CHAPTER

THEORETICAL PERSPECTIVES

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A theory is a statement that attempts to explain connections among events. It is not in itself a fact but a concept that brings facts together into a sensible overall picture. There is nothing mysterious about the process of making, testing, and using theories. Even quite young children construct useful theories about events in their daily lives. These take the form of ideas such as “If I say I’m sorry, Mommy won’t hit me” or “If I do good at school, my parents will give me a present.” These ideas are based on observations of previous events. On a simple level, they enable the child to understand, predict, and sometimes control the environment.

The process of theory making goes on throughout life. The fact is that the individual is constantly being bombarded with incoming stimuli. Without mental structures to classify and organize these events, the individual would be overwhelmed and unable to function in an organized way. In this sense, theory making is absolutely essential to successful living.

Just as personal theories enable the individual to function effectively, scientific theories enable the human services worker to function effectively. In this chapter, we look at a number of major theories that help workers understand the causes of disorders and plan effective action to either prevent or treat
these disorders. We begin by discussing the nature of scientific theory. We then examine two general theoretical frameworks for helping: the medical model and the human services model. This is followed by a detailed look at three more specific theoretical viewpoints that can be applied within the broader frameworks. These are the psychoanalytic, the humanistic, and the behavioristic systems of therapy. The chapter includes a brief look at some nontraditional paths to fulfillment and closes with an account of systems theory, which some believe holds great promise as a theoretical viewpoint for the future.

**Scientific Theory**

There is no hard-and-fast distinction between personal and scientific theories. All theories are intended to help us make sense of the world around us. The distinguishing features of scientific theories are that they are consciously formed, tested, and shared with other researchers. One purpose of scientific theories is to serve as a guide to future research. Ideally, theories should be continually tested and modified to fit newly discovered facts.

Of course, scientists often fall short of this ideal. Many theories once accepted by reputable authorities are now completely discredited. Sometimes incorrect theories are based on faulty, or limited, observations. For example, a number of early investigators attributed criminal behavior to inherited tendencies (Lombroso-Ferrero, 1911). In this view, the criminal was a “born type” who could be distinguished from “normals” by certain physical traits, such as a low forehead, an unusually shaped head, eyebrows growing together above the bridge of the nose, and protruding ears. Modern investigators found that this theory did not account for criminals who lacked these physical characteristics and that it ignored data that linked criminal behavior to poverty and certain social conditions.

Because theories often serve as guides to action, the blind acceptance of an incorrect theory may have harmful consequences. The only remedy against the hazards of bias is to be receptive to all of the relevant facts in a situation.

**Theories about Human Disorders**

Now that we have presented a general idea of what theories are and what purposes they serve, our focus shifts to the main concern of this chapter: theories about human disorders. Very simply, these are theories that try to explain why and how certain disorders come about. Based on this understanding, each theory proposes certain treatments designed to alleviate the disorder in question. Theories, then, are not merely matters for dry academic discussion; they also have a powerful impact on what the helper does for or to the client.

Traditionally, human disorders are divided into two main types: physical and mental or psychological. The latter will be emphasized because these are of main concern to the human services worker. All of the major theories to be reviewed offer reasonable explanations of how and why psychological disor-
ders occur. However, the explanations are quite different from one another. Why are there so many different explanations? There are several possible answers to this question. One is that human behavior is so complex that no single theory can explain every disorder. Another answer is that each theory tends to focus on certain kinds of abnormal behavior. A third point, related to the other two, is that different theories tend to focus on different levels of observation. Before proceeding to the specific theories, it is necessary to clarify what is meant by levels of observation.

Three Levels of Observation

Each theory tends to focus on one of three general levels of observation: the biological, the psychological, or the social level. In other words, researchers tend to specialize in the study of events at one particular level.

From the biological point of view, an organism is viewed as a physical or biochemical system. Disease, physical damage to the body, or inadequate development of internal organs may all hamper an individual’s ability to get along in the outside world. For example, some forms of mental retardation are due to abnormal development of the brain and nervous system. It is also known that one form of senility is due to a breakdown in the blood vessels of the brain. Physical abnormalities are the main province of medical science. The medical approach to treatment (to be described) employs medication, surgery, and other physical methods to cure, or at least ameliorate, disorders.

From the psychological point of view, the individual attempts to gain gratification of needs and goals by interacting with the outer environment. To adapt successfully, the person must behave in ways that suit the immediate situation. The person’s skills, motives, needs, emotions, and ways of handling stress all play a role in this adaptive struggle. Obviously, some individuals are more successful than others in attaining satisfactions. Some of the psychological problems familiar to the human services worker are clients’ low self-esteem, lack of skills, and self-defeating ways of trying to achieve stated goals in life.

The social level refers to the powerful influences of family, school, neighborhood, and society. To the human services worker, one of the most important social variables is socioeconomic status. This includes specific factors such as income, level of education, and the prestige value of one’s occupation. High-level executives, administrators, and professionals rate higher on this scale than do blue-collar workers and welfare recipients. The majority of those who receive help from human services are concentrated in the lower income levels.

Controversy, and some confusion, exists about applying these three levels of observation to specific disorders. Biological, psychological, and social theories have been forwarded about alcoholism, schizophrenia, criminality, and many other disorders. Various investigators proclaim that one level is more important than the other two in causing these disorders. There is, for example, intense debate about the relative importance of inherited physical traits in predisposing an individual toward one disorder or another. The fact is that all three levels may be involved in the development of a certain disorder.
Multiple Causes

In both medical and social sciences, it is now generally accepted that many disorders have more than one cause. For example, on the biological level, the immediate cause of tuberculosis is infection by a certain bacterium. Because this is a common bacterium, the following question arises: Why do some people come down with the disorder, whereas others do not? The answer is that the victim is often in a physically run-down state in which the body’s normal defenses against infection have been depleted. Further investigation usually shows that a number of psychological and social factors play a role in getting the victim into this state. For example, the patient’s lifestyle often seems to have a frantic, overactive quality. Social factors are implicated by the fact that the incidence of tuberculosis is far higher in poor than in affluent communities. Obviously, then, biological, psychological, and social factors may all be involved in causing a particular disorder.

Political Implications of Theory

The controversies among theories are not merely matters of factual evidence but also involve underlying political and economic factors. For example, it makes a difference if the behavior problems associated with poverty are attributed to (a) psychological defects such as laziness or lack of intelligence or (b) the impact of society, which has stacked the cards against the poor. In the first case, the individual is held fully responsible for his or her poor circumstances. In the second, the person is seen as the victim of social and economic factors beyond his or her control. Obviously, a more sympathetic response goes along with this second point of view.

Models of Dysfunction

This brief introduction to theory paves the way for discussion of two general models of dysfunction: the medical model and the human services model. The term model in this context refers to a general theoretical point of view about the causes of disorders. Perhaps the earliest model was the religious or magical perspective, which emphasized evil spirits as the cause of illness. The medical model, with its scientific focus, gradually replaced the spiritual notion of causation. The medical model emphasizes biological factors, such as bacterial, viral, or genetic agents, in causing diseases. More recently, the human services model, with its focus on social factors, has challenged the medical model. We will first take a detailed look at the medical model.

The Medical Model

As applied to psychological disorders, this model stresses the causative role of factors within the individual. Adherents of the medical model do not claim that all so-called mental disorders are due to biological or organic factors. In fact, they make a distinction between organic and functional disorders.
The **organic disorders** are caused by physical abnormalities of the brain, nervous system, and other internal systems. Epilepsy, senility, some kinds of retardation, and certain psychotic states are examples of disorders in which some physical abnormality has been found to play a role. Organic disorders may be caused by inherited defects, chemical imbalances, viral infections, malnutrition, and various drugs and poisons. Disorders associated with physical damage are likely to be long-standing, whereas those associated with drugs may represent temporary disorders of brain function.

The **functional disorders**, in contrast, are due to psychological factors operating within the individual. These might include poorly controlled drives and impulses, unrealistic ideas, and unresolved conflicts. Addictions, antisocial tendencies, neuroses, and some psychotic reactions are classified as functional disorders. This means that the major causes are presumed to relate to the personality of the individual rather than to any physical defects. Some disorders, such as the schizophrenias, cannot be classified with great confidence because of doubt about the causes.

**Medical Procedure**

Regardless of whether a disorder is organic or functional, the procedures of medical practice can be applied to it. This means that a certain psychological disorder can be approached as though it were a physical disorder such as measles or tuberculosis. The first step in medical and psychiatric practice is to arrive at a **diagnosis**, which means to classify and label the disorder according to the presenting symptoms. Next comes the formulation of a treatment plan, which may include medication, shock therapy, psychotherapy, and/or confinement to a mental hospital. The treatment is related to the **prognosis**, which is an educated guess about what degree of recovery can be expected for the patient.

For example, a young man became despondent over losing his fiancée to someone else. He made the rather dramatic suicidal gesture of threatening to jump from the roof of an apartment building but let himself be talked down by the police. He was taken to a community mental health center and admitted to a ward for observation and treatment. He was diagnosed as suffering from a depressive reaction. The treatment plan included brief counseling sessions to help ventilate his feelings of hurt, loss, and anger. In addition, he was put on a mood-elevating drug. In view of his history of good functioning, the prognostic outlook was favorable. This is the medical model in action: a psychological or emotional reaction is handled with the basic procedures of medicine.

**Treatment Approaches of the Medical Model**

Because the medical model is accepted by many professionals employed in mental hospitals, prisons, schools, mental retardation centers, and other settings, the human services worker needs to understand something about the treatments derived from this model.
By far the most common treatment approach is drug therapy, sometimes called chemotherapy. Recent decades have seen the development of a wide variety of powerful drugs that are capable of modifying mood and emotional states. The major tranquilizers, for example, are a class of drugs first introduced to this country in the 1950s. They quickly became a major treatment modality in psychiatric clinics and hospitals when it was found that they suppress or ameliorate some of the disturbed behavior of psychotic patients. They are likely to be used when a patient shows extreme tension, aggressiveness, delusions, hallucinations, or insomnia. Without producing a cure, they often make the patient more manageable by staff. Thorazine, Mellaril, and Stelazine are the trade names of three of the most frequently used drugs of this type.

