ATLANTIC INTERNATIONAL UNIVERSITY

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PSYCHOLOGY

EXAMS: PSYCHOTHERAPY 2

Chapter 14

Introduction to topics in the chapter

ORIGINS OF BEHAVIORAL THERAPY

Goal of behavioral therapy

Over time psychotherapy outcome researchers have tried to explain by empirical methods the results of psychodynamic and humanistic psychotherapy and had much difficulty**.** The goal of Behavioral therapy basically is to establish by examination, proof of psychotherapy outcomes. Behavioral therapy strives to explain problematic behavior as the reason for therapy and not any underlying factors causing it, that cannot be observed or measured empirically. While medical-model approach is common to other types of therapy, Behavioral therapy does not adopt the medical model approach to therapy. Behavioral therapy therefore focusses on treating the unwanted behavior itself and not attribute it to some underlying causes. Outcome of therapy can therefore be measured by observable behaviors and not by inferences which are predominant in psychoanalytic and humanistic therapies.

Types of conditioning

Behaviorists consider behavior to be the outcome of conditioning. They assert that every behavior is determined by the condition that produces it. Behavior can therefore be created or altered by changing the condition in which it was birthed. Conditioning can be in two ways: **classical** and **operant.** A conditioning technique can be said to be classical if, a conditioned stimulus results in a conditioned response in either human or animal. Operant conditioning is an animal or human use of consequence to an action in determining future behavior. The 'creature' in operant conditioning studies the outcome of an action in response to a stimulus, whether it is favorable or not and use it to figure out what his next behavior will be.

Techniques based on classical conditioning

Exposure therapy: A client may associate fear with a harmless stimulus like darkness, height, water and this can impair his work or normal life. A clinical psychologist frequently exposing the client to the feared object will eventually take away the aversive outcome from the stimulus. This is exposure therapy. The feared stimulus becomes demystified over time in the process of repeated interactions with it. **Systematic desensitization** is an anxiety treatment strategy that separates a harmless stimulus from fear by replacing the aversive response with relaxation. Normally client is given some training in relaxation technique before the systematic desensitization is deployed. Each time the stimulus is released the client responds with relaxation and not fear. **Assertive training** is fit for managing clients that are easily frightened in social settings and experience interpersonal fears. It is a form of systematic desensitization but in this case, the aversive response is replaced with assertiveness instead of relaxation. This training helps clients to put their feet down on issues and confidently insist on their position or make a request positively.

Techniques based on operant conditioning

Contingency management

Consequences control behavior. A desirable or an undesirable behavior can be brought about by manipulating the consequences that will produce it. This is contingency management. It can either be by **reinforcement or by punishment**. Reinforcement refers to consequences that encourage a particular behavior to repeat under a given circumstance. If the consequence 'add something good' to the person, then it is **positive reinforcement**. If it 'takes away something bad' from him, then it is **negative reinforcement**. Consequence that punishes for unacceptable behavior can be termed **positive punishment** if it 'adds something bad' to the person and **negative punishment** if it 'takes away something good' from the person. When consequence that maintain a behavior is contemplated or new contingency is being considered to alter the behavior then extinction comes to mind**. Extinction** is the taking away of an expected reward that lessen the number of times a behavior repeats. **Token economies** is awarding rewards to clients for performing pre-agreed target behavior. Instances where target behavior is multiplex or demanding, therapist could resort to rewarding every little step taken that align with the expected target behavior. This is **shaping.**

Alternatives to behavior therapy

Behavioral consultation is an alternative to direct clinical services involving three parties, the consultant psychologist, the client and the consultee- a person who has some regulation over the contingencies that control the client's behavior. It can be a parent, Teacher or a caregiver. The consultee carries out instruction given by the consultant on how to consequence manage the client**. Parents training** is suited for a number of problematic behaviors with children, for example bedwetting, defiant behavior, fear of the dark. Therapist may not have direct contact with the client when adopting this strategy. Parents must take care not to reinforce behavior they are trying to do away with.

Outcome issues

Empirical proof supports Behavioral therapy much more than psychodynamic and humanistic therapy**.** Behavioral therapy successfully handles a wide number of disorders with empirical proof of effectiveness.

Questions of exams

1. **Do you believe that the law of effect is equally powerful in humans and animals?**

   Answer:

   The law of effect states that; Response that gives rise to a rewarding effect in a specific situation is more likely to repeat under the same condition while response that brings about discomforting effect is less likely to repeat under the same condition.' The above law clearly applies to both human and animals alike. Humans and animals avoid any stimulus causing pain. If a situation creates discomfort for humans or animals, whatever response that led to it will not be repeated. If a child was called into a room and instead of getting a toy got a knock on the head, the child will most likely not respond to same call next time under the same condition. Similarly, if a Dog is called probably hoping for a piece of meat, but received a whack, the Dog will most likely not respond to same call under same condition next time. The law of effect proves that humans and animal response are governed by consequence. Favorable and rewarding consequences encourage response to repeat while unfavorable and unrewarding consequences discourage a response from repeating.

   If a father returns home everyday with some snacks the children love, they will always stay up till he is back from job in the hope of getting some good treat, their staying awake for their father to return will be repeating because, there is a comforting consequence of good snacks, if their father had been bullying them each time he returns, smacking and picking up quarrels, the children's response of staying up for his return will be discouraged, because of the unfavorable and negative consequence that follows.

   Animals in like manner repeat their response more often when the consequence is favorable. A Dog will wag its tail and show friendly disposition towards her care giver each time he comes around hoping something good is in the offing.

   A student will work harder at school to earn better grades, if the father has in place a reward system that the student esteem high highly. The reward system will enforce the behavior of the student to do more study for better grade. It may not be so in another family where such motivation is absent.

