Chapter 17: Therapies

I. **Therapies**: Psychological interventions designed to promote new understandings, behavior, or both on the part of the client. The different ways these are introduced is what determines the differences between the interventions

   A. Assumes also that the therapist is receptive, warm, empathetic & non-judgmental
   B. Assumes that people are able to make changes
   C. Although several hundred different types of therapy are listed, insurance companies have demanded that the effectiveness of therapy be empirically demonstrated: This chapter discusses the most widely accepted pharmacological and psychological treatments in use today

II. **Who** seeks treatment?

   A. Those experiencing a recent crisis
   B. Physician referrals for patients whose physical symptoms may be psychologically influenced
   C. Parent-child, & relationship problems
   D. Fewer men than women
   E. Long term chronic problems of poor adjustment and unhappiness
   F. Those seeking self-growth and greater individual motivation and potential

**Conclusion: There is no typical client and no "model therapy"**

III. The Therapeutic Relationship: **the therapeutic alliance** is in itself a form of therapy: a sense of working together; agreement about treatment goals; and the emotional bond between the client and the therapist: similarity; client motivation and therapist personality

IV. Problems with **measuring** therapy:

Regression -to- the- mean effects? Testing effects? Are the tests reliable and valid? What about follow up studies? Systematic self monitoring of specific behaviors still doesn't rule out the effect of placebo. How much improvement occurs w/o therapy?

B. Data: significant changes by 21 sessions; after 40 sessions, 75% have improved

C. Efficacy Studies using randomized clinical trials (RCTs) are used by drug companies to test the efficacy of their medications. Blind - double blind procedures using placebo controls.

1. When using this model to evaluate psychotherapy, need to come up with a reasonable placebo group or non-therapeutic control (waiting list control?).

2. Even when using manualized therapy, personality differences, appearances, and styles and presence are still differences that may render some therapeutic control.

3. Even when considering the efficacy studies on specific psycho-social treatments, large numbers of clients are omitted from these studies (can only have one Dx and no co-morbidities, e.g), so the results of the research may not be generalizable to all clients

IV. Medication or Psychotherapy: Osherhoff vs Chestnut Lodge:

A. The case of Osherhoff vs Chestnut Lodge resulted in a lawsuit because a depressed doctor was not being given anti-depressant medication. It is now required that all mental health professionals present their clients all the treatment options.

1. Based on the results of this case, therapists may now be liable for failing to provide medication to patients with certain disorders for which medications are known to be effective

B. Research agrees that with one or the other, effectiveness is about 55%; when meds and therapy are combined, effectiveness is 85% for such conditions as intractable depression.
III. **Early attempts at biological interventions**

A. Included primitive techniques such as purging (laxatives and emetics), and bleeding, and later electrical shocks to the body.

B. By 1917, Wagner-Jauregg discovered a treatment for general paresis: a mental condition due to syphilis (neurosyphilis). Treatment involved infecting patients with malaria producing fever that would kill the syphilis spirochete.

C. Convulsions induced by drinking camphor to cure “mania”: Paracelsus (15 hundred Swiss physician). Used until the end of the 18\textsuperscript{th} century, but not used in the 19\textsuperscript{th}.

D. In 1934, Von Meduna (Hungarian physician) induced epileptic seizures in schizophrenics, because he thought that schizophrenia (erroneously) did not occur in epileptics. First done with rats, then induced camphor into a schizophrenic, which returned him to normal. Later he used Metrazol rather than camphor because it induced seizures faster.

E. **Insulin Coma Therapy**: Used by Sakel in 1932: used to treat schizophrenia and also used for morphine withdrawal. Administer increasing amounts of insulin (hormone used to regulate sugar metabolism in the body) until the patient goes into shock (causes a hypoglycemic coma caused by an acute deficiency in sugar). Pt goes through 50-1-hour comas, which were then terminated by the administration of glucose. This caused stress to cardiovascular and nervous systems. **Not effective: high relapse rate; did not help severe schizophrenics; hard to know what the real causes for improvement, when they occurred, were.**

F. **Electroconvulsive Shock Therapy**
1. 1849: John Bucknill used electrical stimulation of the skin & potassium oxide to treat patients with melancholic depression

2. Value of electro-stimulation was considered after Von Meduna's work on Metrozol-induced seizures in the treatment of mental disorders.

