Quadrant II – Transcript and Related Materials

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Psychosocial Approaches to Treatment

The different clinical approaches that the therapists use are as follows:

III) HUMANISTIC-EXPERIENTIAL THERAPIES

The humanistic-experiential therapies are based on the assumption that we have both the freedom and the responsibility to control our own behavior-that we can reflect on our problems, make choices and take positive action. Humanistic -experiential therapists feel that a client must take most of the responsibility for the direction and success of therapy, with the therapist serving merely as counselor, guide and facilitator.

a) CLIENT-CENTERED THERAPY

The client-centered therapy focuses on the natural power of the organism to heal itself. The primary objective of Rogerian therapy is to resolve this incongruence-to help clients become able to accept and be themselves. A psychological climate in which clients can feel unconditionally accepted, understood and valued as people. The therapists employ nondirective techniques such as empathic reflecting or restatement of the client's descriptions of life difficulties. If all goes well, clients begin t feel free, for perhaps the first time, to explore their real feelings and thoughts and to accept hates and angers and ugly feelings as part of themselves. As their self-concept becomes more congruent with their actual experience, they become more self- accepting and more open to new experiences and new perspectives, in short, they become better integrated people.

b) MOTIVATIONAL INTERVIEWING

this is a brief form of therapy that can be delivered in one or two sessions. It was developed as a way to help people to resolve their ambivalence about change and make a commitment to treatment. At its center is a supportive and empathic style of relating to the client that has its origins in the work of Carol Rogers. However, MI differs from client-centered counselling because it also employs a more direct approach that explores the client's own reason for wanting to change. The therapist

encourages “the change talk” by asking the client to discuss his or her desire, ability, reasons, and need for change. These are reflected back by the therapists, thus exposing the client to periodic summaries of his or her own motivational statements and thoughts about change. The result is that client can develop and strengthen their commitment to change in an active, accepting and supportive atmosphere.

Motivational interviewing is most often used in the areas of substance abuse and addiction. When added to the beginning of a treatment program, it appears to benefit patients, perhaps because it facilitates patients’ staying in treatment and following treatment plan.

The collaborative and nonconfrontational style of motivational interviewing may also make it acceptable to adolescents. Even a very small number of sessions of motivational interviewing can promote behavior change in adolescents who use drugs and alcohol.

c) GESTALT THERAPY

Gestalt Therapy was developed by Frederick Perls as a means of teaching clients to recognize their bodily processes and emotions they had been blocking off from awareness. As with the client-centered and humanistic approaches, the main goal of gestalt therapy is to increase the individual’s self-awareness and self-acceptance. The individual may be asked to act out fantasise concerning feelings and conflicts or to represent one side of conflict while sitting in one chair and switch chairs to take part of the adversary. Often the therapist or other group of members will ask questions as,” what are you aware of in your body now?” and “what does it feel like in your gut when you think of that?”

EVALUATING HUMANISTIC-EXPERIENTIAL THERAPIES

Many of the humanistic-experiential concepts the uniqueness of each individual, the importance of the therapists genuineness, the satisfaction that comes from realizing one’s potentials, the importance of the search for meaning and fulfilment and the human capacity for choice and self-direction have had a major impact on our contemporary views of both human nature and the nature of good psychotherapy.

However, humanistic-experiential therapies have been criticized for their lack of agreed upon therapeutic procedures and their vagueness about what is supposed to happen between client and therapist. In response, proponents of such approaches argue against reducing people to abstractions, which can diminish their perceived worth and deny their uniqueness. Because people are so different, they argue, we should expect different techniques to be appropriate for different cases.

IV) PSYCHODYNAMIC THERAPIES

this is the oldest form of psychological therapy and begin with Sigmund Freud. The therapy is mainly practised in two basic forms: classical psychological therapy and psychoanalytically oriented psychotherapy. As developed by Freud and his immediate followers, classical psychoanalysis is an intensive, long term procedure for uncovering repressed memories, thoughts, fears and conflicts presumably stemming from problem in early psychosexual development and helping individuals come to terms with them in light of the realities of adult life.

In psychoanalytically oriented psychotherapy, the treatment and the ideas guiding it may depart substantially from the principles and procedures laid out by orthodox Freudian theory, yet the therapy is still loosely based on psychoanalytic concepts. Likewise, the relatively passive stance of the analyst is replaced with an active conversational style in which the therapist attempts to clarify distortions and gaps in client’s construction of the original and the consequences of his or her

problem, thus challenging client "defenses" as they present themselves. It is widely believed that this more direct approach significantly shortens total treatment time.

