

Treating Symptoms vs. Solving Problems: An Analysis of Available Literature

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ABSTRACT

This paper surveys available literature in the mental health and disorder arenas in an attempt to determine where resources are being directed (toward alleviating presenting symptoms or identifying and resolving underlying problems). It proposes that helpers need to be focused on the underlying problems, both within the individual and in society. It then suggests ways in which helpers can better work to alleviate such problems by directing their focus on the individual as a person needing help in solving problems, rather than a collection of symptoms which need immediate and direct elimination.

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1. Introduction and Purpose

In this age of high need and limited resources in the human services fields, few would disagree that, now more than ever, we need to make the best use of our resources in combating problems in our society that affect those we serve.

The purpose of this paper is to analyze available literature with respect to the question, “Are we focusing our efforts primarily on the treatment of the presenting symptoms of clients or are we actively working to identify, understand and find solutions to the underlying problems?” While this question can — and perhaps should — be asked of nearly all areas of social problems from heart disease to inflation, this paper will focus primarily on affective disorders such as depression and anxiety, attention deficit/hyperactivity disorders and autistic spectrum disorders. Further, the paper will take the view that such terms are classifications of specific groupings of symptoms and not definitions of specific problems.

2. Types of Problems

Everyone faces problems in their lives. Some face more problems, some less. Problems, especially difficult or unresolved ones, can frequently create stress for the individual. And stress “often leads to depression and anxiety” (Nordenberg, 1998, ¶41).

2.1. Internal Struggles and Their Symptoms

Andrew Newburg and Eugene D’Aquili refer to a “cognitive imperative,” which they define as “the almost irresistible, biologically driven need to make sense of things through cognitive analysis of reality” (Newburg & D’Aquili, 2001, p. 60). Essentially, we are always trying to make sense of our world. But in a world of increasing complexity — where we are expected to know more, understand more, and do more — for many, it becomes increasingly difficult to “make sense of things.”

Newburg and D’Aquili also note that researchers have shown that “the mind, when confronted with an overwhelming flow of sensory information,” like we are experiencing in the modern era, “reacts with increasing anxiety” (Newburg & D’Aquili, 2001, p. 60).

In his *New York Times* column “Side Effects,” James Gorman rather humorously demonstrates this information overload anxiety:

So now I was distressed about my proneness to distress, worried about being worried, which made me worried about being worried about being —you get the idea. (Gorman, 2005, ¶11)

2.1.1. Choice Overload

We as individuals have more choices today than people have ever had in our existence. Choice is good, but are we beginning to suffer from too much of a good thing? Barry Schwartz, author of *The Paradox of Choice*, thinks so. He reports that “The American ‘happiness quotient’ has been going gently but consistently downhill for more than a generation” (Schwartz, 2004, p. 201). His explanation for this decline of happiness? “When the results of decisions . . . are disappointing, we ask why. And when

we ask why, the answers we come up with frequently have us blaming ourselves” (p. 201).

2.1.2. Identity

We are constantly navigating through the streams of our life experiences in an attempt to form a cohesive sense of identity. But what happens when our life experiences give us conflicting messages? Barry Stevens gives a glimpse into what happens:

In the beginning was I, and I was good.

Then came in other I. Outside authority. This was confusing. And then other I became *very* confused because there were so many different outside authorities. (Rogers & Stevens, 1967, p. 9)

It would seem that many —if not most —people go through life as two (or more) people: the person we are when we are alone with ourselves and the person we present to others. This internal schism* creates stress in the individual, but if this split-self isn't recognized and acknowledged, the source of stress and anxiety remains hidden, even if the symptoms are clearly visible.

2.2. Society-Based Problems and Their Symptoms

The individual often faces conflict between the wants of self and their limitations and expectations of their position in society. If those conflicts are not resolved, they can ultimately manifest themselves as serious mental and physical conditions.

One prominent area where society creates problems for many individuals is when people are subjected to poverty. David Shipler notes that depression is “a frequent companion of poverty” (Shipler, 2004, p. 53). While such a correlation does not prove a causal relationship, there are many factors of living in poverty that can create an increased level of anxiety and lowered mood.

* It is interesting to note that both the words *schism* and *schizophrenia* are derived from the Greek verb “to split.”

Unlike their wealthier counterparts, the poor, Shipler observes, “expend considerable energy thinking about money” (Shipler, 2004, p. 27). Without a steady income sufficient to meet all of one’s basic needs, one is apt to expend energy worrying about questions such as, *Will I still have a telephone (or electricity) tomorrow because I could only afford to pay my rent?* or *Will I be evicted because I paid my phone bill and now haven’t enough to pay the rent?* or *What will happen if I get sick and can’t work?* Such a constant stream of real and valid anxieties can easily produce the symptoms of an anxiety or depressive disorder.

