

Therapy

CHAPTER 13 OUTLINE

I. BASIC FEATURES OF TREATMENT

A. The basic features of **psychotherapy** include a *client*, or patient; a *therapist*, or helper; a special *relationship* between the two; a *theory*, or rationale, of the client's problems; and a set of *procedures* to address the client's problems.

1. *Inpatients* receive treatment while staying in a hospital or other residential institution. They have impairments severe enough to create a threat to their own well-being or that of others. Their treatment almost always includes psychoactive drugs. *Outpatients* receive treatment while living in the community.
2. There is a diverse assortment of providers of psychological treatment.
Psychiatrists are medical doctors specially trained to treat mental disorders. **Psychologists** who do psychotherapy have completed a doctoral program in clinical or counseling psychology, sometimes with additional specialized training. They may not prescribe drugs.
 - a. *Clinical social workers, marriage counselors, family therapists, and licensed professional counselors* usually hold a master's degree in their field and provide therapy in a hospital clinic or private practice.
 - b. *Psychiatric nurses, substance abuse counselors, pastoral counselors, and paraprofessional* providers provide therapy, usually as part of a hospital team.
3. The basic goal in psychotherapy is to help troubled people change their thinking, feelings, and behavior to be happier and more productive.
4. The majority of mental health professionals see themselves as *eclectic therapists*, borrowing methods from many types of therapy.

II. PSYCHODYNAMIC PSYCHOTHERAPY

How did Freud get started as a therapist?

Psychoanalysis, Sigmund Freud's treatment method, seeks to understand unconscious conflicts and how they affect clients. Almost all forms of psychotherapy reflect some of Freud's ideas, including his one-to-one method of treating people; his systematic search for relationships between an individual's life history and current problems; his emphasis on thoughts and emotions in treatment; and his focus on the client-therapist relationship.

A. CLASSICAL PSYCHOANALYSIS

1. Originally, Freud had hypnotized patients to recall events that might have caused their problems. Later, he merely had patients lie on a couch, relax, and report whatever came to mind -- *free association*.
 - a. Many patients taking Freud's "talking cure" reported memories of childhood sexual abuse. Freud decided that these reflected childhood fantasies and unconscious conflicts, a judgment that has since been criticized.
2. Classic psychoanalysis uses free association, dream analysis, and analysis of the way the client reacts to the therapist (*transference*), to help a client gain insight into problems. Clients also *work through* the many ways in which those unconscious elements affect their everyday lives.

B. CONTEMPORARY VARIATIONS ON PSYCHOANALYSIS

Classical psychoanalysis is not as prevalent as it was.

1. In *short-term dynamic psychotherapy*—called *supportive-expressive therapy*—the therapist looks for the "core conflict" that appears across a variety of the client's relationships.
2. In *Object Relations therapy*, the powerful need for human contact and support is important. Object relations therapists work to develop a nurturing relationship with their clients, providing a "second chance" for these clients to receive the support that might have been absent in infancy and to counteract some of the consequences of maladaptive early attachment patterns.

III. PHENOMENOLOGICAL PSYCHOTHERAPY

Humanistic psychologists, sometimes called *phenomenologists*, emphasize the ways in which people interpret the events in their lives. They view people as able to take responsibility for their own decisions.

A. BASIC IDEAS

Treatment is seen as a human encounter between equals, not a cure from an expert. Clients will improve on their own. Ideal conditions in therapy can best be established through a therapeutic relationship in which clients are made to feel accepted and supported as human beings. It is the client's experience of this relationship that brings beneficial changes. Clients must remain responsible for choosing how they will think and behave.

B. CLIENT-CENTERED THERAPY

1. Carl Rogers's **client-centered therapy** relies on the creation of a relationship that reflects three intertwined therapist attitudes: unconditional positive regard, empathy, and congruence.
 - a. Therapists show **unconditional positive regard**, always treating the client as a valued person, no matter what. The therapist listens without interrupting, accepting and trusting the client's insights without judgment.
 - b. Therapists try to see the world as the client sees it. They try to develop **empathy**, an emotional understanding of what the client might be thinking and feeling. Empathy is shown by active listening and **reflection**, communicating back to the client what he or she seems to be saying and feeling.
 - c. **Congruence**, or *genuineness*, refers to consistency between what the therapist feels and the way she or he acts toward the client. The therapist must not just say the client is accepted and valued—the therapist must *feel it*.

