Chapter 2
The psychological perspective

LEARNING OBJECTIVES

After reading and studying this chapter and participating in lectures and discussion, students should be able to:

1. Understand and critically evaluate Freud's psychoanalytic approach and its derivatives.
2. Understand and critically evaluate behavioural explanations of psychopathology and their related therapeutic approaches.
3. Understand and critically evaluate the subsequent cognitive behavioural explanations of psychopathology and their key therapeutic strategies.
4. Understand and critically evaluate the humanistic perspective and Rogerian approaches to treatment.
5. Critically consider the effectiveness of each therapeutic approach, and how common therapeutic factors may explain much of their outcomes.

CHAPTER OUTLINE

This chapter takes the reader through a historical overview of a range of psychotherapies from the beginnings of psychoanalysis to the 'second wave' cognitive behavioural interventions. In order to do this, the chapter provides an overview of each theoretical model of psychopathology before considering their related therapeutic approach.

2.1 The psychoanalytical approach

Freud

Five stages of psychosexual development

Defence mechanisms

Criticisms of Freudian theory

Freud's contemporaries and descendants

Jung

Klein

The practice of psychoanalysis

Freudian psychoanalysis

Contemporary psychoanalysis

2.2 Behavioural approaches

Classical conditioning

Operant conditioning

Combining classical and operant conditioning

Behaviour therapy

Systematic desensitization

Flooding

Relaxation techniques

2.3 Cognitive approaches

Emerging clinical models

Cognitive behavioural therapy

Changing cognitions

Cognitive techniques

The flow of therapy

Experiencing cognitive behavioural therapy

2.4 Humanistic approaches

Humanistic therapy

Experiencing person-centred therapy

2.5 How effective are the different therapies?

QUESTIONS FOR DISCUSSION

These may be useful at the beginning of the teaching session to get a sense of where people lie on these issues, to spark some interest in them, and as a link to refer to as the lecture progresses.

1. Does psychoanalysis have any credence in the 21st century?
    a. Yes
    b. No

2. Can entirely behavioural therapies, with no attempt to change cognitions, be justified?
    a. Yes
    b. No

3. Which of the following is likely to be the most effective form of intervention?

    a. Psychoanalysis
    b. Behaviour therapy

c. Cognitive behaviour therapy
d. Humanistic therapy

LECTURE SUGGESTIONS

The surprise at the end of the chapter, counter to a number of early findings, is that the effectiveness of therapies of different types and theoretical underpinnings are now proving very similar. The effectiveness of therapy is likely to be as influenced by factors common to the therapies (instillation of potential for change, motivating factors, etc.) and therapist qualities as by the type of therapy itself. This is an interesting conclusion at the end of a lecture which focuses on the differences between therapies! And it may form a useful debating issue (see below).

Nevertheless, there are a number of schools of therapy that have evolved over time either adopting and adapting techniques from their antecedents (cognitive and behaviour therapy) or rejecting them (humanistic therapies' rejection of both psychoanalysis and behaviour therapy). The key to the lecture is really to draw out these processes and also (in my opinion) to be fair to each approach and place them within the context of time and place. It is easy, for example, to challenge Freud's sexual and development theories and even find them somewhat amusing. But translate Freud's biological processes (id, ego etc) into cognitive terms such as competing beliefs and attitudes, and some aspects of the theory may appear much more 'modern'. Central to the issue of the transition from behaviour therapy to cognitive therapy as developed by Beck et al, is really the fact that the names are a bit of a misnomer. The behavioural approach was not transcended by a cognitive approach; rather, it incorporated it. So, the term should really be 'cognitive behavioural' and not 'cognitive', as Beck liked to call it. Incidentally, it may be of interest to your students to note that Beck was a trained psychoanalyst, and his theory of depression reflects this, at least in part, by having a critical childhood period during which schema are established that will influence us through the life course (see chapter on Affective Disorders for more on this).

CLASSROOM ACTIVITIES

Small group discussion: What advice would you give to a friend when asking what type of psychological therapy to pursue? This is a realistic situation for many people. So, how do and should people make these decisions? Should they follow an 'empirical' approach and engage with the most effective – but is there a 'most effective' - therapy? Should they pursue one consistent with their own philosophy or beliefs, even if it falls outside the mainstream and has little empirical base - such as Primal Therapy, Neurolinguistic Programming (NLP) and so on? Or should they simply work with the therapist they get on with best?

Small group discussion: Given the historical progress and increasing sophistication of our theories of psychopathology and the therapies on which they are based, why has there not been a step-change in the effectiveness of therapy? This is not an easy question to address. However, potential arguments could include that the basic approaches already had the key

processes identified. We know, for example, that the key to most anxiety intervention is to engage behaviourally with the feared stimulus: cognitive change does little to enhance this. Complexity may even counter the effectiveness of therapy. To achieve cognitive change, for example, can be difficult, and people with no real insight into their own psychological processes may struggle to master the techniques, which might lower their motivation to engage with therapy. As noted at the end of the chapter, it may simply be that the skill of the therapist in engaging individuals in change is actually the core requirement for therapy, and that any 'techniques' are simply a means of facilitating these skills. Finally, as a sort of adjunctive question, it would be good to debate why, if all therapies discussed are pretty much equal in effectiveness, cognitive behaviour therapy has become the dominant therapeutic approach.

Case discussion in pairs: Chapters later in the book consider 'cases' with specific diagnoses in more depth, but students should be able to develop a basic theoretical explanation, and related intervention, for a simple condition such as phobia. This may be psychoanalytic or cognitive/behavioural (humanistic therapy is too general for this specific problem). The key to developing case discussions is to focus on the detail. It is relatively easy to state that the optimal treatment for a phobia of cars following a road traffic accident should involve systematic desensitisation. It becomes more complex when you are asked to consider how you would prepare the individual to cope with the desensitization process (perhaps using relaxation or cognitive strategies), what the hierarchy of exposure would involve, and how you would handle things like driving in fast moving traffic, the movement of which cannot always be predicted. Could you use virtual exposure? Who should determine the nature of the hierarchy, and how big should any steps be?