Employment is a vital key to one’s identity in most modern cultures. Indeed, Harvard psychiatrist Richard Mollica states that, “the best antidepressant is a job” (qtd. in Satel, 2005, ¶21). Perhaps, conversely one of the best depressants is job loss. Indeed, researchers at the University of Michigan reported that, “Unemployment can start a vicious cycle of depression, loss of personal control, decreased emotional functioning and poorer physical health” (“Job loss,” 2002, ¶2).

3. Goals of Agencies and Helpers

What do human service agencies and helpers see as the goals of their relationships with clients? Is it to provide the client with relief from their suffering, or to facilitate the client’s ability to solve the problems life presents them with?

Gerald Corey gives us one answer to this question: “Therapists are not in business to change clients, to give them quick advice, or to solve their problems for them” (Corey, 2005, p. 5). This suggests that we should avoid preconceived expectations of the client. It also suggests that immediate, short-term, or “quick” fixes should be avoided where possible.

3.1. Scope of Treatments

Unfortunately, short-term solutions seem to be becoming more common. Dr. Eric Plakun warns that, in this age of limited resources and managed care, “Quality is in danger of falling by the wayside in favor of cost containment as the watchword by which clinicians practice their art” (Plakun, 2005, ¶1). Drs. Peter Breggin and David Cohen echo this diminishing quality, noting that “a doctor often takes only a few minutes to make an evaluation before writing a prescription” (Breggin & Cohen, 1999, p. 16).

The restrictions imposed by both limited resources and by managed care organizations, such as HMOs, seem to be making it impossible for many professionals to be able to provide the depth of evaluation that is required to make an accurate diagnosis, or to understand the problems and situations which led to the presenting symptoms. Breggin and Cohen note that both therapists and clients are often pressured by managed care organizations to seek drug treatment (Breggin & Cohen, 1999, p. 190). From a financial perspective, this may make sense for the HMO —especially if the client’s health plan doesn’t include a drug benefit, but is such a short-term-cost containment approach really not doing both the client and society a disservice in the long run?

Drs. Breggin and Cohen note that in stimulant research with laboratory animals, “The drugged animals, like compliant school children, lose their motivation to explore, to innovate, to socialize, and to escape” (Breggin & Cohen, 1999, p. 33). The ability to explore and to innovate —and in some professions, to socialize —are the very abilities required by most jobs available in the United States today. By quickly suppressing symptoms with drugs or other quick-fixes, and not digging deeper into the originating problems, it would appear that we may be needlessly restricting many clients’ abilities to provide their best to society. Psychiatrist Terry Lynch is concerned by what she sees in her field; specifically that “The supposed mental illness becomes the focus of attention and *the underlying human issues go unnoticed and unresolved* [emphasis added]” (Lynch, 2003, p. xvii). Such a limited scope of treatment does the client and society a disservice.

3.2. “Incurable Problems”

It has been argued that —for many psychiatric conditions —it is only possible to treat symptoms, because the client’s condition or disorder is viewed as “incurable.” Indeed, an article on the U.S. Food and Drug Administration’s web site on depression “requires *medical* attention [emphasis added]” (Nordenberg, 1998, ¶6) and is caused by chemical imbalances in the brain (¶16), a phrase heard so often it is frequently taken as fact.

There is, however, far less consensus on this issue among researchers than there appears to be in the popular media. For some, such as Drs. Breggin and Cohen, the theory of biochemical imbalances as the root of depression is viewed as nothing more than speculation (Breggin & Cohen, 1999, p. 6). They also call into question the locus of the problems associated with depression, ADHD and other psychiatric conditions:

Besides, whose biochemical imbalance are we looking for? That of the child who is out of control or the caregiver who has difficulty disciplining? That of the child who isn’t learning or the teacher who hasn’t figured out how to reach this child? That of the individual who becomes anxious in dealing with people or the adult who abused the individual as a child? . . . In short, whose brain isn’t working right? (Breggin & Cohen, 1999, p. 6)

If we study and diagnose an individual in isolation from the rest of the world, there can be only one locus of any problem: the individual. But people never exist in isolation. From the moment of our conception, we are surrounded by, and interact with, other people. When we look at the individual in the context of being in relationship with others and society, we must consider where problems which create undesirable symptoms in an individual originate. Do they originate in the individual? Another person? Social institutions? A combination of all? The medical and psychiatric communities remain largely silent on these relationship-oriented questions. According to Lynch, this is “Because relating does not fit into the medical model. And anything that does not fit into the medical model is discarded as unworthy of serious consideration” (Lynch, 2003, p. xx–xxi).

