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EGC 812

Behaviour Modification

Module 3

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Module 3

Unit 1 Behaviour Therapy

1.0 Introduction

In the last unit, you studied reasons for therapy; who provides psycho-therapeutic services; measurement of success in psychotherapy therapeutic approaches, and biological approaches. In this unit, a detailed treatment will be given to behaviour therapy as a means of changing clients' maladaptive behaviours. It is important for you to remain attentive as you learn now.

2.0 Objectives

At the end of this unit, you should be able to:

- discuss the concept of behaviour therapy
- explain behaviour modification
- analyse operant conditioning
- list and explain the processes involved in token economy.

3.0 Main Content

3.1 Behaviour Therapy

Behaviour therapy refers to techniques based (primarily) on classical conditioning, developed by psychologists such as Eysenck and Wolpe. Wolpe (1958) defined behaviour therapy as 'the use of experimentally established principles of learning for the purpose of changing unadaptive behaviour'. To explain behaviour therapy properly, you will learn about (i) systematic desensitisation (ii) implosion (implosive therapy) and flooding (iii) aversive therapy.

Systematic desensitization

The case little Peter represents the earliest example of any kind of behavioural treatment. Peter was a two – year-old living in a charitable institution. Jones was mainly interested in those children who cried and trembled when shown an animal (such as a frog, rat or rabbit). Peter showed an extreme fear of rats, rabbits, feathers, cotton wool, fur coats, frogs and fish, although in other respects he was regarded as well adjusted. It was not known how these phobias had arisen.

Jones, supervised by Watson, put a rabbit in a wire cage in front of Peter while he ate his lunch. After 40 such sessions, Peter ate his lunch with one hand and strokes the rabbit (now on his lap) with the other. In a series of 17 steps, the rabbit (still in the cage) had been brought a little closer each day, then let free in the room, eventually sitting on Peter's lunch tray (Jones, 1924). The methods used to remove his phobia of animals were later called systematic desensitisation (SD) by Wolpe (1958). It represents a form of counter-conditioning, and the key principle in SD is that of reciprocal inhibition. According to Wolpe (1969), "if a response inhibitory of anxiety can be made to occur in the presence of anxiety – evoking stimuli it will weaken the bond between these stimuli and the anxiety" (Wolpe,

1969). In other words, it is impossible for someone to experience two opposite emotions (e.g. anxiety and relaxation) at the same time. Accordingly, a patient or client with a phobia is first taught to relax through deep muscle relaxation. So, relaxation and fear of the object or situation 'cancel each other out' (this is the desensitisation part of the procedure).

The systematic part of the procedure involves a graded series of contacts with the phobic object (usually by imagining it), based on a hierarchy of possible forms of contact, from the least of the most frightening. Starting with the least frightening, the client, while relaxing, imagines the object (e.g. the forthcoming examination) until this can be managed without feeling of any anxiety at all. Then, and only then, the next most feared contact will be dealt with, in the same way, until the most frightening contact can be imagined with no anxiety (the examination date and sitting down with question paper and answer booklet on the desk).

Implosion (implosive therapy) and flooding

Implosion is essentially about exposing the client to what, in systematic desensitisation, would be at the top of the hierarchy. Instead of gradual exposure accompanied by relaxation, the client is thrown in at the deep end' right from the start. This is done by getting the client to imagine terrifying form of contact. How can we make this process to work?

The client's anxiety is maintained at such a high level that eventually some process of exhaustion or stimulus satiation takes place – the anxiety level can only go down. Extinction occurs by preventing the client from making the usual escape or avoidance response. Implosion (and flooding), therefore, represents a form of 'forced reality testing' (Yates, 1970).

Flooding is exposure that takes place in vivo. This means confronting real-life situations.

Aversion therapy

In aversion therapy, some undesirable response to a particular stimulus is removed by associating the stimulus with another, aversive stimulus. For example, alcohol is paired with an emetic drug (which induces severe nausea and vomiting), so that nausea and vomiting become a conditioned response to alcohol.