Another popular treatment approach involves the use of minor tranquilizers to reduce tension and anxiety. In the 1960s, Roche Laboratories introduced two drugs that were members of the chemical family called benzodiazepines: Librium and Valium. These drugs soon captured a large share of the market for psychotropic medications, prompting other drug companies to produce and market similar drugs (Lickey & Gordon, 1991). In 1975, about 85 million prescriptions for benzodiazepines were written in this country. This was followed by a wave of concern in the medical community about the possible overprescription of these medications. As professionals became worried about the risks of abuse, including addiction and dependence, the rate of prescription began to decline. It was found that withdrawal from the drugs may bring serious complications, including an anxiety state more severe than the original anxiety disorder (Miller & Mahler, 1991). However, during the 1980s, there was a gradual return to high consumption of these drugs, until the current level of 60 million annual prescriptions was reached. Most of the prescribing is done by general practitioners rather than by psychiatrists. The drugs provide a handy means of pacifying patients who complain of tension, anxiety, mild depression, and insomnia.

Another relatively recent drug therapy is the use of lithium carbonate for persons suffering from manic-depressive disorders. It is particularly useful in controlling the excessive elation, irritability, and talkativeness of the manic phase. Another group of mood-altering drugs is the antidepressants, which have been effective in combating certain types of severe depressive states.

Table 4.1 lists the generic and brand names of some of the frequently prescribed psychotherapeutic medications. New drugs are constantly being marketed, and it is likely that the table will need updating by the time you see it. All human services workers in medical settings are advised to prepare their own table of medications commonly used in their service. An essential reference book is the Physicians’ Desk Reference (PDR; 1996), a comprehensive text on all kinds of drugs that is updated annually. We suggest that students learn how to use it.
Other Medical Treatments

Drugs are only one type of medical model treatment. A number of convulsive therapies have been developed for use with psychiatric patients. The most common of these in current use is the famous (or infamous) electroconvulsive therapy (ECT). Used extensively in private psychiatric hospitals, it involves administering an electric shock at the patient’s temples for a brief (0.1–0.5-second) duration. Treatments are given several times a week and may continue for five or six weeks. ECT is used mainly to treat patients who are depressed, especially when there is no obvious external stress such as loss of job or divorce. Probably no other form of therapy evokes such negative feelings as this one. Despite modern trappings, it appears to many to be some kind of medieval torture. During the 1950s, there were many reports of abuse and sloppy administration of the procedure. It was used with a wide variety of disorders, and results were often unfavorable. Recent refinements of the technique have reduced side effects and increased its effectiveness.

Another medical-type treatment called psychosurgery has also been sharply criticized by human services workers. The most frequently used procedure of this type is the lobotomy, which involves cutting nerve fibers connecting the frontal lobes to other parts of the brain. Literally thousands of these operations were performed on mental patients during the years before the introduction of major tranquilizers. It was used mainly with patients who were so aggressive that they presented severe management problems. Unfortunately, the procedure often produces serious irreversible side effects such as lethargy, childish behavior, and mental dullness.

Valenstein (1986) has provided a fascinating history of psychosurgery. He tells the story of how it came about that “tens of thousands of mutilating brain operations were performed on mentally ill men and women in countries around the world” (p. 3). By the 1960s, it was apparent that these lobotomies were causing severe damage to the victims. These operations, now thought bizarre and obsolete, were part of the mainstream medicine of their time. They were due in part to many psychiatrists’ readiness to believe in simple, biological approaches to the treatment of the mentally ill. Valenstein also shows that the physicians who developed and promoted this procedure were driven by intense ambition to deceive themselves and others about the value of their “cure.” These events clearly show the need for clinical testing of new, potentially harmful procedures before they are allowed to be used on a large scale.

Other therapies related to medical approaches, such as rehabilitation and occupational therapy, are described in Chapter 6.

Criticisms of the Medical Model

A number of authors have cried out against the injustices that arise from the medical/psychiatric approach to mental illness. Szasz (1973), for example, charged that his psychiatric colleagues were guilty of persecuting mental patients
### Table 4.1 Major Types of Psychotherapeutic Medications

<table>
<thead>
<tr>
<th>Type of Drug</th>
<th>Generic Names</th>
<th>Brand Names</th>
<th>Major Uses</th>
<th>Possible Side Effects</th>
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<tbody>
<tr>
<td>Major tranquilizers</td>
<td>Chlorpromazine</td>
<td>Thorazine</td>
<td>Sometimes called antipsychotics, these medications help control severe anxiety, agitation, delusions, hallucinations, hostility, and hyperactivity associated with schizophrenia and other psychotic states.</td>
<td>Confusion, restlessness, insomnia, euphoria, exacerbation of psychotic symptoms, muscle weakness, and fatigue. Prolonged use may result in tardive dyskinesia, a neurological disorder featuring involuntary muscular movements.</td>
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<td></td>
<td>Phenothiazines</td>
<td>Stelazine</td>
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<td>Mellaril</td>
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<td>Prolixin</td>
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<td>Compazine</td>
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<td>Haloperidol</td>
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<td>Haldol</td>
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<tr>
<td>Minor tranquilizers</td>
<td>Benzodiazepines</td>
<td>Valium</td>
<td>These antianxiety medications are widely prescribed by primary care physicians when anxiety, irritability, and agitation—symptoms often related to situational stress—become severe enough to interfere with daily functioning.</td>
<td>Drowsiness, dizziness, headache. Since these drugs depress the central nervous system, reflexes are slowed. Caution must be taken when driving and operating machinery. Dangerous when used in combination with alcohol and other CNS depressants. Some patients may become addicted to these drugs.</td>
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<td>Librium</td>
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<td>Serax</td>
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<td>Restoril</td>
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<td>Xanax</td>
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<td>Equanil</td>
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<td>Meprobamates</td>
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<td>Valium</td>
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<td>Librium</td>
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<td>Equanil</td>
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<tr>
<td>Antidepressants</td>
<td>Tricyclics</td>
<td>Elavil</td>
<td>These medications generally lift mood and are used to combat severe depressions. They have been found to be particularly effective in endogenous depression—having no apparent situational cause.</td>
<td>Anxiety, restlessness, exacerbation of psychosis, dry mouth, blurred vision, skin rash, fatigue, sensitivity to sun.</td>
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<td>Sinequan</td>
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<td>Tofranil</td>
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<td>Aventyl</td>
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<td></td>
<td>MAO inhibitors</td>
<td>Nardil</td>
<td>The MAO inhibitors are often used in patients who do not respond favorably to treatment with tricyclics.</td>
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<td></td>
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<td>Parnate</td>
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<td>Combination agents</td>
<td>Limbitrol</td>
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<td>Triavil</td>
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<td>Category</td>
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<tr>
<td>Second-generation antidepressants</td>
<td>Fluoxetine, Setraline, Paroxetine</td>
<td>Although the major use is still to elevate mood, these medications are increasingly being used to treat eating disorders, including obesity, and obsessive-compulsive disorders.</td>
<td>May cause nausea and headaches but are reported to have fewer undesired effects than the earlier antidepressants.</td>
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<tr>
<td>Antimanic</td>
<td>Lithium carbonate</td>
<td>Primarily used to treat manic episodes and bipolar affective disorders. It is also being used in some cases of schizophrenia.</td>
<td>Levels of lithium in the blood must be monitored and carefully regulated, as it can act as a toxic agent impairing various bodily processes. Overdosage may produce serious complications and may be lethal.</td>
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<tr>
<td>Sedative-hypnotic</td>
<td>Barbiturates</td>
<td>Used to produce a calming effect and to induce sleep. Can be used to treat convulsive disorders.</td>
<td>Extreme dullness and drowsiness. May be deadly when taken with alcohol or other CNS depressants. May be habit forming.</td>
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<tr>
<td>Anticonvulsant</td>
<td>Phenytoin sodium, Primodone</td>
<td>Used to help control epileptic seizure disorders.</td>
<td>Insomnia, nervousness, motor twitchings, headache, nausea, vomiting, and many other symptoms.</td>
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<tr>
<td>Stimulant</td>
<td>Amphetamines</td>
<td>Have been used in treating overweight and narcolepsy (uncontrolled fits of sleep), allow under-functioning areas of the brain to increase their function, thereby helping control hyperactivity and inattention.</td>
<td>Insomnia, restlessness, talkativeness, loss of appetite, paranoid ideation, and possible aggression and anxiety.</td>
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<tr>
<td>Antialcoholic</td>
<td>Disulfiram</td>
<td>Used as an aversive therapy in treatment of alcoholism. When alcohol is taken while a person is using Antabuse, a potent negative reaction occurs including nausea, vomiting, racing heart, and flushing.</td>
<td>Use is contraindicated in people with certain physical disorders; may be carcinogenic with prolonged use, and may cause nervous system toxicity.</td>
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</table>
under the guise of treating them. In particular, he questioned the validity of labeling certain individuals as mentally ill when, in fact, they were merely suffering from problems in living. Mental illness, he went on, is a myth, not a genuine disease at all. The underlying purpose of labeling (diagnosing) certain people as mentally ill is to provide society with a convenient means of getting rid of undesirable deviates. These are typically people who have committed no real crime but are bothersome, annoying, or frightening to other people.

Along the same lines, Kovel (1980) charged that psychiatry’s focus on the psychological aspects of the patient “is a handy way of mystifying social reality” (p. 73). The same author argued that psychiatrists exert social control over social misfits by telling them they have a case of this or that and then imposing a treatment plan. What is left out of the process is acknowledgment of the damaging role of poverty, poor housing, lack of opportunity, unemployment, and other social ills.