2. **To what extent do you agree that the primary goal of psychotherapy should be observable behavior change?**

   Answer: It is behaviors observed to be inconsistent with an individual's normal lifestyle or contrary to cultural norms that informed the need for therapy in the first place, observable behavior change therefore should be the primary goal of psychotherapy. Psychological disorders will normally manifest in the form of behavior that is unusual to the person's way of life or unacceptable in the culture. Focusing on behavior change is key to both the therapist and the client. How will the therapist convince himself something significant has been done in course of the therapy, except he can observe and measure behavioral change in the client.?

Whatever is happening within the client that a therapist may try to deduce by inference or insight, is of little or no consequence if it has no manifest observable behavior in the client that can be measured and understood to be unacceptable in the culture. It is behavior that establishes that there is need for therapy. All that may be revealed through in-depth probing of the mind by a therapist can only be meaningful in noticeable and measurable behaviors. Behavior therefore is everything therapy should focus on. It is behavior that will show something has gone wrong and change in behavioral pattern will show therapy has worked. It is proper to emphasize behavior in therapy as it is all the reason for coming to therapy.

A client coming to therapy and complaining of a mental problem that does not manifest in observable and measurable behavior will be difficult to treat. Even Psychotherapist in other schools of thought rely on change in behavior to measure the success of their therapy. Behavior change is very central to therapy. It is what the therapist will read and be convinced something is wrong or measure to assure himself he has done a good job. Psychotherapists could fall for jokers masquerading as clients if behavior change is not taken as the focus of therapy. Therapist taking baseline data will observe that baseline behavior is normal and will not proceed with the therapy no matter how the joker may frame his complain.

In course of therapy a client may be overcoming anxious feelings, suicidal thoughts, depressive tendencies, all these internal changes can hardly be measured and treated empirically except it can be established in observable and measurable behavior. Feelings and thoughts are subjective experiences but observable behavior is objective and can be treated empirically. It is therefore important to treat change in behavior as a principal thing to look out for in therapy.

Question.

3. **To what extent do you agree with the medical model of psychopathology?**

Answer:

It is not unreasonable to accept that every **effect** has a **cause,** even in psychopathology. Someone showing symptoms of depression must be reacting or responding to something that has happened elsewhere within or outside of him. I agree that medical model of psychopathology is a proper method of diagnosing and treating psychological disorders. Every ailment that is treated from the **cause**, can be said to have been dealt with from the roots. It is important to know that in psychopathology, symptoms do not just show up as a problem on its own, something had ignited it. Using the medical model of psychopathology while handling disorders is a logical way of treating problems, although it may not be empirically explicable to a Behaviorist therapist.

Medical model of psychopathology shows symptoms as indicators of some underlying problems, if the therapist carefully figures out these underlying problems showing up as ‘symptoms on the surface’, he will be doing a great and enduring job. If a client for instance, is showing signs of depression, as a result of abuse he is experiencing at home or work environment, but the therapist is only interested in handling the observable behaviors of depression without reaching for the root cause, the client who might have shown signs of recovery could relapse back into the unwanted experience because, he is living with the cause of the problem which was

ignored. It is proper therefore to handle cases of psychopathology holistically (cause and effect) than concentrating only on the symptoms.

Medical model of psychopathology will save time and facilitate treatment. If cause of a disorder is attended to from the outset, it will save time spent treating the symptoms repeatedly. If water is dripping from a container at home and a family member concentrates on wiping the floor instead of stopping the drip, he will spend countless hours cleaning. Going beyond the wet floor and solving the cause of the floor getting wet will provide a lasting solution. Medical model of psychopathology will ensure a lasting solution to treating a disorder. Once the cause is attacked and cleared, the effect which is the symptom cannot remain.

Attending to causes or reasons behind an abnormal behavior is crucial to treating a disorder. It could take a long while before certain symptoms of psychopathology become obvious. Medical model of psychopathology could help a therapist deal with a disorder early enough even when the symptoms are not so obvious for people to observe. A treatment model that take a serious look at causes of psychopathology could deal with a disorder in a good time than waiting for the symptoms (behavior) to manifest before treating it.

4. In your opinion, what can behavioral therapists do to make imaginal exposure as similar to in vivo exposure as possible?
Answer:

A psychotherapist can do a few things to make imaginal exposure as similar to in vivo. A client with phobia for snakes visits a therapist for professional help, the therapist de-mystify snakes in the mind of the client by talking in a way to allay client's fears before any form of exposure. Hearing that not all snakes are dangerous and snakes may only attack in self-defense to a large extent will prepare the mind of the client for any form of exposure therapy. Conversation with the therapist on snakes will go a long way familiarizing client with the object creating fear and will be making imaginal exposure as similar to in vivo.

Imaginal exposure can be as similar to in vivo when therapist show pictures the client can relate with. In the example above, if the client is shown pictures of snakes, it will denigrate fear for snakes in his mind even when he has not been physically exposed to it. Pictures are powerful study aids and can be very helpful in this regard. Client's sight of snakes in pictures and therapist allowing client to touch picture of snakes, play with it and stay with it, will do a lot in his mind to put out fear for snakes. Pictures can give a vivid representation of the object causing fear in the mind of the client.

Therapist can introduce client to several videos of snakes. Client being exposed to videos of different snakes in separate settings can desensitize him of the fear for snakes even when he has not been exposed to it real life. Imaginal exposure will be close to in vivo if therapist can continue to present to his client the feared object in video forms. Client can begin to relate with the feared object in his mind and get more familiar with it as often as he watches it in a video clip. Rolling it over and over in his mind while watching the clips and even visualizing it afterwards will make imaginal exposure close to in vivo exposure

Therapist can make imaginal exposure close to in vivo by showing relics of the feared object to the client. Naturally, client will be less apprehensive of a charred remain of a feared object than a live one. For example, Snakes grow, but their skins do not, so they shed it.