3. In 1938, two Italian physicians, Cerletti & Bini visited a slaughter house and observed animals rendered unconscious by electric shock; tried to pass electric current through a patient's head. Became known as ECT (electroconvulsive shock therapy). Widely used today to treat depressive and manic episodes. Do not know the mechanism through which it works (maybe through the changes in certain neurotransmitters or by changes in receptor sensitivity).

   A. We do know that stimulation of seizures in certain pathways will determine the effectiveness of ECT

   B. Two types of ECT: Bilateral and uni-lateral. General theory of both is to pass a brief electrical impulse from one side of the head to the other for up to 1.5 ". Patient looses consciousness and undergoes muscle contractions (seizures). Anesthetics and muscle relaxant pre-medications are used to prevent violent contractions that in the past have been known to induce fractures of the vertebrae.

   1. Patient wakes up several minutes later and has amnesia for the period of events preceding the therapy and is confused for the next hour or so. Tx consists of @ 12 sessions (3 x /wk for 4 weeks). Disorientation occurs and clears after termination of the treatment.

   2. In unilateral ECT, current is only passed through one side of the brain (the non-dominant side, which is
usually the right side for most people). This has fewer side effects (memory impairment). Other studies suggest that Unilateral ECT is not as effective as Bi-lateral. Some suggest starting with unilateral and then switching to bi-lateral.

3. Tx is controversial: But data suggest that it is highly effective for pts who do not respond to anti-depressant medication, pregnant women who cannot take anti-depressant medication, and the elderly who have pre-existing medical conditions. Data also show that it is an effective treatment for recurring mania that does not respond to medication

- New data show that ECT does not produce structural damage to the brain if properly administered.
- NIMH panel has determined that mortality rates following ECT have been reduced to 2.9 deaths/10,000 patients.
- Recommended for (1) psychotic depression and (2) acute mania. NOT recommended for dysthymia or schizophrenia
- Relapse rates for depression and mania following ECT were high unless the treatment was followed by maintenance doses of medication for unipolar or bi-polar disorders
- New guidelines have been established for the training and standards used in ECT, along with new policies for obtaining informed consent from those who may not be competent to give it (to prevent lawsuits).
- Virtually every neurotransmitter system is affected by ECT. This technique downregulates the receptors for norepinephrine, increasing the functional availability of the transmitter, but we still don't know how.
- Recommendations: Start with unilateral first; If no improvement switch to bilateral after 5-6 treatments. (With bilateral, patients cannot form new memories {anterograde amnesia} for about 3 months).
4. **Neurosurgery** (used to be called **psychosurgery**: surgery for CNS disorders): Today both terms refer to brain surgery for emotional disorders
   a. 1935: Antonio Moniz from Portugal: Frontal lobes of the brain were severed from the deeper centers underlying them. Now known as **prefrontal lobotomy: resulting in permanent structural changes in the brain**. Won the 1949 Nobel Prize in Medicine
   b. Side effects included inability to inhibit impulses or undesirable absence of feeling.
   c. 1935-1955 tens of thousands of such surgeries. Then the anti-psychotic meds were developed and the surgeries decreased. 1951 the Soviet Union banned these surgeries but they are still legal in the US and are making a comeback for some hard to treat psychiatric problems (**intractable psychoses; severe OCD, & severe pain in terminal illness**)
   d. Surgeries are more carefully monitored and permanent brain damage has been minimized. Surgeries involve the selective destruction of minute areas of the brain, such as the "cingulotomy" which seems to relieve the subjective experience of pain: the cingulus is a small bundle of nerve fibers connecting the frontal lobes with the limbic system, which is interrupted with virtually pinpoint precision
   e. In the **capsulotomy**, small holes are drilled into the patients skull, and tiny electrodes are inserted into the brain by destroying adjacent cellular structures. Sometimes hole drilling is replaced by the use of a **gamma knife or proton beam**
   f. Such neurosurgery is only used for pts who have not responded to other standard forms of treatment for a period of 5 years, who have extreme and disabling symptoms, and are rational enough to be able to sign informed consent papers (to avoid legal lawsuits).
   g. Strong data to support the use of psychosurgery for some extreme forms of **OCD**: also reports of absences of negative
side effects such as seizures and headaches. Rare effects on
cognition or personality, and no risk of suicide following such
surgery as in the past

