Treating Mental Disorders

Behavioural Therapies for Psychological Disorders

Aims: Describe and Assess Behavioural Therapies

Objectives:

By the end of this session you should be able to:

- Outline the behavioural model of psychological disorders
- Describe two behavioural treatments for psychological disorders
- Assess the appropriateness of these therapies for different disorders
- Assess the effectiveness of these therapies
- Outline one ethical issue with behavioural therapies

Assessment

Essay Question:

Describe and evaluate one behavioural treatment for psychological disorders

Behavioural Treatments

The Behavioural Model

- Behaviourists see psychological disorders as the result of maladaptive learning
- They do not assume that sets of symptoms reflect single underlying causes
- Symptoms are acquired through classical and operant conditioning
- Treatment focuses on helping the patient to unlearn maladaptive responses
- Treatment may also involve the patient learning alternative behaviours to symptoms

Behavioural Therapy: General Procedure

Functional analysis: the therapist analyses the clients problem in terms of:

1. Which behaviours are actually the problem
2. Which environmental stimuli trigger the behaviour

Treatment: the therapist designs a programme to help the client:

1. Unlearn the maladaptive responses
2. Learn more adaptive behaviours (if appropriate)

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Common Types of Behavioural Therapy

Therapy	Type of learning	Used for	Involves
Systematic desensitisation	Classical conditioning	Phobias	Gradually deconditioning fear & anxiety responses
Flooding (implosion)	Classical conditioning	Phobias	Intensive deconditioning of fear & anxiety responses
Behaviour modification	Operant conditioning	Various (e.g. teaching basic skills to autistic children)	Use of reinforcement and punishment to shape appropriate behaviours (e.g. eating, dressing)
Token economy	Operant conditioning	Institutional-isation	Like behaviour modification, but on an institutional scale

We will look more closely at

- Systematic Desensitisation
- Token Economy

Systematic Desensitisation

- Based on the idea of **incompatible responses**
- It is impossible to be anxious and relaxed at the same time
- Aims to substitute the patient's anxiety response with a relaxation response

Functional Analysis

- The therapist and patient construct a **hierarchy of fears.**
- A number of phobic situations are described
- The client ranks them in order of fearfulness
- The therapist and client agree of the goals of therapy

Desensitisation Therapy

- The client is taught a number of relaxation techniques
- E.g. control over breathing, muscle detensioning
- The client is gradually exposed to the phobic stimulus
- Intensity follows the hierarchy of fears
- During exposure, the client applies their relaxation techniques
- Once relaxation is possible, the intensity of the phobic stimulus is increased

The number of sessions required depends on the severity of the phobia. Usually 4-6 sessions, up to 12 for a severe phobia.

The therapy is complete once the agreed therapeutic goals are met (not necessarily when the person's fears have been completely removed).

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Exposure can be done in two ways:

- **In vitro** – the client imagines exposure to the phobic stimulus
- **In vivo** – the client is actually exposed to the phobic stimulus

Appropriateness of Systematic Desensitisation

Disorder	Likely to help?	Reason
Simple phobia	Yes	Can decondition anxiety responses to specific objects
Social phobia	Possibly	May help if anxiety is the only problem, but not if it's something else too e.g. lack of social skills.
Agoraphobia	No	Underlying problem is likely to be something else (panic attacks).
Eating disorders	Possibly	Might help client to overcome anxiety associated with eating. Won't tackle the core problem.
Depression	No	Disorder is too complex. Does not address underlying causes.
Schizophrenia	No	Disorder is too complex. Does not address underlying causes.

Effectiveness of Systematic Desensitisation

Source	Type of client	Outcome
McGrath et al (1990)	Simple phobia	• CSI in 75% of patients
Menzies & Clarke (1993)	Simple phobia	• Superior to no therapy. • In vivo exposure slightly more effective than in vitro.
Craske & Barlow (1993)	Agoraphobia	• CSI in 60-80% of cases. • In many cases, improvement only slight. • 50% relapse within 6 months
Barlow & Durand (1995)	Simple Phobia	• Overexposure of phobic stimulus during early stages can intensify the phobia

Summary

- SD is highly effective where the problem is learned anxiety of specific objects/situations.
- Functional analysis must be done carefully to avoid overexposing the client and making matters worse.
- SD could help treating some of the additional problems that may accompany anorexia and schizophrenia.
- However, it will not be effective in treating the underlying causes of these disorders.

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Token Economy

- A type of **behaviour modification** therapy
- Only carried out in institutional settings (e.g. hospitals, schools)
- Based on the use of reinforcement to promote specific behaviours
- May involve punishment to extinguish unwanted behaviours

Functional Analysis

The management of the institution decides:

1. Which specific behaviours they wish to promote
2. Which (if any) specific behaviours they wish to extinguish

Therapy

- Institution staff closely monitor patients' behaviour.
- When a patient displays desired behaviour, they receive a token.
- Different numbers of tokens can be exchanged for reinforcers.
- Staff may take away tokens if they wish to punish certain behaviours.

Tokens act as **secondary reinforcers**. They have no intrinsic value, but they can be used to obtain things that do (**primary reinforcers**).

Primary reinforcers in a token economy could include:

- Sweets and drinks
- Cigarettes
- Access to television
- Trips out
- Increased freedom within the institution

Appropriateness of Token Economies

- Token economies do not cure people of psychological disorders
- However, they may reduce some behavioural problems that may accompany psychological disorders
- E.g. aggression, inappropriate social interaction
- They are particularly good for tackling 'institutionalisation'
- People in long-stay care may lose their motivation for everyday self-care behaviour (e.g. dressing, washing)
- Token economy can help to restore these behaviours.

Effectiveness of Token Economies

Source	Type of Client	Outcome
Allyon & Azrin (1968)	Long term inpatients	• Increase in targeted behaviours, including participation in group therapy
Paul & Lentz (1977)	Long term inpatients	Improvements in: • Socialising • Self-care • Vocational skills
Zimbardo (1988)	Long term inpatients	• Increase in targeted behaviours in institution • Improvements disappeared after discharge
Barlow & Durand (1995)	Long Term inpatients	• When reinforcers were gradually withdrawn, improvements lasted longer after discharge

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Summary

- Most token economies bring about increases in targeted behaviours.
- Improvements may not last after release due to lack of reinforcement.
- Improvements last longer when reinforcement is gradually withdrawn before the patient is discharged.
- It is not clear whether improvements occur due to reinforcement or for other reasons.
- Alternative explanations include better organisation of wards and increased positive interaction with staff.

Ethical Issues with Token Economies

Possible problems:

- **Dehumanising** – treats people like automata/circus animals.
- Makes clients **dependent**, not independent.
- Requires patients to be deprived of **basic rights**.
- **Therapeutic goals** not set by client.
- Possibly done for the **benefit of the institution**, not the patients.

Summary

- Behavioural therapies are based on classical and operant conditioning.
- The aim is for the client to unlearn maladaptive behaviours.
- Systematic desensitisation (classical) is effective in reducing anxiety responses.
- Token economies (operant) can help reduce institutionalisation.
- Behavioural therapies can raise ethical issues if the therapeutic goals are not set by the client.

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