Therapist can use the shed skin of snakes to further allay the fear of his client for snakes, even when he has not been exposed to a live one. Use of relics can do more to make imaginal exposure close to in vivo.

5. **For what types of clinical problems does contingency management seem most and least likely.**

Depression is one clinical problem for which contingency management will most likely resolve. A depressed client will likely avoid social interactions, stay indoors, talk very little. contingency management could help the depressed progress step by step out of the malady. If every compliance with therapist's advice is rewarded by way of reinforcement, the client will be motivated to repeat the expected behavior. Progressively reinforcing targeted behaviors in the depressed client will cause him to do more towards his recovery from depression. When a depressed client come outdoor and interact with a neighbor, and something is given or done for him by way of reinforcing that behavior, it is likely the behavior will repeat and the client's social interaction will improve. If he is withdrawn and absolved in negative thoughts and a book is given him to read every week, rewarding his compliance each time he completes a book will promote positive thinking and hasten recovery.

Contingency management can also be used to control **defiant behaviors.** A child exhibiting defiant behaviors can be managed using contingencies that will deter repetition of those unacceptable behaviors. The use of contingencies to manage the child's acts of rebellion will most likely dissuade him from repeating the unwanted behavior. Rewarding the defiant child's good behavior can keep him in a good spirit to receive further instructions with the hope of being recognized and awarded for exhibiting acceptable behavior.

If a child is manifesting **temper tantrum** at home and parents resolve to seek the help of a clinical psychologist, the therapist could decide to reinforce aspects of the child's behavior that will promote desired behavior and use contingency management to discourage repetition of the unwanted ones. Rewarding the child every time he demonstrates self control with something of interest will encourage the desired behavior to repeat while punishing every feat of anger by denying or depriving him the use of somethings will discourage the temper tantrum from repeating. The child knowing, he has something to gain for self-restraint in a provocative circumstance will continue to keep a lid on his temper. This will lead to extinction of the negative behavior. Contingency management will work effectively in handling **drunkenness.** A client consulting a clinical psychologist for drunkenness could be managed by reinforcing his positive attitude and behavior toward restraining himself from drinking. Such reinforcements will encourage a more responsible behavior while punishing indulgent ones to deter his drunkenness. progressively withdrawing things of interest from the client as consequence for failing to keep to agreed plan for managing the drunken behavior as well as reinforcing compliant behavior will facilitate a successful therapy.

A client with psychological disorder and is **out of touch with reality** may not respond to therapy using contingency management He is not in conscious control of his behavior, so may not appreciate goodwill in terms of reinforcements or punishment for non-compliant behaviors. A client that is out of his mind, how can he recognize rewards however fantastic and appealing.? Contingency

management will least apply in such cases. Client will need to be managed back to reality for contingency management to work effectively.

CHAPTER 15 COGNITIVE PSYCHOTHERAPY

Introduction to topics in the chapter

Cognitive therapy is juxtaposed between behavioral and psychodynamic psychotherapy approaches**.** Behavioral approach has been seen to be inadequate in addressing a number of psychological disorders looking at the symptoms alone. Psychodynamic therapy involves some mental processes

Goal of cognitive therapy

Behavioral approach is limited in addressing a good number of psychological disorders from the point of symptoms alone. The way an individual think or perceives a stimulus from the environment determine how will respond to it. Rational thinking about a situation or problem is the goal of cognitive psychotherapy. An unrealistic thinking about a problem can result in a psychological disorder. Cognitive therapy therefore trains on suitable response to life situations that will enhance mental wellness. Having a proper perspective of an event at anytime is the first means of keeping away psychological problem. If every situation can be rightly perceived and appropriately responded to most cases of psychological disorder will not happen in the first place.

Importance of cognition

When events happen and we respond by reacting positive or otherwise, it is not the event itself that caused the action but the interpretation we give the event that informed the action. Rain fell yesterday and you were happy, same rain falls today and you are sad. A clear indication that it is not the event that determine your action but how you interpret the event. This shows how important cognition is between every life event and our response to it.

Revising cognition

Our interpretation of most events in life come automatically. We hardly sit to ponder on how to interpret situations when they happen. We just arrive at conclusions in our minds so quickly. When we interpret life events in a way it does not correspond logically to the situation, we may create a state of psychological disorder. A cognitive therapist could help a client revise such irrational thought and settle for what is more appropriate for the situation. Three stages are involved, **recognizing** the irrational thought, **challenging** it and **revising** it. Such revision of how situations are construed is done within the context of client's culture not therapist's culture.

Teaching as a tool

Cognitive therapists teach their clients**.** Clients need to understand the process of revising thoughts to be able to practice it between therapy sessions. Therapist may give written assignments in the form of writing done events, feelings and attempts to revise them or instruct client to perform certain behaviors then have them discussed in subsequent meeting.

TWO APPROACHES TO COGNITIVE THERAPY

Albert Ellis

A pioneer cognitive therapist developed the Rational emotive therapy approach which was later renamed Rational Emotive Behavior Therapy **(REBT).** The significance of this approach is, the less irrational our thoughts the happier we become. A man's ability to boost his logical thoughts as against the illogical will enhance psychological stability. Albert Ellis created the ABCDE model of cognitive therapy and it has been useful to a great number of practicing therapists and clients. The first three letters of the acronym stand for; **A- Activating event, B- Belief, C- emotional consequence**. This is the flow path of events and our normal response to them. We most often base our emotional response on noxious and irrational belief which has the capacity to harm our psyche. Albert Ellis therefore innovated the idea of challenging the belief that informed our emotional response with the aim of settling for a new one more appropriate for the situation. He added D and E which stand for **Dispute** and **Effective new belief**.