**The Human Services Model**

The *human services model* received its major impetus during the 1960s. It was closely associated with social movements devoted to bettering the lives of oppressed minority groups. Human services workers thought of themselves as warriors and sometimes even as revolutionaries. Impatient with the medical model and its emphasis on the inner person, these workers wanted to bring about great social changes by improving the environment. In particular, they focused on the harsh external conditions that oppressed the lives of the poor. These workers were not interested in formulating complex theories. Their attitude was pragmatic—that is, based on a spirit of practical problem solving. The idea was if something worked, use it.

The basic assumption of this model is that maladaptive behaviors are often the result of a failure to satisfy basic human needs. The first step in intervention is not diagnosis but an assessment of the victim’s life situation with a view to discovering what needs are not being met. The person may be in need of decent housing, medical attention, a job, or a more adequate diet. Others may be lacking these essentials and may also be extremely lonely and in need of social interaction. It is not surprising that emotional problems are intensified by factors such as unemployment, loneliness, and low social status. Society, not the individual, is seen as the culprit. Therefore, society must be prodded to provide the needed goods and services.

**Hansell’s Theory**

One of the most elaborate theories used by human services workers is Hansell’s motivation theory (Hansell, Wodarczyk, & Handlon-Lathrop, 1970). He and his colleagues theorized that people have to achieve seven basic attachments to meet their needs. If a person does not achieve each attachment, he or she goes into crisis or a state of stress. Here is a list of the seven basic attachments, along with signs of failure of each one:
1. Food, water, and oxygen, along with informational supplies. Signs of failure: boredom, apathy, and physical disorder.
2. Intimacy, sex, closeness, and opportunity to exchange deep feelings. Signs of failure: loneliness, isolation, and lack of sexual satisfaction.
3. Belonging to a peer group such as social, church, or school group. Signs of failure: not feeling part of anything.
5. A social role that carries with it a sense of being a competent member of society. Signs of failure: depression and a sense of failure.
6. The need to be linked to a cash economy via a job, a spouse with income, social security benefits, or other ways. Signs of failure: lack of purchasing power, possibly an inability to purchase essentials.
7. A comprehensive system of meaning with clear priorities in life. Signs of failure: sense of drifting through life, detachment, and alienation.

**Human Services Interventions**

Hansell’s scheme readily lends itself to the task of helping the client in practical ways. The worker needs to find ways to satisfy some of the client’s unmet needs. The client’s complaints are related to the signs of failure just described. Sometimes, the nature of the unmet need is blatantly obvious; at other times, it may be quite subtle. The client is not always able to cooperate with the helper. For example, the client may deny having a certain need or may feel demeaned by accepting the kind of help available. The aim of human services counseling is usually to link the client with sources of satisfaction. This might involve helping the client secure welfare benefits, find a job, join a club or social group, return to school, or locate a temporary shelter. The focus is on solving problems here and now. Past problems and bad experiences may be discussed, but they are not the main focus of counseling.

The human services worker is usually a generalist trained to work in a variety of agencies to provide across-the-board services to clients and their families (Southern Regional Education Board, 1978). By definition, a generalist is familiar with a variety of therapeutic approaches rather than specializing in one or two areas. The main goal of intervention is usually to identify the needs and problems of the client and then to provide resources to meet the needs and solve the problem. Of course, the worker is not usually able to meet needs in a direct, personal sort of way but is familiar with service providers in the community. These include doctors, ministers, lawyers, police, parole officers, mental health professionals, and just about anyone else who may be able to help the client. If needed services are not available, the worker may be able to influence the community to set up new programs. More of this is discussed in Chapter 8.

A wide variety of roles may be played by the human services worker, each calling for special skills. The worker may be an advocate, a mobilizer, a teacher, or an administrator. The skills required by these activities are discussed in further detail in Chapter 5. The immediate point is that the underlying purpose is usually the same: identifying and meeting the needs of clients.
Human services workers have sometimes criticized mental health professionals (psychiatrists, clinical psychologists, and social workers) for overlooking obvious practical solutions to human problems. One reason for this oversight is that these professionals are often trained in intricate psychological theories and treatment methods. They often see problems as reflecting deep emotional conflicts rather than poverty and other external factors. Psychoanalytic theories in particular confer status and prestige on therapists. One author suggested that the mundane problems of poverty hold little fascination for the middle-class professional, who would prefer to psychologize about the poor and prescribe the latest fashion in psychotherapy (Pelton, 1978).

**ISSUES UNDERLYING CONFLICT BETWEEN MODELS**

The conflict between adherents of the medical and human services models goes far beyond disputes over theory. A host of issues related to power, money, and licensing have not been fully resolved. For example, human services workers maintain that the criteria for delivering service should center around competence to do the job. They point out that indigenous workers who live in the community served are often more effective in helping residents than highly educated professionals. They also point out that generalist human services workers are often able to perform counseling and therapy just as effectively as traditional professionals. Without denying the usefulness of indigenous workers and paraprofessionals, traditional mental health professionals are likely to emphasize the importance of advanced academic training, degrees, and licenses in determining job duties, salaries, and responsibilities. They see themselves as supervisors of workers with less academic training. Each side accuses the other of basing claims on narrow self-interest rather than considering the needs of the clients.

Although this topic is discussed further in subsequent chapters, we can state here that human services workers are steadily growing in numbers and assuming more and more responsibility for delivery of services. With this growth has come an increased desire for professional training and status. What is emerging is a new breed of professional, trained not in medical model disciplines but in human services.

**THE HOLISTIC TREND IN MEDICAL THEORY**

As we have seen, the traditional medical model views disease as a departure from a biological norm and, accordingly, stresses biological or physical approaches to treatment. Increasingly, this model is being criticized for its limited scope and for overlooking the social settings in which disease occurs. The holistic approach, which considers all aspects of a person’s life, is gaining favor among both physicians and human services workers as an alternative model. It is based on the idea that environmental, social, and psychological factors may all contribute to illness or to health. It follows that health promotion need not be limited to biological or physical interventions. Practitioners of holistic healing attempt to find a balance between a person’s mind, body, and spirit in
a given environment. In specific cases, the holistic ideal may translate into any of the following kinds of treatment: changes in diet, meditation, relaxation, biofeedback, and stress reduction (Popple & Leighninger, 1990). Because it emphasizes lifestyle factors, the holistic approach lends itself to prevention of illness. Holistic programs, aimed at promoting healthier lifestyles, have been established in industrial, hospital, and school settings.

**Psychoneuroimmunology (PNI)** This is a new field of study that has already provided evidence that supports the basic ideas of the holistic model. PNI attempts to find connections among psychological states, the nervous system, and the immune system. To use somewhat outdated terminology, it is the study of interactions between the mind and the body. As Lerner (1994) explains, “emotional states and behavior patterns may profoundly affect not only our symptoms but the progress of our disease itself” (p. 137). Experimental studies have shown that acute stressors (for example, electric shock, bright lights, extreme temperatures, or overcrowding) often cause suppression of the immune system in animals. The immune system is our first line of defense against disease: it consists of complex mechanisms that detect and destroy foreign invaders such as bacteria and viruses. It also defends against cancer cells that originate within the body. Early findings, reviewed by Lerner, indicated that humans under stress also undergo a weakening of the immune system, putting them at increased risk of infectious disease and tumor growth. These findings help explain the repeatedly found connection between disease and stressful life events that we discussed in Chapter 1. Lerner (1994) expresses astonishment at the lack of attention paid to emotional factors by some conventional doctors in the treatment of cancer and other serious disorders.

**Alternative Medicine** Lynn Payer (1988), a leading medical journalist, compared medical practices in the United States with those of several modern European nations. She found that American medicine is more aggressive than that of England, France, and Germany. American doctors perform more invasive diagnostic examinations and more surgery than others. Up to one-third of American patients have been seeking alternative methods. Some seek alternatives when they have not been helped by traditional medicine, but an increasing number are simply bypassing the regular doctor. Still other patients seek alternative treatments for certain conditions and regular treatment for other conditions (Ricks, 1995).

There is a large menu of unconventional methods from which to choose. For example, asthma, chronic pain, drug addiction, and other disorders may be treated by means of **acupuncture**, a traditional Chinese method in which needles are inserted into the skin at certain critical points. Chinese doctors believe that a system of meridians, or energy pipelines, runs through the body. The points at which the needles are placed are like valves where the energy levels can be adjusted. Although some may question whether these meridians really exist, there is little doubt that acupuncture has proved its value in controlling pain and nausea. Other uses are now being seriously researched (Lerner, 1994). Also growing in popularity is Chinese herbal medicine, which has a very long history of use in the Far East.
A number of doctors are now providing nutritionally oriented alternatives to more conventional drug-oriented approaches. Medical schools have long been criticized for failing to educate doctors in nutrition, but they are beginning to make up for this deficiency. It is well known that poor nutrition, particularly the high-fat/high-sugar diet of Americans, contributes to heart disease, high blood pressure, diabetes, and other ills. Thus, it makes sense to seek improved health through better nutrition.

Visualization or imagery therapy has received a good deal of attention in the popular media in recent years. In this form of therapy, patients are first taught to relax and then to develop their own images for fighting the disease. Apparently, this technique makes use of the power of suggestion. There is much evidence from religious healing, experimental studies, and other sources that our expectations can sometimes be used to alleviate anxiety and promote healing (Frank & Frank, 1991). The so-called placebo effect refers to the strong influence that inactive “medications,” such as sugar pills, may have on a patient’s condition. Again, it is the patient’s expectations that may influence the effect of a given pill.

So many other alternative approaches are available, such as homeopathic medicine, Hindu methods of healing, and aromatherapy, that we could not possibly detail them all here. Critics have conceded that some of the alternative methods have been proven to be effective, but others may have dubious value in regard to a particular disorder. It is up to the consumer to carefully evaluate the evidence pertaining to a particular therapy before getting involved with it.