Clients would, typically, be given warm saline solution containing the emetic drug. Immediately before the vomiting begins, they are given some glass of whisky, which they are required to smell, taste and swill around in the mouth before swallowing. If vomiting has not occurred, another glass of whisky is given and, to prolong nausea, a glass of beer containing emetic. Subsequent treatments involve larger doses of injected emetic, or increases in the length of treatment time. Between trials, the client may sip soft drinks to prevent generalisation to all drinking behaviour and to promote the use of alcohol substitutes. Meyer and Chesser (1970) found that about half their alcoholic clients abstained for at least one year following treatment, and that aversion therapy is better than no treatment at all. The next focus is on behaviour modification in behaviour therapy.

3.2 Behaviour Modification

Behaviour modification refers to techniques based on operant conditioning, developed by psychologists such as Ayllon and Azrin, to build up appropriate behaviour (where it did not

previously exist) or to increase the frequency of certain responses and decrease the frequency of others.

According to Baddeley (1990), most behaviour programmes follow a broadly similar pattern involving a series of steps:

Step 1 Specify the behaviour to be changed. It is important to choose small, measurable, achievable goals

Step 2 The goal should be stated as specifically as possible

Step 3 A baseline rate should be measured over a period of several days, that is, how the person 'normally' behaves with respect to the selected behaviour. This may involve detailed observation, which can suggest hypotheses as to what is maintaining that behaviour.

Step 4 Decide on a strategy. For example, selectively reinforce non-yelling behaviour (through attention) and ensure that yelling behaviour is ignored.

Step 5 Plan treatment. It is essential that everyone coming into contact with the patient behaves in accordance with the chosen strategy.

Step 6 Begin treatment

Step 7 Monitor progress

Step 8 Change the programme if necessary (Baddeley, 1990 as cited in Gross, 2011). These steps presented are very important in behaviour modification and it is therefore suggested that we should pay attention to them. The next section deals with operant conditioning.

3.3 Operant Conditioning

In operant conditioning, behaviours will be learnt most quickly if they are paired with the reward or punishment every time the behaviour is emitted. This consistent response is called a continuous reinforcement schedule. Behaviours can be learnt and maintained, however, on a partial reinforcement schedule, in which reward or punishment occurs only sometimes in response to the behaviour. Extinction – eliminating a learnt behaviour – is more difficult when the learnt behaviour was through a continuous reinforcement schedule. This is because the organism will continue to emit the behaviour learnt through a partial reinforcement schedule in the absence of the reward, anticipating that the reward will eventually come. A good example is gambling behaviour. People who frequently gamble are seldom rewarded, but they continue to gamble in anticipation of that occasional, unpredictable win (Nolen-Hoeksema, 2004).

3.4 The Token Economy

The token economy (TE) is based on the principle of secondary reinforcement. Token (secondary or conditioned reinforcers) are given for socially desirable/acceptable behaviours as they occur, and can then be exchanged ('chased in') later on for certain 'primary' reinforcers.

The TE was introduced by Ayllon and Azrin (1968), who set aside an entire ward of a psychiatric hospital for a series of experiments in which reinforcements were provided for

activities such as face-washing, teeth-brushing, dressing properly and making beds, and withheld for withdrawn or bizarre behaviour. The participants were 44 female chronic schizophrenic patients, with an average 16 years of hospitalisation. Some screamed for long periods, some were mute, many were incontinent, and a few were assaultive. Most no longer ate with cutlery, and some buried their faces in the food.

A baseline measure was made of how often socially desirable behaviours normally occurred. They were then systematically reinforced every time the desired behaviours occurred with plastic tokens that could later be exchanged for special privileges (e.g. listening to records, going to the cinema, renting a private room, extra visits to the canteen). The entire life of each patient was, as far as possible, controlled by this regime. Results showed that the patients significantly increased the frequency of the desired behaviours when they were reinforced (Gross, 2010).

If the introduction of chlorpromazine and other antipsychotic drugs in the 1950s marked a revolution in psychiatry, the introduction of TE programmes, during the 1960s was, in its way, equally revolutionary (Gross, 2010).

4.0 Conclusion

In this unit, you studied behaviour therapy which is based on classical conditioning and operant conditioning respectively. Both see adaptive and maladaptive behaviour as being acquired in the same way, and both rejected the medical model.

5.0 Summary

In this unit, behaviour therapy and modification were discussed. You also learnt systematic desensitisation developed by Wolpe. He emphasised the exposure of clients to the active ingredients that seems to be the feared object/situation. Furthermore, implosion, flooding, aversive therapy, operant conditioning and token economy were studied.