C. GESTALT THERAPY

1. **Frederick S. (Fritz) Perls** and his wife Laura were founders of **Gestalt therapy**. They believed that people create their own versions of reality and people's natural psychological growth continues only as long as they perceive, remain aware of, and act on their true feelings.
 - a. Gestalt therapists may focus clients' attention on their body language, thoughts, and feelings "here and now," pointing out clients' avoidance and insisting that it stop.
 - b. Clients may conduct a kind of one-person drama involving imaginary dialogues with people and even inanimate objects or parts of their own personalities.

IV. BEHAVIOR THERAPY

A. BASIC IDEAS

1. *Behavior therapies* treat disordered behavior and thinking as maladaptive results of earlier learning, and thus as problems that can be changed through learning principles alone. Features of this therapy include a good therapist-client relationship, careful listing of behaviors and thoughts to be changed, a therapist who acts as a kind of teacher by providing learning-based treatments, and constant evaluation of therapy's effects.
2. Methods that rely mainly on classical conditioning are called **behavior therapy**; those that rely mainly on operant conditioning are called **behavior modification**;

and those that focus on altering both cognition and behavior are called **cognitive-behavior therapy**.

B. TECHNIQUES FOR MODIFYING BEHAVIOR

1. *Systematic Desensitization*. During **systematic desensitization**, a client practices progressive relaxation while imagining fear-provoking situations from an anxiety hierarchy. The process of remaining calm while thinking about something feared weakens the learned association between anxiety and the feared object or situation.
 - a. *In vivo*, or "real life" desensitizations appears to be especially effective, but were difficult to arrange or control. A new technique, *virtual reality graded exposure*, makes it possible for clients to "experience" precisely graduated versions of the feared situations without actually being exposed to them through the use of technology (such as virtual reality).
2. *Modeling*. Through participant **modeling**, a client can learn about or get comfortable displaying desirable behaviors.
 - a. The therapist demonstrates desirable behaviors, and the client gradually practices them.
 - b. The clients can learn to be more appropriately self-expressive and more comfortable in social situations through assertiveness and *social skills training*.
3. **Positive Reinforcement**. A therapist systematically uses positive reinforcement to alter problematic behaviors. They set up *contingencies*, or rules, that specify the behaviors to be strengthened through reinforcement. The receipt of rewards or tokens is dependent upon a client's display of desirable behaviors. In institutions, behavior therapists sometimes establish a **token economy**.
4. **Extinction**. Behavior can be modified by removing reinforcers that normally follow a particular response. A procedure called **flooding**, which extinguishes a conditioned fear response, keeps a patient in a feared but harmless situation. As a result, the client who is deprived of the normally rewarding escape pattern has no reason for continued anxiety.
5. **Aversive Conditioning**. This technique uses classical conditioning to reduce undesirable behavior by associating it with some psychological or physical discomfort.
 - a. *Covert sensitization* involves the client first visualizing the stimulus or situation that is to be made less attractive and is then exposed to frightening or disgusting stimuli. Aversive conditioning is unpleasant and because its effects are often temporary, it is used only long enough to allow the client to learn alternative behaviors.

6. **Punishment.** To eliminate a dangerous or disruptive behavior, an unpleasant stimulus is presented after the behavior, which reduces its occurrence.

C. COGNITIVE-BEHAVIORAL THERAPY

Therapy relies on learning principles to help clients change the way they think as well as how they behave.

1. **Rational-emotive behavior therapy (REBT)** was developed by Albert Ellis. REBT aims at identifying and replacing self-defeating, problem-causing thoughts.
 - a. **In *cognitive restructuring***, one replaces upsetting, irrational thoughts with adaptive, calming thoughts to use in anxiety-provoking situations.
 - b. ***Stress inoculation training*** involves clients imagining being in a stressful situation, then practice newly learned cognitive skills to remain calm.
2. Aaron Beck's **cognitive therapy** is based on the idea that certain mental disorders can often be traced to errors in logic and false beliefs.
 - a. These learned *cognitive distortions* occur quickly and automatically so that the client never stops to consider that they might not be true.
 - b. Cognitive therapy is an organized problem-solving approach in which the therapist first helps clients learn to identify the logical errors, false beliefs, and other cognitive distortions that precede anxiety, depression, and other psychological problems.
 - c. The client and therapist together observe how the client's negative thoughts precede anxiety or depression. They subject each such thought to critical thinking and hypothesis testing, providing concrete evidence that challenges and ultimately destroys erroneous beliefs.