5. Psychopharmacological Txs: These drugs are called
Psychotropic Drugs, meaning mind altering. (Important to
remember there are great individual differences in the rate in which
people metabolize drugs {how quickly the bodies break down the
drugs after they have been ingested} : Af. Am. Metabolize anti-
depression sand anti-psychotic medications more slowly: therefore,
show a more rapid and a greater response to these drugs but also
show more side effects.

a. There are 4 major categories of Psychotropics:
   {1} **Antipsychotics**, {2} **antianxiety** (minor
   tranquilizers), {3} **anti-depressants**, and {4} Lithium and
   other **mood stabilizing drugs**

   1. **Antipsychotics**: as a group are called **neuroleptics or major
      tranquilizers**: Used for schizophrenia and psychotic mood
      disorders: affect psychotic symptoms of delusions and
      hallucinations and often remove **negative symptoms**. With the
      treatment of psychotic symptoms, other forms of therapy may be
      introduced. All these drugs **block dopamine** but in varying
      degrees. 60% of schizophrenic patients show a near complete
      remission of positive symptoms within 6 weeks compared to
      20% treated with a placebo. About 20-30% do not respond to
      these meds, esp those with prominent negative symptoms or
      chronic schizophrenia

<table>
<thead>
<tr>
<th>Class</th>
<th>Trade Name</th>
<th>Used to Treat</th>
<th>Effects &amp; Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conventional</td>
<td></td>
<td>Most conventional anti-psychotics effective *only for positive. symptoms</td>
<td></td>
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<tr>
<td>Antipsychotic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Low</td>
<td>Thorazine</td>
<td>Psychotic symptoms Esp. schiz. involving</td>
<td>Variable effects; side effects such as dry mouth; may produce long term</td>
</tr>
<tr>
<td>Potency</td>
<td>Drug(s)</td>
<td>Symptoms/Complications</td>
<td>Notes</td>
</tr>
<tr>
<td>------------------</td>
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<td>-------------------------------------------------------------</td>
<td>--------------------------------------------</td>
</tr>
<tr>
<td>Potency dopamine block</td>
<td>Mellaril, Serentil</td>
<td>Extreme agitation, delusions, hallucinations, aggressive or violent behavior</td>
<td>Motor disturbances such as Parkinsonism and tardive dyskinesia</td>
</tr>
<tr>
<td>(b) Moderate potency dopamine block</td>
<td>Trilafon, Loxitane, Mobane, Navane, Stelazane</td>
<td>Same as above</td>
<td>Same as above</td>
</tr>
<tr>
<td>© High potency dopamine block</td>
<td>Haldol, Prolinx</td>
<td>Same as above</td>
<td>Same as above</td>
</tr>
<tr>
<td>(d) Atypical Antipsychotic</td>
<td>Clozaril, Zyprexa</td>
<td>Schizophrenia, suppresses psychotic thinking</td>
<td></td>
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<tr>
<td></td>
<td>Risperdal, Seroquel</td>
<td>Schizophrenia, side effects: Parkinsonism and tardive dyskinesia</td>
<td></td>
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<tr>
<td></td>
<td>Geodon, Abilify</td>
<td>Schizophrenia, sedation, seizure, hypotension, fever, vomiting, weight gain &amp; diabetes problems</td>
<td>Fewer negative side effects than Conventional.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Advantages of the atypical antipsychotics is that they also treat negative symptoms. 1% of those taking this drug may develop immune deficiency.</td>
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</tbody>
</table>

Atypical antipsychotics require careful blood monitoring, which makes the drug and its treatment very expensive. These drugs operate on different dopamine receptors than do the older antipsychotics.

Neuroleptics are distinguished also by their dosage level differences and the Half-life of each drug. The half-life is the time it
takes for the level of the active drug in the body to be reduced by 50% (through metabolisis & excretion):

1. **Advantages** of a long half-life: (a) less frequent dosing (b) less variation of the concentration of the drug in the blood plasma (c) less severe withdrawal

2. **Disadvantages** of a long half life: (a) risk of drug accumulation in the body (b) increased sedation and psychomotor impairment during the day

b. Other uses for anti-psychotic drugs:

2. mania, psychotic depression, schizoaffective disorder, psychotic symptoms in borderline personality disorder, Tourette's, and Alzheimer's: the delusions, hallucinations, and paranoia and agitation that accompanies this disorder

c. Side effects of antipsychotics: Dryness of the throat & mouth, sedation, weight gain. Also extrapyramidal symptoms, which mimic the classic symptoms of Parkinson's disease: tremors in the extremities, muscle tightening, akinesia (decrease in spontaneous movements), akathesia (motor restlessness: fidgety, purposeless movements). Many side effects are temporary and can be relieved by substituting another drug in the same class, switching classes, or changing the dosages.

i. Tardive dyskinesia, disfiguring disturbance of motor control of the facial muscles. Can be progressive and irreversible. Symptoms appear absent when sleeping. Symptoms include: involuntary thrusting movements of the tongue, chewing movements, lip smacking, eyeblinking, and dancing like movements in the extremities: these are due to the chronic blocking of
dopamine in the brain, creating **supersensitive dopamine receptors**. Symptoms may appear years after the drug treatment has been initiated or stopped. TD has higher rates if schiz are alcohol abusing, and in those over 55. More common in women who are not schizophrenic.

d. Usually dose daily by mouth; or depot neuroleptcs are injected (* injection effects can last for up to 4 weeks, which can be good for non-compliance of medication problems)

### B. Anti-depressants

<table>
<thead>
<tr>
<th>Class of anti-depressants</th>
<th>Trade Name</th>
<th>Used to treat</th>
<th>Effects &amp; side effects</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>(a) Tricyclics</em></td>
<td>Tofranil</td>
<td>Severe depression esp psychotic depression (unipolar), Panic Disorder &amp; OCD &amp; Bulimia</td>
<td>Variable. Takes 3-5 weeks. Not safe in overdose. Side effects may be uncomfortable.</td>
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<tr>
<td></td>
<td>Elavil</td>
<td>Discovered when found that schizophrenics who used them got increases in mood</td>
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<td></td>
<td>Norpramin</td>
<td>Functional long term effects are to reduce available norepinephrine &amp; serotonin at the synapse</td>
<td>Functional long term effects are to inhibit norepinephrine &amp; to a lesser degree, serotonin at the synapse after they have been released</td>
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<tr>
<td></td>
<td>Aventyl</td>
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<td></td>
<td>Vivactil</td>
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<td></td>
<td>Sinequan</td>
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<td></td>
<td>Surmontil</td>
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<tr>
<td></td>
<td>Anafranil</td>
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<tr>
<td>(b) MAO Inhibitors: Monoamine oxidase</td>
<td>Nardil</td>
<td>Depression (atypical depression: hypersomnia) Panic disorder &amp; Social phobia &amp; overeating</td>
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<tr>
<td></td>
<td>Parnate</td>
<td>Requires dietary restrictions to foods rich in the amino-acid: tyramine (Salami &amp; Stilton cheese): some dangerous side effects.</td>
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<tr>
<td></td>
<td>Eldepryl</td>
<td>Originally found by discovering the drug increased the mood of tuberculosis pts: they were first used to treat tuberculosis!</td>
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</tr>
<tr>
<td></td>
<td>Marplan</td>
<td>Used now only for atypical depression characterized by overeating and hypersomnia and do not respond to other antidepressants.</td>
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</tr>
<tr>
<td>SNRIs: Serotonin &amp; Norepinephrine Re-uptake inhibitors</td>
<td>Effexor</td>
<td>More effective that SSRIs in the treatment of severe major depression</td>
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<tr>
<td></td>
<td>Vestra</td>
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<tr>
<td>© SSRIs: Selective Serotonin Re-uptake Inhibitors</td>
<td>Prosac</td>
<td>Depression, OCD, Panic Disorder, Bulimia</td>
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</tr>
<tr>
<td></td>
<td>Luvox</td>
<td>Response: when treatment results in 50% improvement</td>
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</tr>
<tr>
<td></td>
<td>Zoloft</td>
<td>Remission: 100% symptom improvement</td>
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<tr>
<td></td>
<td>Paxil</td>
<td>Recovery: if remission exceeds 6-12 months</td>
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<tr>
<td></td>
<td></td>
<td>Takes three wks; some nausea, insomnia, and sexual dysfunction.*</td>
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<tr>
<td></td>
<td></td>
<td>Prosac is the most widely prescribed SSRI in the world.</td>
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<tr>
<td></td>
<td></td>
<td>Inhibits Serotonin uptake only. Fewer side effect than MAOIs or Tricyclics: include nausea, diarrhea, nervousness, insomnia, and sexual side effects. Are not fatal in overdose. Not better than Tricyclics, but safer and better tolerated.</td>
<td></td>
</tr>
<tr>
<td><strong>(d) Atypical antidepressants</strong></td>
<td><strong>Desyrel (trazadone)</strong></td>
<td><strong>Depression</strong></td>
<td><strong>Not as effective as TCA; cognitive slowing; Desyrel first non-lethal SSRI in overdose. But has heavy sedation effects. Usually taken with other SSRIs. Can produce priapism in men: prolonged erection in the absence of sexual stimulation.</strong></td>
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<tr>
<td><strong>Wellbutrin Serzone</strong></td>
<td><strong>Depression</strong> (Wellbutrin is not an SNRI or an SSRI, but does increase noradrenergic function in other ways. No sexual side effects. Serzone is related to Desyrel; inhibits reuptake of both Serotonin &amp; nor-ep. But no insomnia or sexual side effects. Serzone requires freq. blood tests to check for kidney functioning)</td>
<td><strong>When Pts do not respond to TCA or SSRIs</strong></td>
<td></td>
</tr>
<tr>
<td><strong>(e) Antimanic (bipolar) or mood stabilizers</strong></td>
<td><strong>Eskalith Lithane Lithonate</strong></td>
<td><strong>Mania &amp; some severe depressions</strong></td>
<td><strong>Effective with mania but variable with depression; multiple side effects; high toxicity, requires careful monitoring: increased thirst, gastrointestinal problems, weight gain, tremor, fatigue.; can be toxic at high levels or if kidneys fail to excrete. Still not clear how lithium works: may alter electrolyte balance that then effect neurotransmitter functions.</strong></td>
</tr>
<tr>
<td><strong>Tegritol</strong></td>
<td><strong>Mania</strong></td>
<td><strong>Effective with Bipolar disorder; neurotoxic side effects inc tremor, unsteady gait &amp;</strong></td>
<td></td>
</tr>
</tbody>
</table>
restlessness