Aaron Beck

He used his approach to remedy depression cases which was very effective, but its application has been extended to other psychological issues in later years. It is called **the cognitive triad**. Aaron Beck postulated in his theory of depression that three cognitions are responsible for our psychological well being -thoughts about self, the external world and the future. If these three thoughts are negative, it can lead to depression. Beck introduced a form for clients to fill during therapeutic procedure called **Dysfunctional thought record.** It has a close resemblance to Ellis' ABCDE model. Labelling illogical thoughts according to the **common thought distortion,** helps clients do away with irrational thinking and have in its place a more appropriate one.

RECENT APPLICATIONS OF COGNITIVE THERAPY

The third wave: mindfulness-and acceptance -based therapies

In recent times, psychotherapy has metamorphosed from pure behaviorism through cognitive to a newer approach referred to as 'third wave' which is premised on mindfulness and acceptance. The 'third wave' therapies are in three forms; Acceptance and commitment therapy (ACT), dialectical behavior therapy (DBT) and metacognitive therapy, with mindfulness and acceptance being central to all three. **Acceptance and commitment therapy (ACT)** advocates consenting to internal psychological experiences like thoughts, emotions and

sensation rather than diverting them through avoidance and cower to enhance psychological wellness. Struggling for control of these psychological experiences should be gradually dropped**. Dialectical behavior therapy (DBT**) is an altered type of cognitive behavior therapy suited for persons having difficulty with managing the magnitude of their feelings. It teaches living in the now, control emotions and improve on relationship with other people. Three key exercises are pivotal to Dialectical behavior therapy; Problem solving, validation and Dialectics**. Metacognitive therapy** proposes that the A in the ABCDE of Albert Ellis' model for cognitive therapy may be perception and not an external event. Thoughts about a wrong perception of an event can cause a psychological problem not necessarily the external event itself.

Cognitive therapy for medical problems

What medical patients think about their illnesses have a ripple effect on their recovery. Negative thoughts about an illness could hinder recovery in a reasonable time.

Outcome issues

Empirical evidences have shown that a large number of cognitive therapy outcomes have been successful. It's application in treating various psychological disorders have been on the rise**.** Studies have shown a drastic reduction of anxiety after client's completion of a cognitive therapy with a clinical psychologist.

Questions of exam

1. **To what extent do you agree with the fundamental cognitive assumption that illogical or irrational thinking underlies psychological problem?**

Answer:

When thoughts of an individual are not logically appropriate for a given event, it creates mental stress for him and If this continue for a considerable length of time, it could lead to a psychological problem. Negative and irrational thoughts often come as an automatic response in the mind, especially when undesirable things happen. The psychological imbalance caused by irrational thinking imperceptibly alters the mental indices of the individual over time and the end result is psychological problem.

Irrational thinking about a problem such as: personalization, catastrophizing, magnification/minimization, overgeneralization, ultimately affect the psyche of an individual. Someone who takes an event personal on himself even when accountability is not his

responsibility in the matter, is surely going to have so much headache he did not bargain for. Blaming himself for whatever goes wrong is irrational and it creates a psychological burden for the mind which can result in a psychological problem. Self-blaming for everything that goes wrong is a good way to losing sound mind which the body needs for psychological wellbeing. Illogically taking needless blame due to personalizing issues can therefore birth psychological problem.

Catastrophizing issues is another irrational thinking that can cause psychological problem. Thinking the worst outcome out of every event is an 'overkill'. When things go wrong, they do not always grow worse, let alone go worst. Someone catastrophizing an event make it worse in the mind more than in reality. This is borne out of irrational thinking. Having a perception that things will always get worst once it goes wrong can offset the balance of mind and body thereby creating a psychological disorder. It is safe to see things in proper perspectives to maintain one's psychological equilibrium all the time.

Maximizing negative events while minimizing positive ones are irrational ways of thinking that can cause psychological problem. Life is made up of high moments and low ones. Enjoying little moments of happiness, making the best out of it no matter how small promotes a healthy mind needed for a sound body. Irrational thinking will not take this route, rather it can minimize the happy moments counting it of little or no consequence, while maximizing negative moments. For example, angry moments, loss of property, failure in an examination are often taken too seriously than necessary thereby creating a mental burden and the end result could be a psychological problem.

2. If you were the client, how would you respond to the assignment of homework by your therapist?

As a client with a cognitive therapist adopting the Albert Ellis's ABCDE model, I will meticulously deliver on my assignments. Earlier, therapist had briefed me that events lead to thoughts which eventually lead to feelings. I have responsibility to dispute irrational thoughts that come handy when things happen and replace them with more rational ones suited for the situation. For example, I have told my therapist of the frustration I am having with my children's defiant behaviors and my wife disrespectful manners, so I am feeling depressed as a result. I have been asked to do a homework using Albert Ellis's model to track events, thoughts and emotions while at home.

The acronym ABDCE means. A- activating event, B- belief, C- consequence, D- disputing the irrational belief, E- effective new belief. I will record in a tabular form as required events at home and what my responses are. A - **Activating event –** children's defiant behavior.

B - Belief – I am worthless, I am finished

C – consequence - feeling bitter and showing depressive symptoms**.**

D – disputing irrational thoughts – What is the proof of my worthlessness? How can children's disobedience or wife's disrespect end my life.?

E – **effective new belief –** children will be better behaved as they grow and know better, wife may be seeing things from a different perspective, not disrespectful as presumed.

Every event that occur while away from therapeutic session, I will record with the attendant responses as stated above. If I can carefully follow the instructions, especially disputing the irrational thought and come up with an effective new belief for each event, I will diminish my depressive symptoms and keep a psychologically balance state of mind.

I will reserve questions for the therapist where I am in doubt about how to respond or record certain events. It is sometimes difficult to know how to put down the **belief** that inform the consequence that follow an action. Therapist will help out in such instances. Knowing the belief that is responsible for the consequence of an event will make filling information easier.