V. EVALUATING PSYCHOTHERAPY

How effective is psychotherapy?

A. DOES PSYCHOTHERAPY WORK?

1. In 1952, Hans Eysenck reviewed studies evaluating psychotherapy. Though others disagreed, he concluded that recovery occurred no more often in those receiving therapy than in those who did not. He followed up with additional evidence in 1961 and 1966.
2. There is a problem of how to measure improvement in psychotherapy that is further complicated by the broad range of clients, therapists and treatment involved.

D. CULTURAL FACTORS IN THERAPY

1. Virtually all mental health training programs in North America seek students from traditionally underserved minority groups to provide a better client-therapist match of cultural backgrounds.
2. Some states in the United States require psychologists to complete courses in the role of cultural factors in therapy before being licensed.

E. RULES AND RIGHTS IN THE THERAPEUTIC RELATIONSHIP

1. Psychotherapists are bound by law and professional ethics to obey certain guidelines of conduct.
2. Confidentiality is critical to a therapeutic relationship. Most state laws in the United States regard information revealed in therapy to be privileged communication. The next edition of APA's code of ethics will include new standards for protecting confidentiality for the growing number of clients who seek psychological services via *telehealth* channels (phone, e-mail, internet).
 - a. Under certain conditions, a therapist is required to violate confidentiality.
 - i. A client is so severely disturbed or suicidal as to require hospitalization.
 - ii. A client uses a mental illness and therapy history to defend a civil or criminal charge.
 - iii. The therapist must defend against the client's charge of malpractice.
 - iv. The client reveals information about sexual or physical child abuse.
 - v. The therapist believes the client may commit a violent act against a specific person.

VI. BIOLOGICAL TREATMENTS

Is electric shock still used to treat disorders?

A. ELECTROCONVULSIVE THERAPY

In **electroconvulsive therapy (ECT)**, electric current applied to the scalp causes a convulsion. It was used to treat schizophrenia, depression, and sometimes, mania. Patients improved but there were side effects such as memory loss, confusion, speech disorders and, in some cases, death due to cardiac arrest.

1. ECT is now safer. Patients are given an anesthetic so they are unconscious before the shock and a muscle relaxant to prevent bone fractures during convulsions. The shock only lasts about half a second, is delivered to one side of the brain, and number of treatments is limited. ECT is now used mainly in profound depressives who do not respond to drugs, and occasionally in mania.
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B. PSYCHOACTIVE DRUGS

1. **Neuroleptics** (*antipsychotics*) reduce psychotic symptoms such as hallucinations, delusions, and disordered thinking, especially in schizophrenia.
 - a. *Phenothiazines*, such as *chlorpromazine (Thorazine)*, and the related drug *haloperidol (Haldol)*, help 60 to 70 percent of patients.
 - b. Neuroleptics cause many side effects, including dry mouth, blurred vision, urinary problems and dizziness. A permanent side effect in some long-term users is *tardive dyskinesia*, a syndrome of uncontrollable, repetitive movements of the body and face.
 - c. *Clozapine (Clozaril)* does not cause movement disorders and is a very effective schizophrenia treatment. Unfortunately, in about 2 percent of patients, it causes a potentially fatal blood disease, *agranulocytosis*, in which the immune system loses its white blood cells.
2. **Antidepressants** help relieve the symptoms of depression in 50 to 60 percent of patients.
 - a. *Monoamine oxidase inhibitors (MAO-I)* effectively treat depression and some cases of panic disorder.
 - b. *Tricyclic antidepressants (TCAs)* are more effective than the MAO-Is. The side effects are milder and less frequent. Alcohol and TCAs can fatally augment each other's effects.