6.0 Self-Assessment Exercise

1. Explain the processes in systematic desensitisation.
2. List and explain the processes in behaviour modification.
3. Differentiate between operant conditioning and token economy.

7.0 References/Further Reading

Ayllon, T. & Azrin, N. H. (1968). *The Token Economy: A Motivational System for Therapy and Rehabilitation.* New York: Appleton-Century Crofts.

Baddeley, A. D. (1990). *Human Memory.* Hove: Lawrence Erlbaum Associates.

Gross, R. (2010). *Psychology.* (5th ed.). UK: Hodder Education.

Jones, M. C. (1924). "The Elimination of Children's Fears." *Journal of Experimental Psychology,* 7. pp. 382 – 390.

Meyer, V. & Chesser, E. S. (1970). *Behaviour Therapy in Clinical Psychiatry.* Penguin: Harmondsworh.

Unit 2 Cognitive and Cognitive – Behavioural Therapy

1.0 Introduction

In the last unit, you focused on behaviour therapy where you studied behaviour modification, where techniques like systematic desensitisation, implosion, aversion therapies are used. You also learnt about the steps in behaviour modification, and the issues of operant conditioning and token economy were discussed respectively.

In this unit, you will learn about the concept of cognitive and cognitive – behavioural therapy. The rational emotive behaviour therapy of Albert Ellis and Beck's cognitive therapies will be treated in a way that you will be satisfied, and an evaluation of cognitive – behavioural therapies concludes this unit. So be attentive and remain focused to learn now.

2.0 Objectives

At the end of this unit, you should be able to:

- explain cognitive and cognitive - behaviour therapy
- discuss the processes in rational emotive therapy
- examine Beck's cognitive therapies.

3.0 Main Content

3.1 Cognitive and Cognitive - Behavioural Therapy

Early behaviour therapists focused on observable behaviour and regarded the inner thoughts of the clients as unimportant. Because of this, these therapists were often viewed as mechanistic technicians who simply manipulated their clients without considering them as people (Carson et al., 2011). Starting in the 1970s, a number of behaviour therapists began to reappraise the importance of "private events" – thoughts, perceptions, evaluations, and self-statements and started to see them as processes that mediate the effects of objective stimulus conditions and thus help determine behaviour and emotions (Borkovec, 1985; Mahoney & Arnkoff, 1978 as cited in Carson et al., 2011).

Cognitive and cognitive – behavioural therapy (terms used interchangeably) stem from both cognitive psychology (with its emphasis on the effects of thoughts on behaviour) and behaviourism (with its rigorous methodology and performance – oriented focus). At the present time, no single set of techniques defines cognitively oriented treatment approaches. Two main themes are important, however (i) the conviction that cognitive processes influence emotion, motivation, and behaviour, and (ii) the use of cognitive and behaviour change techniques in a pragmatic (hypothesis testing) manner. The next section of this unit will focus on rational emotive behaviour therapy of Albert Ellis and then focus more in detail on cognitive therapy approach of Aaron Beck.

3.2 Rational Emotive Behaviour Therapy

One of the earliest developed of the behaviourally oriented cognitive therapies is the rational emotive therapy (now called rational emotive behaviour therapy – REBT) of Albert Ellis. REBT attempts to change a client maladaptive thought processes, on which maladaptive emotional responses, and thus behaviour, a presumed to depend. Ellis posited that a well-

functioning individual behaves rationally and time with empirical reality. Unfortunately, however, many of us have learnt unrealistic beliefs and perfectionist values that cause us to expect too much of ourselves, leading us to behave irrationally and then to feel that we are worthless failures. For example, a person may continually think, "I should be able to win everyone's love and approval" or "I should be thoroughly adequate and competent in everything I do". Such unrealistic assumptions and self-demands inevitably spell problems (Carson *et al*., 2011).

The task of REBT is to restructure an individual's belief system and self-evaluation, especially with respect to the irrational "should", "ought", and "must" that are preventing the individual from having a more positive sense of self-worth and an emotionally satisfying, fulfilling life. Ellis (1962, 1996) says that we usually talk to ourselves when we experience stress; too often the statements are irrational, making them more harmful than helpful. Ellis abbreviated the therapy process into the letters A, B, C, D, E. Now, look at the steps below.

