia has elements to recommend it, and the efficacy of medications in decreasing positive symptoms of schizophrenia is noteworthy. It would seem that funding research for better medications that are effective for more people and have few if any side effects would be highly worthwhile. But since it also seems that the environment plays a role in the aetiology of schizophrenia (perhaps in interaction with physiological states), concentrating research on only biological factors would mean ignoring half the puzzle. In addition, since there is evidence that expressed emotionality in the family of the person with schizophrenia increases the relapse rate, allocating research funds to education and support for the family also has merit. But where will the money come from to fund all these worthwhile areas?

Try It Yourself (page 450)

Given the discussion of how the various approaches view schizophrenia, do you believe that psychotherapy should be seen as an alternative to the use of drugs, or simply an adjunct? And which approach do you see as most suitable to this role? Do you think that one form of therapy might be better than others for individual symptoms of schizophrenia? For example, which therapy would you recommend if the primary symptom were delusions? What if the primary symptoms were negative symptoms?

With the efficacy of medications to alleviate positive symptoms in many people with schizophrenia well established, it may be better to see psychotherapy as an adjunct. Which kind of therapy would be best might depend on the type of symptoms the person has. Delusional or irrational thinking might be best addressed by cognitive behaviour therapy, while negative symptoms such as body immobility might be handled most effectively by behaviour modification. When a person with schizophrenia is receiving a medication that is effective in removing positive symptoms, he or she may still feel worthless and alone as a result of the stigma society attaches to mental disorders and to the stress of coping with the disorder. In this case, for some, Rogerian therapy may be most useful.