3**. If you were a clinical psychologist practicing cognitive therapy, which of Albert Ellis's ABCDE columns would you expect clients to have the most trouble filling in?**

Answer:

As a therapist, the column of the Albert Ellis's ABCDE model I expect clients to have the most trouble filling is the B – belief column. What belief inform the consequence an event will have on a client. The B- belief component of the Albert Ellis's model is often not taken notice of, as some will assume that events lead to consequence. Clients finding out bases for the consequence events have on them is somehow difficult. You see the event, you know the feelings you get in response to the event, but identifying the belief that informed the feelings is often challenging. For example, you failed an examination and you begin to feel depressed. Why? You might say, the reason is 'I failed an examination'. Failing an examination on its own should not bring about depressive mood if there were no beliefs in between the event and the consequence.

Some irrational beliefs like- 'I have failed and my age mates have left me behind', 'My life plan has been shattered'. 'I am left out, I'm finished'. All these thoughts are irrational and form the basis for the kind of consequence you get for failing in an examination. The consequence of failing the examination was obvious, but these faulty, illogical belief producing the consequence appear hidden and clients may not decipher with ease to fill the B column of the Ellis's ABCDE model.

Until the illogical belief that underlie the consequence afflicting clients is identified, they won't be able to 'dispute' it, let alone form an 'effective new belief' that is appropriate for the situation. Although it's challenging to figure out the belief that inform the kind of consequence

clients have, yet they need look inwards to find out why they feel the way they do. The reasons for the feelings they have are within and must be searched out to be able to progress the filling of other columns of the Albert Ellis's ABCDE model of cognitive psychotherapy.

Therapists can help out in at this point of difficulty by putting clients through the process of figuring out what wrong belief within them underlie the consequence they are currently facing. A few sessions with the therapist on how to think out irrational thoughts that inform negative consequences on clients will help in filling this difficult column of the Albert Ellis's ABCDE model of cognitive.

3. **In your opinion, do any of the common thought distortions that Aaron Beck and his followers defined seem to predispose individuals to particular types of psychological problems (e.g., anxiety, depression, others)?**

Answer:

In my opinion a common thought distortion like, **personalization** can predispose an individual to a psychological problem like depression. Always taking the blame when things go wrong by personalizing the event can bring about countless worries and upset the individual's psychological balance. Questions like 'why are things always going wrong in my hands?'. Another incident happens and he personalizes it again blaming himself for it. The individual is gathering negative thoughts over things that can lead to feeling, 'something is wrong with me', when he cannot find the answers depressive feelings begin to grow. Always asking himself questions for which he does not have the right answers will predispose him to having a psychological problem.

Catastrophizing is one common thought distortion that can also cause a psychological problem. A feeling for the worst when something goes wrong can create needless anxiety for the individual. The individual always thinking the worst-case scenario in every event is painting a big negative picture of things that may never happen in his head and start battling with them. Bringing imaginary negative thoughts into being is a good way to create anxiety. The 'catastrophe' one is thinking about does not exist but he is borrowing the trouble that accompany it. This is anxiety for sure. Repeatedly seeing the worst outcome when things happen even when they are not real is bad for a sane mind. Sooner or later psychological problems will develop.

Maximizing/minimizing is another common thought distortion that can cause a psychological problem. Amplifying negative events out of proportion has the capacity to create mental stress. Making negative things look bigger than they really are, is not for psychological balance of the mind. The bigger we make the problem in our mind, the greater the anxiety that follows and the greater the impact it will have on our mental health. Magnifying problems will always drop our mood and take excitement away from us. When our low moments become the norm because we always magnify little negative events, then we are headed for a psychological problem. Minimizing moments of excitements that should lift our mood will keep the low moments longer. Recognizing, appreciating and enjoying moments of joy can lift someone across the high/low divide and promote a sound mind. Good times need to be appreciated and celebrated not minimized and relegated. It will to keep one away from low moods that gender psychological troubles.

Mind reading is presuming to know that others are thinking critically of you. It is impossible to know what others are thinking, but as a common thought distortion, the assumption can continue to create suspicion and eventual withdrawal from people. Assuming that others are unfavorably disposed toward you, can lead to self-pity, self-protection and a bad feeling for others which will increase one's psychological burden and tendency towards self-isolation and eventual depression.

5. What are the primary differences between traditional cognitive therapy and the more recently developed metacognitive therapy?

Answer:

Traditional cognitive therapy deals with irrational thoughts that arise due to unfavorable external events and their outcome on our psychological well- being. An event happens and our belief produces an outcome (consequence). Traditional cognitive therapy teaches us to dispute the illogical(negative) beliefs that inform the consequence we suffer due to the event. It is expected that an effective new belief formed from disputing the earlier one will be more appropriate for our psychological well-being. A cognitive therapist will educate his client that it is illogical thoughts (belief) that produce the consequence not necessarily the activating external event itself.

Identifying these illogical beliefs, dispute them and come up with an effective new belief is what cognitive therapy is concerned about. The effective new belief is expected to be much less a mental burden as to result in a psychological problem. To this extend traditional cognitive therapy is said to be efficacious.

Metacognitive therapy looks at thought becoming the activating event that produces the irrational thinking we need to deal with instead of an external event. An irrational thought about oneself without an external activating event can become the event itself. Nothing significant may have happened but someone may see himself as 'a misfit', 'a never do well'. This perception of oneself can form the basis for more irrational thoughts that can progress into a psychological problem. Metacognitive therapy deals with the initial negative brooding thought as the activating event that kick start the process of illogical thinking.

In metacognitive therapy, not only negative thoughts have the potential to cause psychological problem, but seemingly positive ones with the possibility of creating mental stress for the individual. Nursing illogical thought that appear positive because it is helping to achieve a goal is equally as harmful psychologically. Metacognitive therapy deals with both positive and negative thinking having the potential to cause irrational thoughts that lead to psychological problem.