The holistic trend in medicine may provide the means of reconciling the medical model with the human services model. This is because the holistic approach recognizes the importance of environmental factors in human disorders. On a practical level, the acceptance of alternative methods of healing will mean a greater role for nonmedical therapists in the treatment of physical illnesses.

**Schools of Therapy**

The perspectives most commonly used in group and individual approaches to psychological problems are the psychoanalytic, the humanistic, and the behavioristic schools or systems of therapy. A “school” in this context is a group of workers who study certain disorders and use similar methods of study. Although the members of a school may disagree about various points, they share certain basic ideas about the causes of psychological disorders. These basic beliefs, in turn, dictate their approach to helping.

**The Psychoanalytic Viewpoint**

The development of psychoanalysis is very much associated with Sigmund Freud and his followers. Actually, many of Freud’s insights, such as the idea of the unconscious mind, had already been discovered by others (Murray, 1988). There is no doubt, however, that Freud was responsible for shaping
psychoanalysis into a coherent system of thought. Under Freud’s direction, psychoanalysis became one of the influential movements of modern times.

**Major Freudian Concepts**

The major idea that evolved from psychoanalysis was that neurotic symptoms are the result of conflicts within the patient. Neurotic symptoms include **phobias**, which involve an intense fear of a specific stimulus such as enclosed places; **obsessions**, which involve the repeated intrusions of certain unwanted thoughts into consciousness; and **compulsions**, which require the patient to repeatedly perform some ritualistic act such as hand washing. These and similar complaints are the result of a conflict between a person’s sexual and aggressive urges on one hand and society’s demands for control of these impulses on the other (Maddi, 1972). The neurotic symptoms represent attempts to resolve the conflict.

In Freudian terms, the personality is made up of three subsystems: the **id**, the **ego**, and the **superego**. The **id** is the seat of primitive instincts such as sexual and aggressive drives. This part of the personality wants what it wants now. It is the first system to appear in the development of the child. The **ego** is gradually developed to help the child attain gratification in a realistic and socially acceptable manner. The ego employs reason and logic and is concerned with helping the person survive in the world. The **superego**, similar to the conscience, is an outgrowth of the taboos and moral values of the society as interpreted by the parents. It aims to inhibit desires that are regarded as wicked or immoral. These three forces are in constant interaction, one factor that makes the theory very complex.

When the ego, the “executive” of personality, is confronted with id impulses that are threatening to get out of control, anxiety and guilt feelings are aroused. In some instances, the anxiety is reduced by coping with the impulses in a satisfactory way. A young person may, for example, decide to gratify sexual urges in the context of marriage. When a realistic resolution of conflict is not available, the ego employs a **defense mechanism** to reduce tension. For example, the entire conflict may be repressed—that is, blocked from awareness. Or the desire may be expressed in some disguised or symbolic way. For example, aggressive urges may be discharged in sports and games, or erotic feelings may be expressed in artistic pursuits.

**Therapeutic Concepts**

Early in his career, Freud began to work with Josef Breuer, a Viennese physician who pioneered in treating neurotics. Breuer treated a number of patients whose symptoms were “hysterical” in nature—that is, due to emotional rather than physical factors. Some of these patients suffered memory losses or paralysis of certain organs but had no physical defect that could account for the
symptoms. Breuer treated them with hypnosis, the method used by earlier therapists. Under hypnosis, patients were often able to recall painful experiences, called *traumas*, associated with the onset of the symptoms. Breuer found that if the patient could relive the painful emotions associated with the trauma, the symptoms often disappeared. This was the beginning of the “talking cure,” a method based on uncovering feelings and experiences buried in the unconscious.

**Free Association**  Freud carried on the talking cure with new patients. He gradually developed the technique of *free association*, in which the patient lies on a couch and is encouraged to say anything that comes to mind, no matter how embarrassing it may seem. The basic aim was to bring into conscious awareness any memories or thoughts that had been repressed—that is, pushed into the unconscious because of their threatening nature. While free associating, clients sometimes “blocked,” or became unable to bring emotionally charged thoughts into conscious awareness. Freud regarded this as a sign of resistance, which can be defined as any tactic or behavior that works against the production of unconscious material. All clients resist therapy at one time or another. Freud recognized that resistances must be approached with caution because they protect the patient from unbearable anxiety. Overcoming resistances became a regular part of analytic therapy.

**Transference**  Freud found that during therapy his clients sometimes experienced feelings, attitudes, and defenses toward him that were derived from previous significant relationships. These feelings and attitudes seemed to have been transferred from the past to the present. The client reacted to Freud as though he were mother, father, or some important figure. Occasionally, patients seemed to fall in love with him and wanted very much to please him. Or sometimes the client would be very hurt if strong feelings were not reciprocated.

According to Freud’s theory, *transference* reactions imply that the client is generalizing from past experience. If the mother was warm and overprotective, the client assumes that the analyst will also behave in this way. Over the years, analysis of transference became a central feature of psychoanalysis because it provided a vehicle for resolving old conflicts. Analysis of transference made it possible for analysts to work toward a radical change in the client’s personality.

The goals of psychoanalytic therapy have changed greatly over the years. The aim of the early work was simply to relieve neurotic symptoms, whereas later analysts aimed to bring about significant personality change. In this sense, psychoanalysis is the most ambitious system of therapy and one reason that therapy may take many years.

**Psychoanalytically Oriented Psychotherapy**

The form of treatment developed by Freud came to be known as *classical* or *orthodox psychoanalysis*. It required three, four, or even five sessions a week and could go on for many years. Free association, dream analysis, and analysis
of transference were the major technical methods. As the analytic movement grew and its practitioners emigrated to America and to other parts of Europe, the treatment was adapted to different cultures. Psychoanalysis became very popular in this country during the 1930s and 1940s, but it was streamlined to suit American needs and tastes. The number of sessions was reduced to one or two a week, an armchair was usually substituted for the couch, and there was relatively greater emphasis on solving present-day problems as opposed to delving into the past. Many psychiatric clinics and mental hospitals employed this modified analytic approach in treatment and training.

Early Revisionists: Adler and Jung

Owing in part to his forceful personality, Freud gained many followers during the early decades of this century. However, some of them found themselves unable to accept critical aspects of his theory. For example, two of his early followers, Alfred Adler and Carl Jung, disputed Freud’s claim that repressed sexual drives were the primary cause of neurotic symptoms. To Freud’s dismay, they both advanced major revisions of his theory and went on to organize psychoanalytic schools of their own. Both argued that Freud had not fully realized the importance of social and cultural factors in shaping personality. Beyond this area of agreement, Adler and Jung went on to construct widely divergent theories.

Adler’s Individual Psychology

Adler firmly believed that human beings are social beings first and foremost, and that personality is formed by patterns of relationships with others. Adler’s best-known concepts are those of inferiority and compensation. He taught that everyone suffers inferiority feelings to some degree because each of us was, in fact, inferior to adults during childhood. In addition, some individuals feel inferior to peers and siblings because of real or imaginary deficiencies. Some children are smaller, weaker, or uglier than others, whereas some compare themselves unfavorably in regard to intelligence or material possessions. The greater the intensity of inferiority feelings, the greater the need to compensate by striving to be superior. The person may seek power, strive for perfection, or develop some special skill or talent to the utmost. The ways in which a person strives for mastery become part of his or her style of life.

Adler developed an approach to treatment that was more direct than the classical approach. He sat opposite the patient and focused the discussion on the patient’s attitude toward other people and society. The path to psychological health was to develop a strong “social interest.” This meant being helpful to others, seeing them as worthy, and controlling one’s urge to compete irrationally against others for power. In general, Adler’s approach is very congenial to those with a human services orientation. He was very much interested in improving the lives of ordinary people and is credited with being one of the first to set up child guidance centers for the benefit of working-class families.
Jung’s Analytical Psychology  Jung is regarded as the most complex and difficult of the analysts, with some of his concepts verging on mysticism. More than any other analyst, he stressed the importance of the religious and spiritual side of human nature. He delved into occult writings and sought insights into the nature of humans by studying the dreams and myths of primitive peoples. *Man and His Symbols*, edited by Jung (1964), is a good introduction to this mysterious world.

Jung agreed with Freud that behavior is often influenced by ideas buried in the unconscious mind. He went on from there to suggest that the unconscious mind is made up of two layers. The first is the **personal unconscious**, which contains personal experiences that have been repressed or forgotten. The second layer is the **collective unconscious**, which contains experiences inherited from our ancestors. All of us share this collective unconscious, which includes images and ideas never experienced on a personal level. These ancient experiences are embodied in **archetypes**, which are significant racial memories passed from one generation to the next. Some of the archetypes include the Great Mother, the Hero, the Wise Old Man, and God—images that recur in every human society. These archetypes are based on common human experiences such as birth, love, conflict, and death. They can be recovered through dreams and fantasies, and they can be tapped to enhance creative abilities and to provide insights about our personal development.

Jung’s approach to treatment stressed the client’s need for personal growth. He observed that many of his patients, particularly those in their middle years, complained of a sense of stagnation in their lives. They had completed certain of life’s tasks, such as raising their children, and now found themselves without any clear sense of direction. Jung used dream analysis and fantasy to help clients get in touch with their true selves. Jung’s ideas about growth of personality influenced the humanistic theorists, to be discussed later.

Later Revisionists: The Neo-Freudians

The next generation of psychoanalytic thinkers included Karen Horney, Erich Fromm, Erik Erikson, and Harry Stack Sullivan. Though they remained in the psychoanalytic tradition, each departed considerably from the Freudian model. The theories of these neo-Freudians are too complex to be presented in detail. However, some of their major ideas can be briefly reviewed.

The neo-Freudians highlighted social factors in the development of personality. Horney, for example, believed that the child’s dominant motive is not gratification of instincts but a striving for security and acceptance by others. When important persons in the family are perceived as hostile and ungiving, the child experiences painful feelings of anxiety. Horney discerned three major trends or tactics that children use to reduce this anxiety and increase security. Some children find themselves in a situation in which moving toward others makes them feel safe; these children may become submissive and self-effacing in their dealings with others. The second pattern shown by some youngsters is
a moving away from others; these children seem to act on the premise that if they don’t get too close to others, they won’t get hurt. The third pattern is moving against others, which may take the form of rebellious and antisocial behavior. The other neo-Freudians developed somewhat different ideas but agreed with Horney’s emphasis on social interaction.