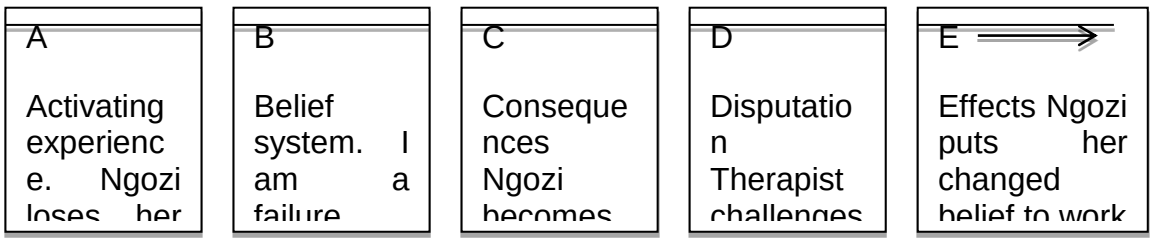

Fig. 1:1 A – E Steps in Ellis Rational – Emotive Behaviour Therapy (Adapted from Santrock, 2000).

Therapy usually starts at C, the individual's upsetting emotional consequences; this might involve depression, anxiety or a feeling of worthlessness. The individual often says that C was caused by A, the activating experience, such as the case of Ngozi that lost her job. The therapist works with the individual to show that an intervening factor B, the individual's Belief system, is usually responsible for why he moved from A to C. Then the therapist goes on to D, which stands for disputation; at this point, the individual's irrational beliefs are disputed or contested by the therapist.

Finally, E is reached, which stands for effects or outcomes of the rational – emotive behaviour therapy, as when individuals put their changed beliefs to work. This disputation stage is very important. It helps to dispute a person's false beliefs through rational confrontation. One must not think that he was not promoted in his work place and because of that he feels that he is worthless.

Concluding, rational emotive behaviour therapy aims at increasing an individual's feeling of self-worth and clearing the way for self-actualisation by removing the false beliefs that have been stumbling blocks to personal growth. The philosophy underlying REBT has something in common with that underlying humanistic therapy which you will learn in unit 3 of this module, because both take a clear stand on personal worth and human values.

3.3 Beck's cognitive therapies

Beck's cognitive therapy approach was originally developed for the treatment of depression and was later extended to anxiety disorders, eating disorders and obesity, conduct disorder in children, personality disorders, and substance abuse. Beck (1993) defines cognitive – behavioural therapy (CBT) as:

The application of the cognitive model of a particular disorder with the use of a variety of techniques designed to modify the dysfunctional beliefs and family information processing characteristics of each disorder.

The cognitive model is basically an information processing model of psychotherapy. A basic assumption of the cognitive model is that problems result from biased processing of external events or internal stimuli. These biases distort the way that a person makes sense of the experiences that he or she has in the world, leading to cognitive errors. Let us now learn about certain cognitive biases that cause people to misperceive reality.

The main cognitive biases in Beck's theory are (i) arbitrary inference, (ii) selective abstraction, (iii) overgeneralisation, and (iv) magnification and minimisation. Let us take them one by one for explanation.

1. Arbitrary inference: a conclusion drawn in the absence of sufficient evidence – or any evidence at all. For example, a man concludes that he is worthless because it is raining the day he is hosting a club meeting.

2. Selective abstraction: a conclusion drawn on the basis of just one of many elements in a situation. For example, a worker feels worthless when a product do not sell well in the market, even though she is not the only one that contributed to its production.

3. Overgeneralisation: an overall sweeping conclusion drawn on the basis of a single, perhaps trivial, event. For example, a student regards his poor performance in a single class on one particular day as final proof of his worthlessness and stupidity

4. Magnification and minimisation: exaggeration in evaluating performance. For example, a man believes he has completely ruined his car (magnification) when he sees a small scratch on the rear bumper. A woman believes herself to be worthless (minimisation) despite a succession of praiseworthy achievement (David & Neale as cited in Gross, 2010).

Beck's therapeutic processes

In the initial phase of cognitive therapy, clients are made aware of the connection between their patterns of thinking and their emotional responses. They are first taught simply to identify their own automatic thoughts (such as, "This event is a total disaster") and to keep records of their thought content and their emotional reactions. With the therapist's help, they then identify the logical errors in their thinking and learn to challenge the validity of these automatic thoughts. The errors in the logic behind their thinking lead then (i) to perceive the world selectively as harmful while ignoring evidence to the contrary; (ii) to over generalise (iii) to magnify and (iv) to engage in absolutistic thinking – for example critical comment and perceiving it as proof of their instance descent from goodness to worthlessness (Carson et al., 2011).