FREUDIAN PSYCHOANALYSIS: the four basic techniques of this form of therapy 1) free association 2) analysis of dreams 3) analysis of resistance 4) analysis of transference.

1)Free Association: the basic rule here is that an individual must say anything that comes into his or her mind regardless of how personal, painful, or seemingly irrelevant it may be. Usually a client lies in a relaxed position on a couch and gives a running account of all the thoughts, feelings, and desires that come to mind as one idea leads to another. The therapist normally takes a position behind the client so as not to disrupt the free flow of associations in any way.

The purpose of free associations is to explore thoroughly the contents of the preconscious- that part of the mind considered subject to conscious attention but largely ignored, analytic interpretation involves a therapist's trying together a client's often disconnected idea, beliefs, and actions into meaningful explanations to help the client gain insight into relationship between his or her maladaptive behavior and the represses events and fantasies that drive it.

2)Analysis of Dreams: Dreams have been referred to as "royal road to the unconscious". Some motives, are so unaccepted to an individual that even in dreams they are not revealed openly but are expressed in disguised or symbolic form. Thus a dream has two kinds of contents 1) **manifest content**, which the dream is as it appears to the dreamer 2) **latent content**, which consists of the actual motives that are seeking expressions but are so painful or unacceptable that they are disguised.

It is the therapist's task, in conjunction with the associations of the patient, to uncover these disguised meanings by studying the images that appear in the manifest contents of the clients dream and their association with them.

3)Analysis of Resistance: during the process of free association or of associating to dreams, an individual may evidence **resistance** – an unwillingness or inability to talk about certain thoughts, motives or experiences. "It really isn't important" or "It is too absurd to discuss". Resistance may also be evidenced by the clients giving a too-glib interpretation of some association, or coming late to an appointment, or even "forgetting" an appointment altogether. Because resistance prevents painful and threatening material from entering awareness, its sources must be sought if an individual is to face the problem and learn to deal with it in a realistic manner.

4)Analysis of Transference: Often people carry over, and unconsciously apply to their therapist, attitudes and feelings that they had in their relationship with parent or other person close to them in the past, a process known as transference. Thus, clients may react to their analyst as they did it to the earlier person and feel the same love, hostility or rejection that they felt long ago. The often affect-laden reactions of the client can be interpreted, it is held, as a type of projection- inappropriate to the present situation yet highly revealing of the central issue in the client's life.

In helping the client to understand and acknowledge the transference relationship, a therapist may provide the client with insight into the meaning of his or her reactions to others. In doing so, the therapist may also introduce a corrective emotional experience by refusing to engage the person on the basis of his or her unwarranted assumption about the nature of the therapeutic relationship. If the client expects rejection and criticism, for example, the therapist is careful to maintain a neutral manner. Or contrarily, the therapist may express positive emotions at a point where the client feels particular vulnerable, thereby encouraging the client to reframe and rethinking his or her view of

situation. In this way it may be possible for the individual to recognize these assumptions and to "work through" the conflict in feelings about the real parent or perhaps to overcome feelings of hostility and self-devaluation that stem from the earlier parental rejection. In essence, the negative effects of undesirable early relationship are counteracted by working through a similar emotional conflict with therapist in therapeutic setting. A person reliving of a pathogenic past relationship in a sense re-creates the neurosis in real life, and therefore this experience is often referred to as a *transference neurosis*.

Often the client is ambivalent-distrusting the therapists and feeling hostile towards him or her as a symbol of authority, but at the same time seeking acceptance and love. In addition the problem sof transference are not confined to the client, for the therapist may also have a mixture of feeling toward the client. this **countertransference ,** wherein the therapists reacts in accord with the client's transferred attributions rather than objectively, must be recognised and handled properly by the therapist for this reason, it is considered important that therapists have a thorough understanding of their own motives, conflicts, and "weak spots" ; in fact, all psychologists undergo psychologists themselves before they begin independent practice.

The resolution of the transference neurosis is said to be the key element in affecting a psychoanalytic "cure". Such resolution can occur only if an analyst successfully avoids the pitfalls of countertransference. That is, the analyst needs to keep track of his or her own transference or reaction to a client's behavior. Failure to do so risk merely repeating, in the therapy relationship, the typical relationship difficulties characterizing the client's adult life. Analysis of transference and phenomenon of countertransference are also part of most psychodynamic derivatives of classical psychoanalysis to which we now turn.