Michael Yapko points out the chicken-and-egg nature of experience and chemistry: “Your experience influences your neurochemistry at least as much as your neurochemistry affects your experience” (Yapko, 2003, ¶4). He also notes a growing body of evidence that suggests family interactions are as much a factor as genetics in cases where depression seems to run in the family (¶10).

Further, in their book *The Mind & The Brain*, Dr. Jeffrey Schwartz and Sharon Begley dispel a long-held belief that the “wiring” of the adult brain is fixed and unchanging. They argue that the adult brain still has *neuroplasticity*, which they define as “the ability of neurons to forge new connections, to blaze new paths through the cortex, even to assume new roles” (Schwartz & Begley, 2002, p. 15). If the brain continues to be so malleable, it is likely that, with proper training, a client’s “incurable” condition may indeed be at least permanently reduced, if not fully abated. But any such training will not be considered as long as the client is seen to be incurable.

3.3. Goals of Agencies and Helpers vs. Goals and Desires of the Individual

It might be assumed that the goals of a helper should be the goals of the client, but that may not always be the case. Biases, prejudices and expectations on the part of both agencies and helpers can affect the (often unstated) goals of those agencies and helpers. These goals may be in conflict with the goals of the client and may ultimately do a disservice to both.

Unfortunately, limited agency resources and external limits from managed care systems often impose the goal of diagnosing and treating the client as quickly as possible. John Shlien tells of the effects of these limits relating to a man admitted to a state hospital:

... My reaction: sympathy, fascination, and challenge. I liked this boy. I wished I could help him. The timer rang indicating *an allotted five minutes* [emphasis added] had passed (the hospital has 8,000 patients), and he was gently dismissed by the overworked psychiatrist. Diagnosis (no question): paranoid schizophrenia. Recommended treatment: electroshock.

(Shlien, 1967, p. 156)

When a psychiatrist has five minutes to diagnose and recommend treatment for a client, can we expect them to consider the client as a person with goals, or even as anything more than an object to be processed?

4. Possible Alternatives

So how do we do better as helpers? There are several possible approaches we could take. Latching onto one methodology and treating it as *the* way to work with a problem, however, risks the possibility of serving the methodology rather than the individual. Stevens suggests the caution with which we should approach ways that seem to work:

I think that when we have found one way, we should use it tentatively, as the best that we have latched onto at this time, and at the same time should go on exploring other ways — with the same tentativeness. (Rogers & Stevens, 1967, p. 170)

With that in mind, three possible approaches we could take are: returning to a greater focus on solving problems with the client; increasing our respect for the individual as a person and not a diagnosis; and, as a society, learning to value the differences of every individual.

4.1. Solving Problems with the Client

The first thing we as helpers must do when working with a client is to put preconceptions aside and work with the client to identify the specific problem or problems that exist in the client's life and are manifesting themselves as the presenting symptoms. This may take some time — certainly more than five minutes, perhaps several sessions — to discover, and it should probably involve identifying sources of stress in the client's life. Author Rose VanSickle, who learned to manage her anxiety and panic using the techniques of Dr. Abraham Low's Recovery, Inc., notes that, "Stress reduction is symptom reduction" (VanSickle, 1996, p. 22). Thus, it is important to identify such stress

sources in order to find ways to reduce them.

When working with our clients, we need to look for ways in which the client can take an active role in solving those problems they have identified, such that they become empowered by, rather than dependent on, us. The client will probably need encouragement along the way. The client may lack faith in himself. Therefore, it is vital to convey a sense that you have a genuine faith in his ability to succeed. The best way to do this is for the helper actually to have a genuine, deeply held belief that the client *can* improve, and can improve *without limit*.

4.2. Respecting the Individual

If we as helpers are to expect anything from our clients, we must, at all times and in all we do, respect the individual *as an individual*, and not dismiss their views or opinions.

Xavier Amador describes the two-way street of respect well. ‘If you want someone to seriously consider your point of view, be certain he feels you have seriously considered his. Quid pro quo. That means that you must empathize with all of the reasons he has for not wanting to accept treatment, even the ‘crazy’ ones’ (Amador, 2000, p. 56–57). If we aren’t willing to listen to the client and enter their world without prejudice, why should we expect them to pay any heed to our views, no matter how many degrees we may hold? We need to order our efforts, according to Gerald Egan, first to understand the client, and then to challenge them if necessary (Egan, 2002, p. 90). This would give us a better chance of identifying underlying problems than the all too common method of listening to diagnose, then — as the ‘expert’ — prescribing a generalized course of treatment.

4.3. Recognizing and Valuing Differences as a Society

“What’s the matter with him?”