- c. A second generation of antidepressants includes *fluoxetine (Prozac)*, now the most prescribed antidepressant in the United States. It has the fewest side effects.
 - d. Another recent development is the use of an herbal remedy from a plant called *St. John's wort (Hypericum)*. A number of studies have shown St. John's wort to be as effective as Prozac and other antidepressants.
 - e. **Lithium**, a mineral salt, reduces the frequency and intensity of both the manic and depressive phases in about 80 percent of bipolar depression patients. Its mechanism of action is unclear. Anticonvulsant drugs have been used as an alternative to lithium in treating mania and they cause few side effects and are easier to regulate.
3. **Anxiolytics**, or *tranquilizers*, are used to combat symptoms of anxiety.
- a. Overdoses of barbiturate-like tranquilizers such as meprobamate (Miltown, Equanil) are potentially fatal.
 - b. *Benzodiazepines* such as chlordiazepoxide (Librium), and diazepam (Valium) pose little danger of overdose, and are now the drug treatment of choice for anxiety. They are now the most widely prescribed and used of all legal drugs.
 - i. Alprazolam (Xanax) is widely used for panic disorder and agoraphobia.
 - ii. Benzodiazepines can cause sedation, lightheadedness, and impaired mental and motor functioning. Long-term use can cause dependence and tolerance.
 - c. Buspirone (BuSpar) avoids some side effects of the other anxiolytics, including the potential for dependence, but requires days to weeks of use prior to symptom relief.

C. DRUGS AND PSYCHOTHERAPY

1. It is unclear which is more effective in treating psychological disorders: drugs or psychotherapy.
2. Combining drugs and psychotherapy may produce little advantage. However, the combination of drugs and psychotherapy is more effective than either method alone in treating certain disorders such as ADHD, alcoholism, chronic depression, etc.
3. It has been suggested that, where indicated, treatment begin with some form of psychotherapy and that drug treatments be added only if psychotherapy is ineffective.

VII. LINKAGES: BIOLOGY, BEHAVIOR, AND THE TREATMENT OF PSYCHOLOGICAL DISORDERS

A. Therapeutic drugs alter neurotransmitter activity by enhancing or inhibiting the binding of neurotransmitters to receptors; acting as receptor antagonists by blocking neurotransmitters' receptor sites and, as a result, inhibiting action potential activity; or increasing the amount of neurotransmitter available at the synapse by stimulating neurotransmitter production or blocking reuptake.

1. The benzodiazepines (Valium and Xanax) exert their anti-anxiety effects by helping the inhibitory neurotransmitter GABA bind to receptors and suppress firing neurons.
2. The phenothiazines and haloperidol block receptors for dopamine.
3. Prozac, Anafranil and some other antidepressants are selective serotonin reuptake inhibitor (SSRIs) because they slow the reuptake of serotonin.

VIII. COMMUNITY PSYCHOLOGY

How can we prevent psychological disorders?

A. **Community psychology's** goals are to treat people in their home communities and to work for social changes that can prevent psychological disorders.

B. The *community mental health movement* arose in the 1960s as a federal attempt to make treatment more accessible to people in need. It provided low-cost mental health care in new community-located mental health centers.

1. In the 1950s, more and better psychoactive drugs and increased concern for patient welfare spurred *deinstitutionalization*, the release of many inpatients from mental hospitals.
2. The local community health centers have not effectively taken on the burden of caring for such deinstitutionalized patients.
3. Some former hospital patients and those who formerly would have been sent to a hospital live in halfway houses and other community-based facilities where they receive *psychosocial rehabilitation*.

C. Community psychology also tries to prevent problems before they need treatment.

1. Some prevention can occur before problems start.

Example: Psychologists may assist in planning housing projects to help residents avoid the stress of living conditions.

2. Some prevention can spot psychological problems in their earliest stages, before they become worse. Early intervention programs, such as suicide hotlines, are examples.
3. Community psychology also supports the notion that nonprofessionals—including relatives and friends of troubled clients can help combat psychological disorders. This led to self-help groups.
4. Other kinds of prevention can minimize the long-term effects of already present psychological disorders, preventing their return.
 - a. Mutual help organizations may improve quality of life for people sharing a problem such as drug addiction, compulsive gambling, or schizophrenia.
 - b. Lack of reliable data makes it difficult to assess the value of many self-help groups, but available information suggests that active members may obtain some moderate improvement in their lives.