Beck's and Ellis' cognitive therapies have some similarities. However, there are also some differences between them. Rational emotive behaviour therapy is very directive, persuasive, and confrontational. It also focuses on the therapist's teaching role. In contrast, Beck's cognitive therapy involves more of an open-ended dialogue between the therapist and the individual. The aim of the dialogue in Beck's approach is to get the individuals to reflect on personal issues and discover their own misconceptions. Beck also encourages individuals to

gather information about them and to try out unbiased experiments that reveal the inaccuracies of their beliefs.

4.0 Conclusion

In this unit, you learnt that cognitive therapies emphasised that the individual's cognitions or thoughts are the main source of abnormal behaviour. Cognitive therapies attempt to change the person's feelings and behaviours by changing cognitions.

5.0 Summary

In this unit, you learnt that Ellis' approach is based on the assertion that individuals become psychologically disordered because of their beliefs, especially those that are irrational and self-defeating. You also learnt that Beck's cognitive therapy was meant for depression which involves getting people to make connections between their patterns of behaviour and emotional responses. With the therapists' assistance, they learn about logical errors in their thinking, then how to challenge these mistakes in thinking.

6.0 Self-Assessment Exercise

In what ways are REBT and cognitive therapy similar? In what ways are they different?

7.0 References/Further Reading

Beck, A. T. (1993). "Cognitive Therapy: Past, Present and Future." *Journal of Consulting & Clinical Psychology,* 61 (2), pp. 194 – 198.

Carson, R. C. *et al.* (2011). *Abnormal Psychology.* (13th ed.). New York: Pearson Education Inc.

Gross, R. (2010). *Psychology.* (6th ed.). UK: Hodder Education.

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Unit 3 Humanistic – Experiential Therapies

1.0 Introduction

In the last unit, you learnt about cognitive and cognitive behavioural therapies. You learnt Albert Ellis-REBT and Beck's cognitive-therapies. You also identified the similarities and differences in both therapies.

In this unit, you will learn about the humanistic-experiential theory. A prominent psychologist – Carl Rogers will be the major focus in client-centered therapy. Furthermore, you will learn about Gestalt therapy and process-experiential therapy. Stay focused.

2.0 Objectives

At the end of this unit, you should be able to:

- discuss the essential elements in humanistic therapy
- explain the central issues in client-centered therapy
- analyse the role of Gestalt therapy in the treatment of maladaptive behaviour
- examine the process-experiential therapy.

3.0 Main Content

3.1 Humanistic - Experiential Therapies

Humanistic-experiential therapies emerged as significant treatment approaches after World War II. In a society dominated by self-interest, mechanisation, computerisation, mass deception, and mindless bureaucracy, proponents of the humanistic – experiential therapies see psychopathology as stemming in many cases from problems of alienation, depersonalisation, loneliness, and a failure to find meaning and genuine fulfillment (Carson *et al.*, 2011). Problems of this sort, it is held, are not likely to be solved either by delving into forgotten memories or by correcting specific maladaptive behaviours.

The humanistic-experiential therapies are based on the assumption that we have both the freedom and the responsibility to control our own behaviour – 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 mainly as counselor, guide, and facilitator. Although humanistic – experiential therapies differ in their details; their central focus is always expanding or clients "awareness". According to Santrock (2000), the humanistic perspective stresses the person's capacity for personal growth, freedom to choose one's own destiny; and positive qualities. Humanistic psychologists believe each of us has the ability to cope with stress, control our lives, and achieve what we desire. Each of us has the ability to break through and understand ourselves and our world; we can burst the cocoon and become a butterfly, say the humanists. You can see how important we are in determining our destiny. The next focus is on client-centered therapy.

3.2 Client Centered-Therapy

The client-centered (person-centered) therapy of Carl Rogers (1902 – 1987) focused on the natural power of the organism to heal itself (Rogers, 1951, 1961). Rogers saw therapy as a process of removing the constraints and restrictions that grow out of unrealistic demands that people tend to place on themselves when they believe, as a condition of self-worth, that they should not have certain kinds of feelings such as hostility. By denying that they do in fact have such feelings, they become unaware of their actual "gut" reactions (natural feelings). As they lose touch with their own genuine experience, the result is lowered integration, impaired personal relationships and various forms of maladjustment.