Chapter 16 GROUP AND FAMILY THERAPY

Introduction to topics in the chapter

Group therapy

Group and family therapy deal with multiple clients at the same time, although they are distinct from each other in operation. Group therapy looks at the way members of a group interact among themselves. The feelings they have one for another, their way of talking to one another and relate among themselves. From **Irvin Yalom** point of view, group therapy deals with issues arising from interpersonal relationships in a group. Difficulty in maintaining relations among members of a group can be responsible for an individual's psychological problem.

Therapeutic factors in Group therapy

Irvin Yalom identified a number of factors in group therapy that enhances the process. They are necessary for a good comprehension of how group therapy works.

Universality is the feeling one has that he is not alone in a particular problem when he is joined with others in a therapy. Be it a uniform or diverse psychological problem that is being handled, the fact that clients are kept together in a session raises the sense of commonness among them. It can be scary facing some kind of challenge alone, being in the company of others with your experience is to say the least encouraging. Knowing that others have similar challenge and you are all facing it, will automatically reduce anxiety associated with having the disorder.

Group cohesiveness is the sense of interrelatedness among clients in a group therapy. It involves confidence, approval and worth, members of a group in therapy attach to themselves. This is a group's ability to accommodate differences in the form vexation, disagreement and expression of divergent opinions. It is the group therapy version of therapeutic relationship in individual therapy. The therapist is not only concerned with developing relationship with a client, but also promote clients' relationship one with another.

Interpersonal learning can be said to mean the knowledge garnered from clients' association with one another and attempt to solve problems arising from their relationships. Clients learn from on another as they bond and relate among themselves. continuous interaction among a group of people, can unconsciously get them into conformity to a pattern of life for which they can be identified. 'Show me your friends and I will tell who you are' goes the saying, applies in this case. Clients copy from each other in the group.

Practical issues in Group therapy

Group membership. Members of a group in therapy can be from 5 – 10, although Brabender and Yalom advocate between 7 and 8 as best possible. Membership can be **open enrollment group or a closed enrollment group.** In open enrollment, members are free to join or leave therapy at any time, as against the closed one in which members start and finish hand in hand with no new person added. Bonding of clients and therapist is more achievable in the closed enrollment group.

Therapist holding meetings with individual members of a group before conducting group therapy helps to prepare their minds for the group session. A member's fear for loss of privacy and possible increase in his psychological symptoms are allayed by the therapist prior to the group meetings. Group therapy goes through stages where members initially show signs of hesitation, then competitiveness and cohesiveness.

Co-therapists attending to members in a group therapy have some advantages as well as disadvantages. It affords the opportunity for a 'second eye' seeing and hearing the interactions going on during group therapy. Therapists jointly attending to clients in a session can serve as a learning ground for clients to appreciate the art of collaboration between two persons. One disadvantage of therapists jointly handling clients in a group therapy is the possibility of competing with one another or encounter conflicts in adopting inharmonious therapy orientations.

Ethical issues in Group therapy

Confidentiality is one virtue at stake during group therapy**.** Therapists by training will keep clients' issues confidential, but other clients in the group may not keep the trust. This breach can cause colossal damage to the therapeutic process. The client whose privacy is violated will feel hurt and others in the group may refrain from speaking out on things they consider as private**.** Therapists will need to address issues of confidentiality during preparatory meetings for group therapy and keep participants in constant reminder of this caveat throughout the therapeutic process

Outcome issues

Results of group therapy have shown that it works almost as much as individual therapy, though research on group therapy has not been broad enough. There are a wide range of disorders that can be treated using group therapy. It is less expensive compared to individual therapy, taking clients one after the other.

FAMILY THERAPY

The system as the problem

Individual therapy had viewed psychological problem as a 'one way' cause and effect thing. Issues arising only from within an individual causing a disorder. Early developers of family therapy introduced the idea that psychological problem reciprocates between cause and effect, not just a cause leading to an effect, but vice versa. A family not functioning well the way they talk and interact among themselves, may experience symptoms of psychological problem in one member. A cause leading to an effect is called **linear causality**. A cause leading to an effect and effect leading to cause again is referred to as **circular causality**. An incongruent behavior that should pass for a psychological disorder in the Diagnostic and statistical manual of mental disorder (DSM) may serve the family for good. In the event of some psychological crisis like a defiance and conduct disorder in the family, its feed-back system creates a check on members and helps in bringing back peace and harmony.

Assessment of families

A therapist needs to know the way a family works, this will help him know how to handle issues within it. This can be referred to as assessment of the family. In course of assessment, therapist will know about present problems, what each individual family member believes and interactions among family members**.** Assessment will include how large the people that make up the family, how they are connected to one another, whether weak or strong. Drawing a family tree that cover at least three generations and also include the kind of relationship that exist among them is a great way of understanding how the family works. This is called **genogram**. The developmental stages of families are important parameters for family assessment. The outset of a young adult leaving home, uniting with a partner that is eventually integrated into the family, raising children with attendant duties, Teenage members of the family getting more independent and care for parents, young adults in the family starting their own lives with parents giving more attention to their declining health are stages an average family goes through. It is referred to as **family life cycle.** As part of family assessment, psychologist needs to know about the existence of abuse and violence if any, to what extent.? The conflict tactics scale (CTS) is designed to realize this objectively**.**

FAMILY THERAPY:

Essential concepts

Approach to family therapy can be broadly divided into three. Ahistorical, historical and experiential styles. 'Classic' concepts are historical styles that are used in present day therapy. 1. **Family structure**: which consist of rules that moderate behavior within the family. Such rules should not be too loose or tough for family members. 2. **Differentiation of self**: Murray Bowen advocates the need for each family member to have the liberty to develop personal capacity and become his distinct self. 3. **Triangles** occur when dissenting parties in a family pull in a third party, especially a child to take sides with either of them. This will always put the child in a fix and create mental stress.