<table>
<thead>
<tr>
<th></th>
<th>Depakote</th>
<th>‘Mania</th>
<th>Fewer side effects than lithium; sometimes with bipolar pts who cannot take lithium</th>
</tr>
</thead>
</table>

**Side effects of Lithium**

a. Blood levels must be monitored: Too little lithium and the drug will be ineffective; too much lithium and the drug can be lethal;

b. Other side effects include lethargy, decreased motor coordination, gastrointestinal problems, increased thirst and urination, & weight gain.

c. Prolonged use could result in thyroid dysfunction and kidney damage, as well as motor and memory problems.

d. These side effects plus missing the mood swings, causes many to stop taking the medication. Lithium is **70% effective w/in 10 days** for reducing mania; it is more effective when used in conjunction with an antipsychotic drug or a benzodiazepine.

**C. Anti-anxiety Drugs: minor tranquilizers**

<table>
<thead>
<tr>
<th></th>
<th>Trade Name</th>
<th>Used to Treat</th>
<th>Effects/side-effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) <strong>Barbiturates</strong></td>
<td>Phenobarbitol</td>
<td></td>
<td>Not used because of the highly addictive effects</td>
</tr>
<tr>
<td>(b) <strong>Propanediols</strong></td>
<td>Equanil Miltown</td>
<td></td>
<td>Not used b/c of addictive properties</td>
</tr>
<tr>
<td>© <strong>benzodiazepines</strong></td>
<td>Valium Librium Dalmane Serax Tranxene</td>
<td>Anxiety, tension or panic attacks; also used as anti-</td>
<td>Variable effects; often used to treat alcohol withdrawal symptoms; can induce drowsiness and lethargy; strong</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>Convulsants and as sleep inducers</td>
<td>Addiction potential; (work to decrease GAD but leave adaptive behavior in tact)</td>
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<td></td>
</tr>
<tr>
<td>(d) New anxiolytics</td>
<td>Buspar</td>
<td>GAD</td>
<td>1-4 wks; Not good for acute anxiety; no addiction potential</td>
</tr>
</tbody>
</table>

3. Side effects include relapse after discontinued use of drug, esp, Xanax used in the TX of panic disorder, which is sometimes chronic.