The primary objective of Rogerian therapy is to resolve this incongruence – to help client become able to accept and be themselves. To this end, client-centered therapists establish a psychological climate in which clients can feel unconditionally accepted, understood, and valued as people. Within this context, the therapist employs non-directive techniques such as empathic reflecting, or restatement of the client's descriptions of life difficulties. If all goes well, clients begin to 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.

Roger's therapy was initially called client-centered therapy, but he rechristened it person-centered therapy to underscore his deep belief that every person has the ability to grow. The relationship between the therapist and the person is an important aspect of Rogers' therapy. The therapist must enter into an intensely personal relationship with the client, not as a physician diagnosing a disease, but as one human being to another. Rogers believed each of us grows up in a world filled with conditions of worth, the positive regard we received from others that has strings attached. We usually do not receive love and praise unless we conform to the standards and demands of others. This causes us to be unhappy and have low self-esteem. Rarely do we feel that we measure up to such standards or that we are as good as others expect us to be.

To free the person from worry about the society's demands, the therapist engages in unconditional positive regard in which the therapist creates a warm and caring environment, never disapproving of the client. Rogers believed this unconditional positive regard improves the person's self-esteem. The therapist's role is "nondirective". The therapist is there to listen sympathetically to the client's problems and to encourage positive self-regard, independent self-appraisal and decision making. Though person-centered therapist gives approval to the person, they do not always approve of the person's behaviour.

In addition to unconditional positive regard, Rogers also advocated the use of these techniques in person-centered therapy:

1. Genuineness, which involves letting a client know the therapist's feelings and not hiding being a façade.
2. Accurate empathy, which focuses on the therapist's identification with the client. Rogers believed that therapists must sense what it is like to be the client at any moment in the client-therapist relationship.
3. Active listening, which consist of giving total attention to what the person says and means. One way therapists improve active listening is to restate and support what the client has said and done (Santrock, 2000). The next focus is on Gestalt therapy.

3.3 Gestalt Therapy

In German, the term gestalt means "whole" and gestalt therapy emphasises the unit of mind and body-placing strong emphasis on the need to integrate thought, feeling and action. Gestalt therapy was developed by Frederick (Fritz) Perls (1969) as a means of teaching clients to recognise the bodily processes and emotions they had been blocking off from awareness.

Perls was trained in Europe as a Freudian psychoanalyst, but as his career developed, his ideas became different from Freud's. Perls (1969) agreed with Freud that psychological problems originate in unresolved past conflicts and that these conflicts need to be acknowledged and worked through. Also like Freud, Perls stressed that interpretation of dreams is an important aspect of therapy.

But in other ways, Perls and Freud were miles apart. Perls believe that unresolved conflicts should be brought to bear on the here and now of the individual's life. The therapist pushes clients into deciding whether they will continue to allow the past to control their future or whether they will choose right now what they want to be in the future. To this end, Perls confronted individuals and encouraged them to actively control their lives and be open about their feelings.

Gestalt therapists use a number of techniques to encourage individuals to be open about their feelings, to develop self-awareness, and to actively control their lives. The therapist sets examples, encourages between verbal and nonverbal behaviour, and uses role playing. To demonstrate an important point to a client, the Gestalt therapist might exaggerate a client's characteristic. To stimulate change, the therapist often will openly confront the client.

Another technique used in Gestalt therapy is role playing, either by the client, the therapist, or both. For example, if an individual is bothered wither by conflict with her mother, the therapist might play the role of the mother and reopen the quarrel. The therapist might encourage the individual to act out her hostile feelings toward her mother by yelling, swearing, or kicking the couch, for example. In this way, Gestalt therapists hope to help individuals better managed their feelings instead of letting their feelings control them.

As you can see, the Gestalt therapist is much more directive than the non directive, person-centered therapist. By being more directives, the Gestalt therapist provides more interpretation and feedback. Nonetheless, both of these humanistic therapies encourage individuals to take responsibility for their feelings and actions, to truly be themselves, to understand themselves, to develop a sense of freedom, and to look at what they are doing with their lives. This is purely taking responsibility on how you want your life to be as a human being. You will now learn about the last therapy under humanists which is called process-experiential therapy.