The new revisionists all doubted Freud’s assumption that adult personality was shaped by early childhood experiences. For example, Sullivan, who founded the interpersonal theory of psychiatry, believed that experiences during the juvenile and adolescent phases could have a profound impact on personality. He felt it was crucial for a youngster to have close friends and confidants during these difficult periods of life. Along with the other neo-Freudians, Erikson (1963) stressed the social aspects of human development. He taught that in each stage of life the person tries to establish an equilibrium between the self and the social world. At each phase of development, the person is faced with a task or a crisis to be resolved. For example, the infant’s basic task is to develop a sense of trust in self, others, and the world. Obviously, the infant is totally dependent on others for survival. In an atmosphere of insecurity, the child may develop a sense of mistrust that can retard progress and color later relationships with others. At each later phase, the person is faced with another crisis. Obviously, it would be helpful for the human services worker to have an understanding of the developmental tasks faced by clients at various stages. It is sometimes important to examine the choices a client made at previous stages of life and to consider how these affect current functioning.

Criticisms of Psychoanalysis

No other psychological theory has been subjected to such intense criticism as has psychoanalysis. Some of the early attacks were harsh and highly emotional in tone and may have been triggered by Freud’s exposure of sexual problems in Victorian Europe. The day is past when professionals are shocked by frank discussions of sexual matters. However, certain other criticisms are based not on outraged sensibilities but on serious doubts about the scientific credibility of psychoanalysis.

Many critics have noted that analysts often base conclusions on what patients remember about their past experience. As Freud himself discovered, there is no way to be sure if the anecdotal reports represent real events, fantasies, or some combination of fact and fancy. Rarely does any independent verification exist of the events reported by patients. Thus, there is some basis for the criticism that psychoanalysts have built a huge theoretical structure on a weak foundation.

Another serious criticism is that analytic theory lacks predictive value and relies on after-the-fact explanations (Hall & Lindzey, 1978). For example, it is not very helpful to be informed that a client attempted suicide due to a strong death wish because the “explanation” is circular. In other words, the strong death wish is inferred from the behavior itself. Other behaviors are explained
in terms of complex interactions between id, ego, and superego. If a patient
gives in to sexual impulse, this might be interpreted as a victory for the id over
the superego. If the impulse is repressed, the superego has won. The problem
is that psychoanalysis does not provide clear rules for predicting in advance if
one or another part of the personality is going to dominate future behavior.

Another type of criticism centers around the general failure of analysts to
report on the effects of their therapy. Considering the popularity of analytic
thinking during the 1920s to mid-1950s, there were very few reports of the
outcome of the treatment. Those reports that did surface usually did not
include a control group—that is, a comparison group of patients who received
no treatment or some other treatment. Prochaska (1984) reviewed some of the
relevant studies and concluded that there is still insufficient evidence to judge
the effectiveness of analytic therapy.

Perhaps the most scathing denouncements of Freudian theory have come
from those with a human services orientation. Certain implications of
Freudian theory can be seen as harmful to the interests of disadvantaged indi-
viduals. For example, Freud’s idea that the child develops an irrational, uncon-
scious mind early in life seems to imply that behavior is largely determined by
these unconscious forces. Maladaptive or antisocial behavior is seen as the
outcome of internal forces beyond rational control, which downplays the role
of here-and-now environmental events. These and other aspects of the analytic
approach were simply unacceptable to the social activists of the 1960s. They
wanted to help people now, and they wanted to do it primarily by changing
the environment rather than by changing the person.

Some Useful Applications of Psychoanalytic Concepts

Psychoanalysis seems here to stay. Although no longer predominant, it is one
of several therapeutic approaches actively competing for students, adherents,
and clients. Certain analytic ideas have withstood the test of time and may be
useful to human services workers.

The concept of defense mechanisms is probably the most widely used con-
cept in psychotherapy. It is often useful to consider how a client reacts to anx-
xiety and guilt feelings and perhaps to discuss some alternative ways of dealing
with these painful emotions. It is also helpful to the client to review those
unpleasant past experiences that may be interfering with present functioning.
Without becoming bogged down in the past, it may be important for both
worker and client to understand how the client got into his or her current
predicament. This review of the past may reveal some self-defeating behaviors
that the client needs to modify in the future.

Regardless of theoretical bias, counselors and therapists acknowledge that
certain Freudian themes come up again and again in therapy. These include the
client’s desire to be preferred by the parent of the opposite sex, sibling rivalry,
guilt feelings about sex, and fear of closeness or intimacy with another. The
therapist can benefit from psychoanalytic insights about these issues without
accepting them as doctrine.
THE HUMANISTIC PERSPECTIVE

The humanistic perspective is not a school with a definite organization and clearly established leaders. It represents a kind of informal association of people who share certain basic philosophical notions. Some of these ideas were derived from existential philosophy, which focuses on the meanings a person gives to his or her experience in the world. The existential approach to therapy is sometimes regarded as a separate school in its own right. However, the humanistic and existential approaches are so closely related that, for present purposes, we will consider them together.

Philosophical Underpinnings

The humanistic orientation emphasizes the unique qualities of humans, especially their capacity for choice and their potential for personal growth. A major assumption is that the individual is free to choose alternatives in life. Humanists deny the psychoanalytic belief that human behavior is dominated by animalistic drives. There is always a capacity for free will and choice even if the person feels trapped by circumstances or compulsive drives. A related assumption is that the person strives toward the highest possible fulfillment of human potentialities. There is potential for growth, or some kind of forward movement, in every human being. In this sense, humanists share a generally optimistic view of human nature.

The existential/humanist position is to some extent a reaction against the methods of modern science. Existentialists, in particular, argue that science tends to dehumanize people by regarding them as mechanical devices. In this view, science tends to pull people apart in a misguided attempt to see how they work. The person is divided into sensations, feelings, drives, perceptions, thoughts, physical systems, and so on. In this process of analysis, the unique quality of the individual is lost.

Furthermore, humanists maintain that this unique person cannot be understood by a distant objective observer. Real understanding requires getting into the frame of reference of the other person—that is, understanding how the other experiences and perceives the world. Some sort of dialogue between two persons is necessary for the understanding to come about. It is also assumed that both individuals engaged in a dialogue are likely to influence and change each other. The human being is never seen as a finished product but as always changing. The following section goes into more detail about some of the concepts and treatment applications devised by humanistic theorists.

The Humanistic Approach to Helping

Humanists take a holistic view toward understanding their clients. This means that they want to understand the person as a whole, as opposed to breaking the personality into its components. The focus is on this person’s private view of the world rather than on objective reality. What a person believes to be true
influences behavior whether it is really so or not. If you are convinced that a person dislikes you, this belief governs how you relate to that person even though the other person may not really dislike you.

The humanistic therapist helps the client clarify feelings, think more deeply about problems, and explore all important aspects of the current life situation. The helper provides an atmosphere in which this kind of exploration can safely take place. Unlike other significant people in the client’s life, the therapist has no desire to push the client in one direction or another. In other words, the helper does not want to mold or shape the client into some preconceived image. Clients are therefore free to search for their own special meanings and directions in life.

Implied in what has been said is that humanists are not sympathetic toward the therapist who plays the role of doctor-expert. The humanistic counselor is less directive than other approaches, but more focused upon a “strengths” orientation with the client. The humanist assumes a superior position from which to look down on the client. Counseling is a dialogue between two individuals, each with his or her unique experiences and perceptions. The helper does not have instant remedies or solutions to life’s problems but helps clients struggle toward their own answers.

**Self-Actualization** The humanistic approach to helping is based on the concept that self-actualization is a primary motivating force in human behavior. Rogers (1959) defined this motivational force as “the inherent tendency of the organism to develop all its capacities in ways which serve to maintain or enhance the organism” (p. 196). Crystals, plants, and animals grow without any conscious fuss; the same kind of natural ordering process is available to guide the development of the person (Whyte, 1960). Very often, however, the forces of self-actualization bump up against conditions that others impose (Meador & Rogers, 1984). In other words, the child may be loved and approved only when behaving in certain specified ways—for example, when good, cheerful, productive, successful, or competitive. These conditions begin to warp the natural process of self-actualization. Often, the child totally accepts these conditions because he or she has no basis on which to question them. In therapy, the person has the opportunity to resume growth in the atmosphere of acceptance provided by the therapist.

Maslow’s (1954) concept of self-actualization is contained in this sentence: “What a man *can* be, he *must* be” (p. 46). This means that individuals must do what they are best equipped to do. One can maximize one’s potential as a secretary, administrator, artist, politician, or mechanic. Skills, interests, background, and inherited tendencies all need to be considered in determining areas of maximal fulfillment. Serious difficulties may arise if the drive for self-actualization is thwarted. For example, if a person who wants
to help disadvantaged people must work as an accountant or if someone with artistic ability is employed as a salesclerk, the need to fulfill potentials is not being satisfied. The individual may feel out of place and may be haunted by a sense of self-betrayal.

**Responsibility**  Many people who seek counseling have been thwarted in their push for self-actualization by a tendency to live for others. All too often, they have been influenced by parents, teachers, or peers to pursue goals that are uncongenial to their true natures. Often, the growing child seeks approval from elders by living up to their demands and expectations. Some adults who seek help remain stuck in patterns of childish dependence. They have not fully accepted responsibility for finding their own path in life. Perls (1969) suggested that a prime goal of therapy is “to make the patient not depend upon others, but to make the patient discover from the very first that he can do many things, much more than he thinks he can do” (p. 29). He added that frustration is essential for growth because it helps individuals muster their own resources to discover that they can do well on their own. The therapist has to be alert to the manipulations of clients who may try to get the therapist to tell them what to do. The general thrust of humanistic therapy is to get the client to assume responsibility for thoughts, feelings, and direction in life. Only then is the person really free to pursue self-actualization.