“His feet are the wrong size for his shoes.”

Douglas Adams, *The Hitch Hiker’s Guide to the Galaxy*

If a podiatrist told his patient, “Your feet are the wrong size for your shoes,” the patient would probably find another doctor, perhaps even register a complaint of incompetence against that doctor. But when dealing with many social, psychological and psychiatric problems, we often focus on what is wrong with the client, or how he or she doesn’t “fit into society.” Rarely do we look in the other direction.

In his book, *Walden*, Henry David Thoreau observed that, “If a man does not keep pace with his companions, perhaps it is because he hears a different drummer.” He continued by suggesting that we as a society should “Let him step to the music which he hears, however measured or far away” (Thoreau, 1949, p. 340).

For Larry Berman, whose daughter has Asperger’s Syndrome, society could do a lot to help with her problems. “Wouldn’t it make a quantum difference if instead of it all being on our kids to flex to meet the rest of the world, the rest of the world would meet them halfway?” he asks (qtd. in Harmon, 2004, ¶41). Liane Holliday Willey, who has Asperger’s Syndrome herself, asserts that, “everyone has the right to figure out their own normal, even as they have the right to know, see and touch how things might be if they work hard to control their difference” (Willey, 1999, p. 120).

We have begun to teach diversity —that it is important to value differences in race, gender, religion and sexuality —but perhaps it is time we start teaching people to value differences —period. Lew Marks, one of the founders of Rochester’s School Without Walls told students to “Recognize that we are all different — value the differences” (Marks, 1987, ¶10). As a society, if we are to make progress in solving individuals’ problems, we must stop the practice of seeing people as part of homogenous groups and start seeing them as individuals, who are different and whose differences give us our vitality as a society.

5. Summary of Findings

Virtually all the literature relating to the question of what direction most of our efforts are going is qualitative in nature, mostly in the form of experience and opinions of qualified professionals. I was unable to find any concrete, quantitative studies comparing efforts to solve fundamental problems vs. efforts to simply treat symptoms. This, in my view, represents a serious gap in the literature.

It is clear, however, that there are several, very real problems and struggles that can happen on both a personal level and at a social level. On the personal level, there is the increasing challenge to build a cohesive understanding of one's self and one's world in a world changing at an ever-increasing rate with a mind-boggling amount of choices and decisions to make. On the social level, poverty and employment issues seem to be key precursors to certain mental health issues, such as depression.

All this is not to say that there are not genuine physical problems, such as lead poisoning, that can manifest themselves with the same symptoms groups. In these cases, physical interventions would almost certainly be necessary. This also highlights the necessity to dig deep enough to identify the core problem or problems manifesting themselves in the observed symptoms. Different problems, even with the same symptoms, will require different approaches.

Further, it is vital that we constantly challenge our assumptions, so that we do not needlessly limit our clients by preconceptions and stereotypes.

6. Concluding Remarks

I have identified some ways in which we might better approach working with our clients in a problem identification and solving manner. All the possible alternative approaches mentioned (section 4.) require greater resources than treating symptoms alone. In the long run, I believe these approaches would pay off in less social costs and more members of society moving closer to their full potential, rather than farther away.

If we are to attempt to integrate these suggestions into our overall approach in dealing with clients, we must also play an active part in ensuring that more resources are available for us to use in problem solving. This means not being satisfied with a less than sufficient budget, and lobbying government officials at all levels, as well as the general public, to make funding for genuine problem solving treatments a true priority.

7. Research Reflection

A good traveller has no fixed plans and is not intent on arriving.

Lau Tzu

I'm not certain this paper is what I had in my mind when I wrote my proposal back in February. In fact, several times during the process, I looked back at the proposal and thought, "I have found tons of information, but *not on any of this*." I was worried I would come to the end of the journey with nothing to show, until I started paying attention to what I was finding rather than what I was hoping to find. "In the end," singer Loreena McKennitt writes, "I wonder if one of the most important steps on our journey is the one in which we throw away the map"¹ In throwing out my preconceptions, I was better able to see what *was* there, much as I suggest helpers do in section 4.

In the process, I certainly discovered evidence that my concerns were indeed founded, especially in the psychiatric community (It seems those working outside psychiatry are doing a better job, though not perfect). I did, however, find there were more people—including several notable psychiatrists—voicing the same concerns than I expected. It was somewhat upsetting, though, that such concerns and person-centered ideas have been voiced nearly four decades ago by Carl Rogers and his colleagues and still seem outside mainstream professional thought. Why do we take so long to see people as people?

¹ McKennitt, L. (1997). *The book of secrets* [CD liner notes]. Stratford, Ontario, Canada: Quinlan Road Ltd.

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