3.4 Process–Experiential Therapy

Process-experiential (PE) therapy is a relatively new treatment approach that combines client-centered therapy and gestalt therapy. Developed by Greenberg and his colleagues (Greenberg, 2004 as cited in Carson et al., 2011), this treatment emphasises the experiencing of emotions during therapy. Clients are also asked to reflect on their emotions and encouraged to create meaning from them. The therapist plays a more active role than in pure client centered therapy and may work to guide the client to experience emotions

more vividly through a variety of different techniques. Like other humanistic-experiential therapies, the relationship with the therapist is regarded as extremely important and the vehicle through which progress in treatment is made. The major impact of this therapy and other humanistic therapies is that they have effects on our human nature and they are viewed as good psychotherapeutic processes.

4.0 Conclusion

Many of the humanistic-experiential concepts used in this unit, such as the uniqueness of each individual, the importance of therapist genuineness and not hiding behind a façade, the satisfaction that comes from realising one's potential, the importance of the search for meaning and fulfillment, and the human capacity for choice and self-direction show that this approach is a good psychotherapy.

5.0 Summary

In this unit, you studied about humanistic-experiential therapies. The humanistic – experiential therapies are based on the assumption that we have both the freedom and capacity to control our behaviour. You also learnt about person-centered therapy of Carl Rogers that emphasised that therapists should show genuineness, empathy and accurate listening. Moreover, you learnt about gestalt therapy of Fritz Perls and the process-experiential therapy of Greenberg that is regarded as a very new approach in the humanistic perspectives.

6.0 Self-Assessment Exercise

1. Explain the techniques used in Rogerian therapy.
2. What are the differences between the gestalt therapy and the Carl Rogers' therapy?
3. Explain the techniques used in gestalt therapy.

7.0 References/Further Reading

Carson, *et al.* (2011). *Abnormal Psychology*. (13th ed.). New York: Pearson Education Inc.

Rogers, C. R. (1951). *Client-Centered Therapy - Its Current Practices, Implications and Theory.* Boston: Houghton Mifflin.

Rogers, C. R. (1961). *On Becoming a Person: A Therapist's View of Psychotherapy*. Boston: Houghton Mifflin p. 663.

Unit 4 Psychodynamic Therapies

1.0 Introduction

In the last unit, you learnt humanistic-experiential therapies. Rogerian therapy that uses the technique of genuineness, empathy and accurate listening was discussed. Frederisk (Fritz) Perls Gestalt therapy was clearly explained and the process-experiential therapy of Greenberg that combined the person-centered and Gestalt therapy was studied.

In this unit, Freudian psychodynamic therapy will be examined with emphasis on his monumental psychoanalytic method of treatment. The other form of psychodynamic therapy known as interpersonal therapy by Harrystack Sullivan will be treated. You need to pay good attention to have good comprehension of this interesting discourse.

2.0 Objectives

At the end of this unit, you should be able to:

- discuss psychodynamic theory of Sigmund Freud
- explain Freudian psychoanalysis
- examine the interpersonal theory of Sullivan.

3.0 Main Content

3.1 Psychodynamic Therapy

Psychodynamic therapy is a treatment approach that focuses on individual personality dynamics, usually from a psycho-analytic or some psychoanalytically derived perspective. Psychoanalytic therapy is the oldest form of psychological therapy and began with Sigmund Freud. The therapy is mainly practiced in oriented psychotherapy. As developed by Freud and his immediate followers, classical psychoanalysis is an intensive (at least three sections per week), long-term procedure for uncovering repressed memories, thoughts, fears, and conflicts presumably stemming from problems in early psychosexual development, and helping individuals come to terms with them in light of the realities of adult life (Carson *et al.*, 2011).

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. For example, many psychoanalytically oriented therapists schedule less frequent sessions (e.g. once per week) and sit face to face with the client whereas Freud had them recline on the couch while he sat in the chair on the left, out of their view (Santrock, 2000). From this point, we now focus on classical psychoanalysis of Freud. What therapeutic approach did he use in his therapy? This takes us to Freudian Psychoanalysis.