Contemporary approaches

Solution-focused therapy is an off shoot of strategic family therapy which is solution-focused rather than problems focused. Clients are made to know that responsibility of improving the condition that brought them to therapy lies in their hands, so must take pragmatic steps focusing on solution. Constructive questions intended to handle present issues swiftly will be of great benefit to therapist. **Narrative therapy** is another contemporary family therapy approach in which clients' perception and talks about their lives have a lot to do with the way they handle new events. Therapist can help client edit his unhealthy perception of life and form a more appropriate and tolerable opinion of himself and his circumstances.

Ethical issues in family therapy

Cultural competence is vital for proper handling of clients in family therapy. Therapist need to be familiar with the cultural setting the family belongs as well as their religious persuasion. This is so important because the issues that brought them to therapy may be rooted in cultural

orientation or religious/ ethnic perception. Family members may be acquainted with prevailing cultural beliefs and practices in varying degrees. Therapist need to be aware of this.

Confidentiality in family therapy is necessary but difficult to handle, it is therefore important to set the rules for confidentiality from the beginning of the therapeutic process. Therapist and family members need to agree on how confidential issues will be handled during therapy. Every family member is expected to abide by the rule of confidentiality as agreed during and after therapy.

Diagnostic accuracy

It is difficult for family therapist to assign diagnosis for a family member that is out of order. Two things, he is either stigmatized the more or the initial supposition that the disorder was individual than systemic. Apart from this, the Diagnostic and statistical manual for mental disorders (DSM) does not provide for family diagnosis but individual.

Outcome issues

Results of family therapy are close to that of individual therapy except family members varying views of the process. Volume of efficacy studies in family therapy is small compared to individual therapy, but have been successful in managing psychological disorders like; schizophrenia, depression, adolescent delinquency.

Questions of exam

1. **In your opinion, which clinical problems seem best and least suited to group therapy?**

Answer

In my opinion group therapy seem best suited for **depression** because, it encourages interpersonal interaction among members of the group. A client suffering from depression in group therapy will have opportunity to hear other members talk about their experiences, answer questions, make friends and will be encouraged to socialize. In a bit to get along with others, he begins to overcome withdrawal from other people which is one of the symptoms of depression. Interaction with members of the group will enlighten him and help to relief him of the illogical thoughts on his mind. Therapist will find it easier handling a depressed client in group therapy due to the effect of friendship and collaboration among members of the group. The ability to speak in the hearing of other members of the group is motivating for the client with depressive symptoms.

Posttraumatic stress disorder (PTSD) is one of the psychological cases group therapy is suited for. Different members of the group have their experiences to tell during therapy and how they are coping with the 'after effect' especially in a homogenous group. Therapist attending to the case of one client will imperceptibly be a lesson for another client listening from the background. Client suffering from posttraumatic stress disorder (PTSD) will benefit from questions asked by other clients in the group as well as the answers provided by therapist.

Clients with **Temper tantrum** will progress well together in group therapy by interacting one with another telling experiences and learning from therapist. Hearing what triggers others and get them inflamed with anger and contrast with your own experiences are great ways of improving one's disorder. Hearing the consequences of bad temper on the life of other members of the group can help create checks on another client's attitude towards anger.

Eating disorder is one clinical problem that is best suited for group therapy. Clients in group therapy will be able to see how members of the group that comply with therapist's instructions fair when they come for therapy. They bond and exchange ideas on how to cope with lifestyle change outside of therapy sessions. Learning from one another in a group therapy of this kind will promote recovery from identified disorder. It is encouraging to associate with someone in your 'situation' adopt and sustain a discipline you have been struggling with.

In my opinion, psychological disorder like **schizophrenia** will least be suited for group therapy because, clients are not in a right frame of mind to take lessons from one another in a therapy group or from the therapist. It will even be challenging getting them together especially cases that have escalated and clients have gone violent. They will scarcely listen to one another or participate meaningfully in a group therapy.

2. In your opinion, which of Yalom's therapeutic factors for group psychotherapy seem most vital to its success? Why?

Answer

Yalom's therapeutic factors that seem most vital in my opinion are: universality, imitative behavior, Group cohesiveness, interpersonal learning and development of socializing techniques. **Universality** is the feeling of 'I'm not alone in this' a client gets when he is together with other members in a group therapy, especially when he knows they all have similar disorder. He is comforted in the company of his 'fellows' that they are facing a common problem and gives him some level of relief before the therapeutic process begins. Sense of togetherness heals.

Imitative behavior. Learning by imitation they say is the easiest way to learn. Imitating someone good can be adopted by a client to improve his own condition. A client might find some helpful qualities in other members of the group and imitate them. He observes what others are doing well, study how they do it and copy them. Clients in group therapy for eating disorder can practice healthy eating outside of therapy and go to gym together which is more supportive and encourage collaboration.

Group cohesiveness

Ability to bond together and have a sense of oneness creates confidence among members in a therapy group. This state of mind promotes mental health. A sense of belonging among them will produce security. This will enable members to share feelings freely and relief the mind of issues that would have been 'bottled' up in the mind. Group cohesiveness will help to lift and carry along a member of the group that has not been responding to therapy. Creating one mind among themselves, members are able to see things in proper perspective and get non-responsive ones to come along.

Interpersonal learning

Making friends promotes interpersonal learning. In a therapy group, friendship among members is enhanced by regular therapy meetings and interactions. This interpersonal-get-together causes one to learn from each other. Peer to peer learning is a powerful way to transmit knowledge. A client might get clear explanation of what therapist was saying during interpersonal interactions. Understudying a friend in the group doing it right by submitting homework and complying with therapist instructions encourages another member to do same. Interpersonal learning among members of a therapy group will therefore promote wellness among them.