**The Self-Concept**  The self-concept is the core or center of the personality around which experiences are organized and interpreted. The “I” or the “self” includes how we see ourselves, how we think others perceive us, and how we would like to be. The self-concept begins to develop early in life. The child begins to evaluate certain experiences as good or bad and, quite naturally, takes on the values of parents, teacher, and peers. However, values imposed from the outside may require the child to ignore inner feelings. For example, if the child learns that anger or sexual urges are bad or not valued, the child may block these urges from awareness.

Rogers (1951) suggested that maladjustment occurs when the person denies awareness to significant experiences that do not fit the self-concept. When one’s behavior and experiences do not mesh with the way one sees oneself, there is a lack of “congruence,” which may lead to tension and anxiety. One goal of therapy, then, is to help the client experience and accept these denied experiences. The client may, for example, come to accept hostile feelings as OK in some situations. The hope is that this acceptance will reduce the tension and conflict.

**Criticisms of the Humanistic Approach**

Some critics believe that humanists exaggerate the benefits of the therapist’s accepting attitude. It may take more than an attitude of positive regard to transform the client into a self-actualizing person. When Rogers (1967) attempted to treat schizophrenics with this approach, the results were not
especially impressive. It may be unrealistic to expect one caring relationship to
overcome years of negative life experiences.

Nor is it always helpful to emphasize that people have choices. Many
poor, discouraged people do not see themselves as having many choices, and
they really do not have the range of options available to affluent persons. They
may need some practical kinds of help and some new opportunities before
they can experience their potential for growth.

The humanistic approach does not seem to apply to patients who are not
intellectually capable of making their own decisions. Young children and
many retarded people and mental patients are not really able to make deci-
sions about direction in life. The major decisions must be made by those
responsible for their care. Although every client can be treated in a respectful
way, it often doesn’t make sense to treat the client as an equal. The behavior-
ist approach (to be discussed) seems to lend itself more effectively to treatment
of people with limited potential.

Positive Aspects of the Humanistic Approach

The most useful aspect of the humanistic perspective is that it provides the
human services worker with a sophisticated understanding of the helping rela-
tionship. Humanistic therapists have gone far beyond armchair speculation on
this issue. Credit must be given to Rogers, his associates, and other humanists
for providing solid research evidence about qualities in a relationship that
facilitate positive change. Because this evidence is discussed in Chapter 5, we
do not need to review it here. Suffice it to say that humanists have contributed
significantly to improving the tools and skills of the counselor.

THE BEHAVIORISTIC MODEL

Unlike psychoanalysis, behaviorism did not begin as a method of treating psy-
chological problems but has its roots in experimental studies of animal and
human behavior. Dating back to the 1800s, it began as a reaction against psy-
chological studies in which human subjects were asked to report on their sen-
sations and perceptions. The early behaviorists felt that psychology wasn’t
getting anywhere by gathering vague reports of conscious experience. They
argued that there was no way to verify a person’s private experiences. They
proposed, instead, that psychology be put on a firm scientific footing by study-
ing overt behavior under such conditions that two or more observers could
agree that a particular action or response had taken place. Psychology, they
said, should focus on the effect of the environment on the behaving organism
and should provide precise measurements of both the stimulating conditions
and the resulting behavior. Private events such as dreams, fantasies, and
thoughts would be ignored until techniques were invented to measure them in
some verifiable fashion.
The early behaviorists believed that important laws governing behavior could be revealed by studying the behavior of animals—cats, dogs, rats, pigeons—in carefully controlled experimental situations. The emphasis was on conditioning, which involved situations that brought about a change in the behavior of the organism. Two general kinds of conditioning were identified and were designated as classical and operant conditioning. It is important for the counselor-therapist to understand both types because therapeutic approaches have been derived from each.

### Classical Conditioning

Classical conditioning involves the study of reflexes—that is, responses elicited by certain stimuli in an automatic fashion. Such responses do not have to be learned or acquired by the individual. For example, an animal or person will respond with an eye blink if a puff of air is applied to the eye. Another automatic response in some creatures is to salivate when eating or chewing. Ivan Pavlov’s (1927) studies of this salivary reflex in dogs are among the best-known experiments in the field of psychology. The basic experimental approach was as follows. Before conditioning, surgery was performed on the dog’s cheek so that the saliva could be collected and measured precisely. During training, a bell, buzzer, or some other neutral stimulus was sounded just before food was given to the dog. As it ate, saliva would naturally begin to flow. The neutral stimulus and the food were presented over and over on subsequent feedings. Eventually, the dog salivated to the neutral stimulus even when no food was presented. Pavlov had succeeded in conditioning the response to a stimulus that would not elicit it before training. He observed that this conditioned response would eventually fade away—become extinguished—if the food were no longer presented.

Classical conditioning would be of limited interest if it applied only to dogs or salivary responses. Its importance stems from the fact that conditioning occurs in many real-life situations. In particular, the laws of classical conditioning seem to underlie the fear response. Many of us have been conditioned by life events to fear certain objects and situations such as dogs, water, examinations, snakes, or enclosed spaces. Fears can also become associated with social situations involving persons of the opposite sex, authority figures, crowds, and so on. Once a fear has become associated with a particular situation, it may not help very much to be told that the fear is irrational or exaggerated. Behaviorists have developed some useful techniques, to be discussed, for helping people overcome their fears.

### Operant Conditioning

The other major type of conditioning, called either operant or instrumental, usually involves responses that are under voluntary control. This is in contrast to the involuntary reflex involved in the classical method. In the operant approach, the animal or person is moving freely in the environment. American
psychologist E. L. Thorndike (1913) studied ways in which the behavior of animals could be influenced by certain environmental inputs. He found that if a response is followed by a pleasant or satisfying consequence, the response is likely to be repeated or strengthened. Similarly, if a response is followed by an unpleasant or punishing event, it is less likely to occur. These simple principles were called the law of effect.

B. F. Skinner is probably the best-known investigator of operant behavior. The basic principles can be demonstrated in the lab by means of the Skinner box. This is nothing more than a chamber with a lever and a food tray. A hungry rat placed in the box first explores its surroundings. Eventually, it pushes down the lever, which causes a pellet of food to drop into the cup. The rat soon begins to press the lever more and more frequently because this response is reinforced—that is, followed by a desirable or gratifying outcome. In everyday life, our behavior is constantly influenced by patterns of rewards and punishments. Children are trained by parents and teachers by means of good things to eat, grades, and expressions of approval. “Bad” or socially unacceptable behaviors may be followed by either punishment or the removal of desired rewards. The general pattern continues into adult life when others shape our behavior by rewarding certain performances with paychecks, promotions, or verbal praise, while discouraging other actions with various punishments and deprivations. The principles of operant conditioning have been applied to a number of therapeutic goals. Some will be reviewed in a subsequent section, but first we look at some early attempts to apply behaviorist principles to therapy.

John B. Watson and Little Albert

John B. Watson was an American psychologist who coined the term behaviorism and did much to make the new approach known to the general public. In his book Psychology from the Standpoint of a Behaviorist, which appeared in 1919, and in numerous magazine articles, he argued that the social environment was a powerful factor in conditioning personality and behavior. He boasted that given control over a child’s early environment he could produce a lawyer, doctor, Indian chief, criminal, or just about any kind of adult.

The immediate importance of Watson is that he advanced the idea that behaviorism could be applied to the understanding and treatment of psychological disorders. His experiment with Little Albert, an 11-month-old boy, attracted a good deal of attention (Watson & Rayner, 1920). The purpose of the experiment was to show that an irrational fear, or phobia, could be acquired through conditioning. The experimental procedure was designed to condition a fear of a white rat in Little Albert, who previously was fond of rats and other
animals. The experimenter, standing behind the boy, struck a steel bar with a hammer when Albert reached out to touch the white rat. The loud noise frightened the child and made him cry. After this procedure was repeated a few times, Albert became very fearful at the sight of the animal even without the loud noise. This newly acquired fear of white rats generalized to rabbits and other furry animals as well as to white furry objects such as a lady’s muff.

Later, one of Watson’s associates devised a method of treating such fears. Mary Cover Jones (1924) first conditioned a fear of a white rabbit in a child named Peter. She then presented the white rabbit at a distance when Peter was enjoying something to eat. Gradually, she brought the animal closer and closer, taking care not to evoke the fear response. The boy’s fear was gradually eliminated, presumably because the once-feared stimulus was progressively associated with pleasant feelings.

The Behavioristic View of Abnormal Behavior

The experiments just described, and similar ones, demonstrated that phobias and other types of abnormal behavior might be the result of learning and conditioning. The implications of these discoveries had a profound impact on the way in which behaviorists view abnormal behavior and “mental illness.” They concluded that there is no basic difference between abnormal and normal behaviors because all behaviors are acquired by the same processes of learning and conditioning. The terms abnormal and maladaptive are simply labels applied to behaviors that are ineffective, self-defeating, or unacceptable to society. For example, one person may have learned through painful experience that stealing is followed by unpleasant consequences. Another person may have learned that stealing pays because the rewards are immediate and the punishment uncertain, absent, or tolerable. It merely clouds the issues to label some behaviors as antisocial or maladaptive. It is even worse to label certain persons as mentally ill or sick because it implies that they suffer from some mysterious defect of mind or spirit. Rather than labeling people, it might be more constructive to help them unlearn undesirable patterns of response and substitute new, more adaptive patterns.