EVALUATING PSYCHODYNAMIC THERAPIES

Classical psychoanalysis is routinely criticized by outsiders for being relatively time consuming and expensive; for being based on a questionable, stultified, and sometimes cult-like approach to human nature; for neglecting a clients immediate problems in the search for unconscious conflicts in the remote past; and for there being no adequate proof of its general effectiveness. Nonetheless, there are some hints that this treatment approach has some value. psychoanalysts also argue that manualized treatments unduly limit treatment for a disorder. They not that simply because a treatment cannot be standardized dose not mean that it is invalid or unhelpful. Whether the clinical benefits justify the time and expense of psychoanalysis, however, remains uncertain.

V) COUPLE AND FAMILY THERAPY

Many problems that therapists deal with concern distress relationships. A common example is couple or marital distress. Here the maladaptive behavior exists between the partners in the relationship. Extending the focus even further, a family system approach reflects the assumption that the within-family behavior of any particular family member is subject to the influence of the bhaviors and communication patterns of other family members.

a) COUPLE THERAPY: Relationship problems are a major cause of emotional distress. The large number of couples seeking help with troubled relationship have made couple counselling a growing field of therapy. Typically, the couple is seen together. Improving communication skills and developing more adaptive problem- solving styles are both major foci of clinical attention. Although it is quit routine at the start of therapy for each partner secretly to harbor the idea that only the other person will have to do the changing, it is nearly always necessary for both partners to alter their reactions to the other.

For many years the gold standard of couple therapy has been traditional behavioral couple therapy. **TBCT** is based on social-learning model and views martial satisfaction and martial distress in terms of reinforcement. The treatment is usually short term and is guided by a manual. The goal of TBTC is to increase caring behaviors in the relationship and to teach partners to resolve their conflicts in more constructive way through training in communication skills and adaptive problem solving.

INTERGRATIVE BEHAVIORAL COUPLE THERAPY (IBCT): instead of emphasizing change, IBCT focuses on acceptance and includes strategies that help each member of the couple come to terms with and accept some of the limitations of his or her partner. Of course, change is not forbidden. Rather, within IBCT, acceptance strategies are integrated with change strategies to provide a form of therapy that is more tailored to individual characteristics, relationship "themes", and needs of couple.

b) FAMILY THERAPY: couple therapy developed in response to large number of clients who came seeking help for relationship problems. Family therapy began with the finding that many people who had shown marked clinical improvements after individual treatments – often in institutional settings-had a relapse when they returned home. Another approach to resolving family disturbances is called **structural family therapy.** This approach, which is based on systems theory, hold that if the family context can be changed, then the individual members will have altered experiences in the family and will behave differently in accordance with the changed requirements of the new family context. Thus, an important goal of structural family therapy is changing the organizations of the family in such a way that the family members will behave more supportively and less pathogenically with each other.

Structural family therapy is focused on present interactions and requires an active but not directive approach on the part of a therapist. Initially, the therapist gathers information about the family – a structural map of the typical family interaction patterns-by acting like one of the family members and participating in family interactions as an insider. In this way, the therapist discovers whether the family system has rigid or flexible boundaries, who dominates the power structure, who gets blamed when things go wrong and so on. Armed with this understanding, the therapist then operates as an agent for altering the interactions among the other members, which often has transactional characteristics of enmeshment, overprotectiveness, rigidity, and poor conflict resolution skills. The "identified client" is often found to play an important role in the family's mode of conflict avoidance. Structural family therapy has quite a good record of success in the treatment of anorexia nervosa.

VI)ELECTICISM AND INTEGRATION

The various schools of psychotherapy once stood more in opposite to one another than they now do. Today, clinical practice is characterized by a relaxation of boundaries and willingness on part of therapists to explore different ways of approaching clinical problems, a process sometimes called ***multimodal therapy***. When asked what their orientation is most psychotherapists reply "**electic**" which usually means that they try to borrow and combine concepts and techniques from various schools, depending on seems to be best for that individual's case. This inclusiveness extends to efforts to combine biological and psychosocial approaches as well as individual and family therapies.

One example of an electic form of therapy is ***interpersonal psychotherapy***. Developed by klerman and colleagues as a treatment for depression, IPT focuses on current relationships in the patient's life and has the goals of reducing symptoms and improving functioning. Interpersonal therapy was based on the interpersonal theory of Harry Stack Sullivan as well as on Bowlby's attachment theory. Its central idea is that all of us, at all times, involuntarily invoke schemes acquired from our earliest interactions with others, such as our parents, in interpreting what is going on in our current

relationships. Although it is sometimes considered to be a form of psychodynamic psychotherapy, IPT uses techniques from several other treatment approaches. It is also focused and time limited. In addition, the emphasis in treatment is on the present, not past.

IPT has demonstrable value in treatment of depression. It has also been adapted for other disorders including bulimia nervosa, anxiety disorders and borderline personality disorder.