4. Benzodiazepines produce their effects through stimulating the action of GABA (gamma aminobutyric acid), a neurotransmitter thought to be functionally deficient in people with Generalized anxiety. GABA usually inhibits anxiety in stressful situations.

IV. Psychological Approaches to Treatment

A. Behavior Therapy

1. Assumes that abnormal behaviors are learned in the same way as normal behaviors, and therefore can be unlearned.

2. Types of behavioral techniques
   a. **Exposure Therapy** (Classical Extinction or Pavlovian Extinction): Patient is exposed to anxiety producing stimuli until the anxiety dissipates {CS is presented over and over w/o the UCS}
      i. Exposure can be gradual and slow, as with **Systematic Desensitization** when items on a fear hierarchy are paired.
with relaxation, and the patient is slowly moved up the fear hierarchy after 0- SUDS are reported to the item on the hierarchy below it.

ii. Exposure can be rapid and intense as with Flooding (agoraphobics are taken outside)

iii. The form of the exposure can be real (in vivo exposure) or imaginary (imaginal exposure) or artificially constructed (Virtual reality exposure). In vivo has been shown to be most effective but some patients are just too fearful; imaginal can be a problem if the patient cannot make visual pictures in his mind; virtual is important if the situation that causes the fear is not easily reproducible, but the technology here is still very new.

b. Aversion Therapy

i. Operant: Applying punishment to an unwanted behavior, such as snapping a rubberband on your wrist every time you are about to say something negative

ii. Classical: Pairing Antabuse with the ingestion of alcohol to create nausea and vomiting in an alcoholic. Usually use noxious drugs or electric shock

iii. Classical: Covert or Vicarious Sensitization: Thoughts of abusing children in a pedophile are paired with slides of possible negative consequences (his own rape in prison)

✓ In all of these situations, the patient is taught some alternative and acceptable way of achieving gratification. Just punishing the unwanted behavior will not maintain the reduction of the inappropriate behavior; must be able to be reinforced for an alternative response

c. Modeling: Modeling is usually combined with instruction and guided exposure to achieve the best effect in conditioned fears

d. Systematic use of Reinforcement (Contingency management or Behavior Modification): changing the existing
contingencies for appropriate and inappropriate behavior. **Token Economies** are a form of this.

- **Overall:** Most effective for **anxiety disorders**, sexual disorders, inpatient treatment programs (autism, retardation, adolescent, drug abuse, psychotic patients) child management: anything where problem behaviors are specific and contingencies are controllable. Leads to fast relief in a shorter amount of time.

**B. Cognitive and Cognitive Behavioral Therapy**

1. **Assumptions:**
   a. Cognition influences emotion, motivation, and behavior
   b. Cognitions and behaviors can be changed by a systematic approach using hypothesis testing to change the reality of our cognitions ("ask 5 of your friends and see if they really do believe they are stupid")

2. **Types:**
   a. **REBT (Rational Emotive Behavior Therapy): Albert Ellis**
      i. Teaches people to re-evaluate our "shoulds, musts, and oughts" that lead to unrealistic expectations of ourselves and others to combat low self-esteem and perfectionism, using rational confrontation- "Why does failing the last exam mean that you are stupid?" *The process used by Ellis is debate and persuasion*
      ii. Also uses homework assignments to provide new experiences (break the old response chains)
   b. **Stress Inoculation Therapy:** Type of self-instructional training that changes a person's self-statements in stressful situations
c. **Aaron Beck's Cognitive Therapy** Originally developed for depression, but now used for anxiety disorders, eating disorders, obesity, conduct disorders, personality disorders, and substance abuse. Similar to Ellis except, uses **mood logs** *(which address "automatic or hot thoughts")* to identify cognitive distortions that make the person vulnerable to depression, to help the person identify his cognitive errors and change the thinking to make it more logical: *"You feel what you think"*

**MOOD LOGS & COGNITIVE DISTORTION LISTS HERE**

- RET: research suggests little effect for carefully diagnosed clinical populations. May be helpful to more healthy people to help them avoid anxiety and depression

- Stress inoculation: Successful with anger, pain, mild anxiety, surgical procedures. Need more research on its actual preventive value

- Beck's Cognitive Therapy: Efficacy is well documented. As **effective as drugs** for most depressions except for extreme cases such as psychotic depression; research shows strong effectiveness for panic disorder and GAD, and is the **treatment of choice** for bulimia. Also showing good promise in the areas of conduct disorder, substance abuse, and personality disorders.