The Growth of Behavior Therapy

In addition to Watson and his associates, a number of other workers began to apply behaviorist ideas to treatment. By and large, however, behavior therapies remained in the shadow of analytic approaches until about the mid-1950s. Since that time, the behaviorist approach has shown extraordinary growth and may soon become the dominant psychological approach to therapy.
Behavioral techniques have been employed in almost every kind of human services facility, including mental hospitals, community mental health centers, correctional facilities, family service agencies, schools, and community settings (Sundel & Sundel, 1982). Behavioral therapies have been developed to treat a variety of problems including obesity, smoking, substance abuse, speech difficulties, bed-wetting, tics and similar nervous habits, sexual dysfunctions, and a variety of psychosomatic problems such as ulcer and high blood pressure. Before describing some of these techniques, we need to discuss the assessment procedure that precedes treatment.

**Behavior Assessment**  
Behavioral treatment begins with a careful assessment of the problematic behavior rather than with the formal diagnosis required by the medical model. The origin of the behavior is considered along with the factors that currently maintain the behavior. This leads to the establishment of *behavioral objectives*—in other words, to specifying the behaviors to be changed and the new behaviors to be acquired. Behaviorists ridicule the pursuit of vague goals in therapy. For example, if a client complains of a lack of self-confidence, the behaviorist attempts to pin down exactly how the client behaves in specific social situations. The therapist might ask how the client would behave if he or she were a self-confident person. These behaviors then become the target behaviors, and a program is set up to help the client acquire them. One advantage of this approach to therapy is that the therapist and the client have a clear idea of what they are trying to do.

The following sections describe some of the treatment methods devised by behavior therapists.

**Systematic Desensitization**  
Systematic desensitization is probably the most widely used therapy based on classical conditioning. As currently practiced, it is an elaboration of the previously discussed method of treating fears and phobias developed by Watson and his associates. Of modern investigators, Joseph Wolpe (1958, 1969) did the most to refine the technique and to establish its therapeutic usefulness.

Treatment begins with an assessment of the stimuli or situations that evoke the fear response in the client. Water, open spaces, dogs, spiders, snakes, high places, and enclosed areas are some of the specific things or situations that may cause intense fear. The method can also be applied to social fears such as being rejected or criticized by certain people.

During initial sessions, the client is taught some variant of the progressive relaxation technique originally developed by Jacobson (1938). This technique helps the client learn to relax by alternately tensing and relaxing the major muscle groups of the body. The next phase of treatment involves making up an anxiety hierarchy—a series of scenes related to one of the client’s fears. The scenes are graded in terms of how much fear they evoke. For example, a student who is fearful of examinations might use a hierarchy in which the first scene involves being told by the professor that an exam is scheduled in two weeks. Further scenes bring this dreaded event closer and closer, until the final scene in which the student imagines receiving the exam itself. In treatment, each scene is imag-
ined and paired with the relaxation procedures. When the client can imagine the least threatening scene without tension, the next scene is presented. Eventually, the client is able to imagine every scene in a relaxed manner.

The results of systematic desensitization have generally been quite positive, showing that the treatment generalizes to real-life situations. In some applications, the therapy takes place in real-life situations rather than in the therapist’s office. For example, clients who are afraid to fly in an airplane may be taken through a real-life hierarchy of situations that ends with their actually getting into a plane and flying. Regardless of where treatment takes place, the basic aim of this approach is to substitute a desirable response (relaxation) for an undesirable response (tension/anxiety) in a gradual, step-by-step process.

**Aversive Therapies** Aversive therapies attempt to reduce an undesirable behavior by means of punishment. The undesirable behavior is followed by electric shock or another unpleasant stimulus. Aversive methods have been used to control head banging, self-mutilation, and other self-destructive behaviors. Applications have also been developed to treat sexual perversions such as child molestation, incest, and exhibitionism.

The basic approach is to associate the undesirable behavior with pain or extreme discomfort. For example, a 12-year-old retarded girl living in an institution was in the habit of hitting her ear with her arm and shoulder. Her ears were badly battered and needed frequent medical attention. She was referred to a behavior intervention ward, where any attempt to bang her ears was followed by a one-second shock to the upper portion of her arms. She was connected to shock apparatus by means of wires that allowed immediate delivery of the shock. This procedure was effective in reducing the behavior. With further training, she was able to do without the machine, and she was eventually reassigned to another ward (Schaefer & Martin, 1975).

Aversive methods do not always work as well as in the preceding example. Sometimes their effect is temporary, and the treatment has to be repeated. In other instances, they may generate rage or excessive fear in the patient. Whenever possible, most therapists prefer to use positive reinforcers to influence behavior.

**Token Economies** Perhaps the most ambitious use of positive reinforcement of voluntary behaviors is the token economy used in some mental hospitals and other institutions. The aim is to encourage desirable behaviors by following them with some gratifying reward. Undesirable behaviors are usually discouraged by depriving the patient of a reward. As usual in behavior therapy, the first step is the establishment of target behaviors. These might include self-care, grooming, and housekeeping behaviors, as well as socializing with others and satisfactory performance on various jobs around the institution. A certain number of tokens can be earned for each behavior. Typically, the task and rewards are shown on a chart prominently displayed on the ward or section. The tokens can be redeemed at a commissary for cigarettes, candy, magazines, personal articles, and so on. In some settings, the patient can exchange tokens for a rental TV or even the freedom to leave the ward.
Ayllon and Azrin (1965) described a token economy at a state mental hospital that was highly effective in modifying social and work behaviors in the patients. There is evidence that longer-term benefits also occur. Another reason for the increasing popularity of the approach is that the principles underlying the treatment are easy to understand. Workers and therapists can learn to apply the methods after a brief training program.

Recent Trends in Behavior Therapy

The methods described so far are based on traditional theories of learning and conditioning. Several new approaches have been put forth in recent decades. These include techniques based on social learning theory, cognitive behavior therapy, and biofeedback. The following sections provide brief summaries of these approaches.

Social Learning Theory and Modeling  Social learning theorists point out that people can learn new responses simply by watching others perform them. For example, everyone has acquired some language and social skills by imitating others. A kid brother might learn something about how to approach girls by watching his older brother in action. Probably all of us have acquired certain actions or mannerisms by watching performers in movies or TV programs. Therapists call this process of learning by imitation modeling.

Modeling has been used in a variety of clinical situations and has been found to be especially effective with children. One important benefit of certain modeling procedures is the reduction of fear in the observer. An example is the use of models to alleviate children’s fear of surgery. Seeing a person do well in a difficult situation is encouraging to another who is faced with the same situation.

Assertion Training  Social learning is also involved in the currently popular assertion training. This is designed to help people who have difficulty standing up for their rights in social situations. Some cannot say no in a firm, polite fashion and may end up being manipulated, pushed around, or abused by other people. Assertion training is not only for meek or shy people but may also benefit those who become so aggressive in social situations that they invite counterattack. Both the shy and overly aggressive types need to learn to assert their rights and interests in a socially acceptable way.

The main technique of assertion training is behavioral rehearsal. The client, usually in the context of a group, rehearses responses to social situations such as declining a date, saying no to the salesperson, or correcting a waiter. In the safety of the therapy situation, the client has the opportunity to rehearse various responses and receive feedback from the therapist and group members.

The Cognitive Trend in Behavior Therapy  In recent decades, some behaviorists have departed from the tradition of sticking with the overtly observable aspects of a learning situation. These cognitive behaviorists argue that much
human behavior is influenced by thinking, particularly by expectations of future reinforcements. Humans think about past experiences, reach conclusions, and plan future behavior in terms of complex goals (Munsinger, 1983). The environment influences thinking, which in turn influences what the person does in specific situations.

The cognitive/behavior approach to treatment owes a great deal to Albert Ellis’s (1973) rational emotive therapy. He maintained that our thoughts and beliefs have a powerful effect on how we behave and feel in certain situations. If one’s thoughts about a particular event are irrational, it is likely that one is going to react in a foolish or maladaptive way. For example, if a student believes it is crucial to be extremely competent in every one of life’s tasks, then failure on an examination may be experienced as some sort of catastrophe. The therapist helps the client by proposing a more rational belief to substitute for the irrational one. The therapist may, for example, suggest that it is desirable to do well on tests, but one failure is not the end of the world. This might be followed by an exploration of the reasons (for example, poor study habits) for the poor performance, with suggestions for improvement.

Biofeedback Biofeedback is another relatively recent application of behavior theories. Based on a mix of operant and classical conditioning, biofeedback makes it possible for people to gain increased control over certain physiological responses not previously under voluntary control. Research has shown that humans and animals can learn to control some of their internal functions, such as heart rate and blood pressure, if given feedback about these responses. The feedback is provided by a machine that measures a certain physiological response in a precise way and converts the information into a signal that the person can see or hear. The feedback may, for example, take the form of a clicking noise, a tone, or a visual display such as an indicator dial.

Here is an example of how biofeedback might be applied in a clinical setting. A client complains of severe tension headaches that are due to excessive contraction of muscles in the forehead. The therapist attaches to the client’s forehead electrodes that register the amount of activity or tension of these muscles. These signals are amplified by the biofeedback device and transformed into a tone of varying pitch. The pitch goes higher as the muscle tension increases and lower as tension is lessened. The client’s task is to lower the pitch and keep it low. As muscle tension is reduced, the tension headache goes away. In subsequent training sessions, the client learns to reduce muscle tension without the biofeedback machine. Just how this learning takes place is still a subject for debate. The immediate point is that the technique often works.

Biofeedback has been used with some success to treat certain cardiac disorders, asthma, insomnia, migraines, speech problems, sexual dysfunction, and chronic anxiety. It is too early for any serious assessment of the effectiveness of biofeedback treatment. New techniques and improvements of older ones are constantly being reported. We can say that the results so far have been promising and warrant further study. One significant advantage of biofeedback is that it does not carry the risk of side effects.
Criticisms of Behavioristic Approaches

Behavior therapy has been sharply criticized by civil rights advocates who point out that prisoners and mental patients have sometimes been subjected to behavior modification programs against their will. In some instances, inmates in institutions have been pressured to “volunteer” for such programs and have been given the distinct impression that noncompliance would be viewed as a failure to cooperate. This kind of threat must be taken very seriously when authorities have the final say about matters of parole or discharge. Even when participation is truly voluntary, the goals of treatment—the desired behavioral changes—are selected by staff, often with little or no input from the “subjects.” Humanists doubt that a person can grow toward maturity and self-responsibility by being treated like a robot. Behaviorists view the matter of choice and free will in quite a different way than humanists. B. F. Skinner’s (1971) *Beyond Freedom and Dignity* elaborates this view that freedom is an illusion.