Development of socializing technique

Some people are naturally introverts and hardly come out of themselves to socialize. In group therapy such persons are put to the task of stretching out of themselves to reach others in their regular therapy sessions. The introverted member of the group begins to learn ways of interacting with people to profit from the therapy. He might find others like himself beginning to socialize and get along with the rest members of the group and will be motivated to grow his own way of reaching out to others and become more involved with the group**.**

3. If you were a clinical psychologist, would you prefer to conduct group therapy alone or with a co-therapist? What factors might influence your decision?

Answer:

As a clinical therapist I would prefer conducting group therapy alone. Factors that will influence my decision includes**; Lack of trust between me and the other therapist**. During therapy, the other therapist may be seeing and hearing clients from a different perspective from mine and might ask questions and interact based on how he perceived the client's position on the matter which may be different from mine. We may find time outside therapy session to reconcile our positions, but it may have impacted on therapy and time spent. Struggling back and forth with this, can affect therapeutic process and eventually the outcome. I will prefer to go it alone and run my personal perspective through-out the period of therapy.

A co-therapist may be more assuming in his approach than I do, creating an 'I know it better' scenario when interacting with clients. Although I also know same, he may be presenting issues earlier than I would like to have them presented and this can create a kind of conflict not only of ideas but, how and when they should be presented to clients. My speed and style of questioning and interacting with clients in the group may not be tolerable to my colleague who may wish otherwise, thereby creating dissatisfaction and disaffection between us. It will therefore be safe to run solo and get clients used to my personal style and speed.

If my co-therapist is a female in an all-male group therapy session, some of the clients with complexes may not freely and unfetteredly participate in therapy. The presence of a female co-therapist may inhibit them from speaking out on certain issues, for fear of been branded indecent by other members of the group. It will be better to handle an all-male group therapy being a man alone. I suppose same might be the case, if in an all-female group therapy handled by a female psychologist a male co-therapist is added. There are things those women may not be able to say in the presence and hearing of the male co-therapist.

In a group therapy jointly handled by two therapists, feeling for clients may differ. Where one therapist wishes to be more-strict with a particular client for results, the other may not feel it necessary to do so and might be too lenient in the other therapist's estimation. The client in question will eventually tilt attention and loyalty towards the more tolerant therapist. This conflict will not be there if I am handling the group alone.

4. To what extent do you agree with the fundamental assumption of family therapy that the system, rather than the individual is pathological?

Answer:

Most psychological problems come as a result of pathological interactions, especially among family members. This assumption among family therapists to a very large extent is true. Unhealthy interactions among people can create a condition for psychological problem. In a family where parents are not always in agreement and quarrels ensue now and then, tension among family members over time can create such condition for mental disorder. One member of the family may show symptoms of psychological disorder, while the family itself is pathological due to its dysfunctional nature. Other members may not show symptoms, but all is not well with them psychologically**.**

Though one may be genetically predisposed to a psychological disorder, pathological interactions within a family could trigger the symptoms to manifest. A healthy family relationship and communication can inhibit certain disorder from manifesting its symptoms in someone in the family for as long as is possible. At the same time, an unhealthy interaction within the family can cause symptoms of psychological disorder to manifest in the family with one or more persons. Therefore, it is necessary to note that what goes on within members of family play a key role in creating psychopathology among them.

In an instance where a member of the family is identified as a patient of psychological disorder, unhealthy interactions within the family can sustain the symptoms. The identified patient may be undergoing therapy, but each time he returns home to the dysfunctional family, he is triggered again and the symptoms continue to manifest because interactions in the family is 'feeding' the disorder. Therapy will scarcely work effectively because of this family condition. Therapist may be wondering why client's response is not sustained. The fault is in the home where the client returns to after therapy.

Fix unhealthy interactions in the family and psychopathological tendencies observed in an identified patient or family member decline over time. This is an indication that systemic pathology within the family informed the symptoms in the identified patient. Family therapist will therefore concern himself with correcting the dysfunctional way family members interact.

5. To what extent might the contemporary approaches to family therapy (e.g., solution-focused therapy, narrative therapy) also be applicable to individual clients?

Solution-focused therapy suited for family therapy can be adopted for individual clients by concentrating on the solution to the problem and not the problem itself. The therapist should use solution- talks rather than talking problems with the client. Something has gone wrong, that is true but how can it be corrected.? Problem-talk is like emphasizing what has gone wrong and engage in a kind of blame trading. Solution-focused therapy as an offshoot of **strategic family therapy** helps an individual client fix a disorder quicker than when focus is on trying to analyze what caused the disorder.

Therapists adopting solution-focused therapy approach in family therapy, teach that clients have the ability to help themselves out of the disorder they are being afflicted with. Same technique can be applied in individual client therapy by encouraging them to take responsibility for their recovery. Individual client has much to do to facilitate his recovery and should dwell on that. Co-operating with therapist, carrying out assignments and following therapist instruction after therapy sessions are roles client must play. This is what therapist will emphasize during therapy. Solution-focused approach will make the client concentrate on how to come out of disorder than focusing on how he got into the problem. This approach quickens the process of recovery. Client knowing that his recovery largely depend on himself, will be more determined to play his part in the therapeutic process than looking up to therapist as though his recovery is the responsibility of the therapist.

Solution-focused therapy approach used for family therapy can also be useful in individual therapy when therapist persuade client to believe that problems will not always be there. They are here today, tomorrow they are gone. This philosophy demystifies whatever the problem is, placing an expiring date on it. Accepting that a problem will not always be there will 'explains away the burden of the issue at stake'.

Narrative therapy approach which is ideally family therapy based can also be adopted for individual clients. Therapist help client to revise the perception he has about himself, which ultimately alters the way he interprets other events in his life. What client says about himself, can

contribute to his psychological disorder. Therapist using the narrative therapy approach causes him to review this story of his life and become more objective in his view of events and estimation of himself.