C. **Humanistic -Experiential Therapies**
1. Assumptions: Man has the freedom and the responsibility to control his own behavior; the central focus is to expand a client's "awareness"
   a. **Client-Centered**: Carl Rogers: Uses reflective listening to provide empathetic environment to help client make his own changes. Therapist does not give opinions or advice **(Rarely used today)** but the listening skills are incorporated into all form of therapy to some extent to make the client feel understood, accepted, and values as people, unconditionally.

   b. **Existential**: The focus is on the person's own phenomenological experience rather than objective reality. Therapist is asked to comment on his own reality (to share himself)

   c. **Gestalt**: Emphasis on the "whole body": emphasis on integration of thought, feeling and action. Dream analysis; switching of chairs; uses much group therapy format: Be the other person and act out his experience or act out the objects in his dream

   - Overall **Humanist Summary**:
   - Not much research
   - Maybe the search for meaning and fulfillment has to remain ambiguous, but it is not clear what is supposed to happen in the sessions

D. **Psychodynamic**: Goal is to try to understand the present in terms of one's past
1. 2 forms: classical psychoanalysis & psycho-analytically oriented
   a. **Classical Psycho-analytic.**.: several sessions a week for several years to try to uncover repressed memories, thoughts, fears and conflicts stemming from problems in early psychosexual
development; To gain "insight" (e.g., excessive orderliness and a focus on humorless self control derived from being toilet trained too early)

b. Major techniques

i. **Free Association**: client is on the couch and therapist is behind him out of view and client is asked to say whatever comes to mind, regardless of how painful or personal it seems to be. **Goal**: To explore the pre-conscious, and to try to determine how all these thoughts fit together

ii. **Analysis of Dreams**: To identify repressed motives and wishes that are too painful to think about when awake. The repressed motivations may be disguised. So the goal is to analyze the **Manifest content** of the dream to understand the hidden meaning or the **latent content** behind the dream symbols.

iii. **Analysis of resistance**: Try to discover why the patient is "fighting" memory by being unwilling to talk about a painful topic, coming late, missing an appointment altogether, etc.

iv. **Analysis of transference**: Pts. Unconsciously transfer whatever feeling they had for a parent upon the therapist( *transference neurosis*); when this happens, the therapist does not respond the way the parent did, but responds in a neutral, non-judgmental manner, to help the pt. work through the negative feelings. The resolution of the transference neurosis is the key to affecting the psychoanalytic "cure". Therapists must watch for countertransference, where he responds to the transference issues with his own transference.

2. **Psychoanalytically oriented Approaches**
a. **Interpersonal**: identify and identify transference and counter-transference phenomena in all of the patient's relationships

b. **Object Relations, Self Psychology** (attachment relations), and other interpersonal variations: Same focus on early development but NOT focusing on the psycho-sexual stages and not looking only at internal libidinal drives

- Classical Psychoanalysis: no controlled outcome studies
- Interpersonal Therapy as done by Klerman has some good outcome data for depression & bulimia. More research is needed and is being done.

3. Other therapy formats
   a. **Marital Therapy**
      i. **Traditional Behavioral Couple Therapy (TBCT)**: communication skills, and problem solving skills, and identification of behaviors that are both helpful and problematic in the relationship: 2/3 improve
      ii. **Integrated Behavioral Couple Therapy**: In this approach, the focus is on acceptance rather than change (preliminary findings are good)

b. **Family Systems Therapy**: One family member's disruptive behavior is simply a symptom if the dysfunction in the family: so see the entire family
   - **Structural Family Therapy**: Focuses on enmeshment, over-protectiveness, rigidity, and poor communication skills. Usually the "identified patient {child}" is the product of the family's tendency to avoid conflict (good research outcomes)

c. **Multi-modal Therapy**: Uses the best techniques of many different types of therapies
4. **Problems:**

   {a} Need more minority therapists to meet the needs of a multi-ethnic culture
   
   {b} Ethical dilemmas that are faced by therapists every day (e.g., Should a 15 year old be counseled to abstain from sex as her parents wish, or should the parents be counseled to accept the world as it is?)