Positive Aspects of Behavioristic Approaches

Despite these and other criticisms, behavior therapy is growing rapidly in popularity, is the object of intensive research efforts, and has produced useful treatments for a variety of human illnesses and problems. Certain behavioristic ideas can be usefully applied by human services workers dealing with different kinds of problems. One useful idea is simply the notion of establishing clear-cut behavioral objectives for the helping process. What is the goal of a session with a client? What objectives is a community organization trying to attain? What would have to happen to solve the problem or meet the need? If an unproductive situation seems resistant to change, it may be worthwhile to discover the reinforcing agents that maintain the situation. Once clear-cut objectives are established and a strategy for meeting these goals is decided on, it is relatively easy to measure progress toward the goal. Whenever possible, it is helpful to gather solid facts and data that indicate this progress.

**Which Theory Is Best?**

Instead of asking which theory is best, it might be better to ask which theory and treatment are the most useful in regard to a particular human problem. Theories are conceptual tools designed to help us understand complex situations. The tool is selected to suit the task to be done. Most helpers agree that certain theories seem to fit a particular client better than others. Probably the majority of skilled helpers are eclectic in approach. This means that they make use of several theories or parts of theories in their work rather than remain firmly devoted to one approach. From the eclectic point of view, it is acceptable to use the concept or treatment that seems appropriate to a particular situation. There is no requirement to be consistent in approach from case to case.
You may now feel somewhat bewildered by the variety of theoretical approaches that can be used in the helping process. Table 4.2 provides a condensed overview of the theories discussed in this chapter. It compares the five major theoretical perspectives along certain dimensions. In other words, it highlights, perhaps exaggerates, the differences between theories. It should help clarify the main points of comparison between these approaches.

**ALTERNATIVE PATHS TO PERSONAL FULFILLMENT**

This chapter has focused on what might be called the traditional approaches to psychological helping. These are the relatively well established approaches that enjoy backing from governmental agencies, universities, and other organizations. You may be aware that there are also a number of unusual or alternative routes to psychological well-being. During recent decades, for example, there has been an explosion of interest in Eastern religions such as Buddhism and Hinduism. Spiritual leaders of these faiths, called *gurus*, have enjoyed considerable popularity, especially in large cities such as New York and San Francisco. Weiten (1986) suggests that this development is due to a need of Americans to turn inward in a quest for peace and serenity. We Americans live in an action-oriented society in which we tend to race about, fulfilling materialistic goals. The Eastern religions place relatively greater value on contemplation, intuition, and spirituality than on action and materialism. They offer the possibility of making contact with the inner self and perhaps experiencing oneself as part of a spiritual universe.

Transcendental meditation is one application of meditative technique that has become popular in this country. The technique has been divorced from its Hindu religious base, simplified, and aggressively marketed to Americans. The meditator sits with eyes closed and focuses attention on a *mantra*, a specially assigned Sanskrit word. The exercise, which involves repetition of the mantra, is practiced twice daily for 20 minutes. Evidence indicates that meditation helps a person enter a relaxed state with calming of emotional responses (Wallace & Benson, 1972). Others maintain that these benefits can be achieved by simply resting or relaxing (Holmes, 1984).

A great many other approaches to self-realization have been proposed in recent years. Erhard Seminars Training (est), Scientology, and Silva Mind Control are three examples that have received nationwide attention. All have aroused intense controversy. Some graduates of these programs proclaim that their lives have been positively transformed. Others are less extravagant in their claims and say only that they received valuable insights and gained certain skills from participation. Critics, including Weiten (1986), believe that they are money-making operations based largely on “meaningless psychobabble” (p. 16) rather than on scientific evidence. We leave it to you to delve further into these controversies if you are interested.
## Table 4.2: A Comparison of Major Theoretical Approaches

<table>
<thead>
<tr>
<th></th>
<th>Medical Model</th>
<th>Human Services Model</th>
<th>Psychoanalytic Model</th>
<th>Humanistic Model</th>
<th>Behavioristic Model</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Complexity of Theory</strong></td>
<td>Complex</td>
<td>Simple</td>
<td>Very complex</td>
<td>Moderately complex</td>
<td>Relatively simple</td>
</tr>
<tr>
<td><strong>Past/Present Emphasis</strong></td>
<td>History used to arrive at diagnosis</td>
<td>Here-and-now solutions sought</td>
<td>Strong historical emphasis</td>
<td>“Here and now” emphasized</td>
<td>Present relearning</td>
</tr>
<tr>
<td><strong>Assumed Causes of Disorder</strong></td>
<td>Physical, bodily malfunctions</td>
<td>Unmet human needs</td>
<td>Internal conflict/instinct versus morals</td>
<td>Experiences that blocked self-actualization</td>
<td>Determined by previous conditioning</td>
</tr>
<tr>
<td><strong>Therapeutic Approach</strong></td>
<td>Medication, surgery, and physical treatments</td>
<td>Connect person with source of need satisfaction</td>
<td>Make conflict conscious</td>
<td>Create climate for growth, self-exploration</td>
<td>Change specific behaviors, habits, and thoughts</td>
</tr>
<tr>
<td><strong>Length of Treatment</strong></td>
<td>Varies depending on diagnosis</td>
<td>Short term preferred</td>
<td>Very long term (years)</td>
<td>Short to intermediate (months)</td>
<td>Usually short term</td>
</tr>
</tbody>
</table>
Systems Theory

A major development in recent decades has been the widespread application of systems theory to scientific problems. A system, living or nonliving, can be defined as a group of related parts having some function or purpose in common. Miller (1978), in applying systems theory to living organisms, proposes that living systems are part of a sequence of larger systems (for instance, family, community, and nation) and are also composed of a series of smaller sub-systems such as organs, tissues, and cells. Each system has a measure of independence from the larger system of which it is part, but it is also dependent on the larger system in some ways. For example, an individual has some independence from family but also remains part of the family in important ways. Each system has a boundary, transfers energy and information across the boundary, and is controlled by some decider system such as parents in a family (Baruth & Huber, 1984). Feedback mechanisms adjust the behavior of the system in somewhat the same way that a thermostat regulates the temperature in a heating system. By these mechanisms, individuals interact with one another so that each influences the others.

Perhaps the major application of systems theory to psychological treatment has been in the field of family therapy. It became apparent to the family therapists of the 1950s and 1960s that traditional theoretical approaches were of limited use in understanding family interactions. It was sometimes observed, for example, that when one member of the family showed improvement, another got worse. The traditional therapies, which had been developed largely in one-to-one treatment, did not provide clear explanations for these kinds of complex interactions. Systems theory was applied to the study of the family and soon became the dominant approach in this field. Systems therapists began to question the prevailing view that the member of the family with the presenting complaint or symptom was the sick one. They also doubted that this symptomatic member, usually a child or adolescent, should be the major focus of treatment. They came around to the view that the identified patient reflects disturbances in the entire family system. Rather than focus on a disturbed family member, these therapists treated the entire family and sometimes even brought in members of the extended family. It was found that present-day conflicts in the family sometimes reflected unresolved issues of previous generations.

One important application of systems theory to the understanding of family dynamics is the notion of circular causality in the family system. This means that interactions between members take place in a circular manner: The behavior of one influences a second, which in turn may influence a third, which may then return to affect the first (Baruth & Huber, 1984).

The usefulness of systems theory is by no means confined to family therapy. Glasser (1981) is one of several authors who have applied systems to individual therapy, and there have been numerous applications of this approach to specific clinical problems (see, for example, Schmolling, 1983). Human services workers should also be aware that systems theory can illuminate their
understanding of large organizations. After all, many human services workers spend much of their professional time as part of a service delivery system. An instructive and amusing introduction to understanding organizations from a systems point of view is provided by John Gall (1977).

Systems theorists are inclined to believe that their model will eventually come to dominate the behavioral sciences. This remains to be seen. There is no doubt that the influence of this approach is spreading rapidly.

**Does Psychotherapy Work?**

This question is so broad that it is difficult to answer with precision. As we have seen, psychotherapy is not a single process applied to a specific disorder. It is up to future research to tell us which treatment strategy is best for what kind of problem. Nevertheless, Corey (1996) provides a useful summary of some of the major research findings of recent decades:

1. Many outpatients improve without formal psychotherapy, suggesting that they benefit from contacts with friends, family, and other primary social supports.
2. Psychotherapy is usually more effective than no therapy at all.
3. There is little evidence to support the superiority of one theoretical approach over another.
4. Certain factors common to various therapy systems account for much of the improvement found in clients. These include support factors, such as therapist warmth, and action factors, such as expectation of improvement.

This last finding clearly suggests that the content of the theories may be less important than these common factors.

Frank (1987, p. 293) argues that the effectiveness of all psychotherapies depends at least in part on their ability to combat the client’s demoralization and discouragement. The therapist’s ability to help depends on convincing the patient that the therapist understands him or her. Merely making sense of the patient’s symptoms raises the patient’s morale by combating feelings of confusion. Frank casts doubt on the assumption that the therapeutic power of a theory depends on how closely it approximates objective truth. The power of the explanation may rest on its capacity to make sense to the patient.

A related factor centers on the client’s belief or faith in the efficacy of the therapy. This anticipation of good results is based on suggestion and is a potent general factor in all kinds of treatment. Of course, this effect is facilitated if the therapist has great confidence in his or her approach and conveys this feeling to the client.

Another set of factors, which is related to the skills, attitudes, and characteristics of the counselor, may also be as important as theory in determining effectiveness. The next chapter discusses these helper attributes in detail.
Additional Reading


References