3.2 Freudian Psychoanalysis

Psychoanalysis is Freud's therapeutic technique for analysing an individual's unconscious thought. Freud believed that client's problem could be traced to childhood experiences, many of which involved conflicts about sexuality. He also recognised that the early

experiences were not readily available to the individual's conscious mind. Only through extensive questioning, probing, and analysing was Freud able to put the pieces of the person's personality together and help the individual become aware of how these early experiences were affecting present adult behaviour.

Psychoanalysis is historical reconstruction. It aims to unearth the part in hope of unmasking the present (Myers, 2004). To reach the shadowy world of the unconscious, psychoanalytic therapists often use the following therapeutic techniques: free association, catharsis, interpretation, and dream analysis, analysis of resistance and analysis of interference. You will learn about these terms now. Be attentive.

Free association: this technique used by psychoanalysts consists of encouraging individuals to say aloud whatever comes to mind no matter how trivial or embarrassing. Usually a client lies in a relaxed position on a couch and gives 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.

Although such a running account of whatever comes into one's mind seems random, Freud did not view it as such; rather, he believed that associations are determined just like other events. The purpose of free association 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 tying together a client's often disconnected ideas, beliefs, and actions into a meaningful explanation to help the client gain insight into the relationship between his or her maladaptive behaviour and the repressed (unconscious) events and fantasies that drive it (Carson et al., 2011).

Catharsis: Catharsis is the psychoanalytic term for people's release of emotional tension when they relive an emotional charged and conflicted experience. Catharsis was a word used by the Greek philosopher Aristotle (384 – 322 BC) to denote the purging of emotions that results from watching a tagged performance of a tragedy. In psychoanalysis, Catharsis is the bringing to consciousness of repressed ideas, accompanied by the expression of emotions, thereby relieving tension. Many therapists believe that catharsis, or the expression of emotions connected to memories and conflicts, is also central to the healing processes in psychodynamic therapy (Nolen-Hoeksema, 2004). Catharsis unleashes the energy bound in unconscious memories and conflicts, allowing this material to be incorporated into more adaptive self-view (Nolen-Hoeksema, 2004).

Dream Analysis

Psychoanalysts believe that dreams express impulses, fantasies and wishes that the client's defenses keep in the unconscious during waking hours. Even in dreams, which Freud termed "the royal road to the unconscious", defensive processes usually disguise the threatening material to protect the dreamer from the anxiety that the material might evoke (Passer & Smith, 2001).

Freud distinguished between the dream's manifest and latent content. Manifest content is the psychoanalytic term for the conscious, remembered aspect of a dream. Latent content is the psychoanalytic term for the unconscious, unremembered, symbolic aspects of a dream. The psychoanalyst interprets the dream by analysing the manifest content for disguised unconscious wishes and needs, especially those that are sexual and aggressive in nature.

Interpretation: interpretation plays an important role in psychoanalysis. As the therapists interprets free association and dreams, the person's statement and behaviour are not taken at face value. To understand what is truly causing a person's conflicts, the therapist constantly searches for symbolic, hidden meanings in what the individual says and does. From time to time the therapist suggests possible meanings of the person's statements and behaviour.

Resistance: this is the psychoanalytic term for the person's unconscious defense strategies that prevent the analyst from understanding the person's problems. Resistance occurs because it is painful to bring conflict into conscious awareness. By resisting therapy, individual do not have to face their problems. Showing up late or missing sessions, arguing with the psychoanalyst, or faking free associations are examples of resistance. Some people go on endlessly about a trivial matter to avoid facing their conflicts. A major goal of the analyst is to break through this resistance (Stream, 1996 as cited in Santrock, 2000). The last point here to be examined is analysis of transference.

Transference: this is the psychoanalytic term for the person's relating to the analyst in ways that reproduce or relive important relationships in the individual's life. As client and therapist interact, the relationship between them may become complex and emotionally involved. Often people carry over, and unconsciously apply to their therapist, attitudes and feelings that they had in their relations with a parent or other person close to them in the past, a process known as transference. This client may react to their analyst as they did to that earlier person and feel the same love, hostility or rejection that they felt long ago. If the analyst is operating according to the prescribed role of maintaining an impersonal stance of detached attention, 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 to of central issues in the client's life. For example, should the client vehemently (but inaccurately) condemn the therapist for lack of caring and attention to the client's needs, this would be seen as a "transference" to the therapist of attitudes acquired in childhood interactions with parents or other key individuals.

In addition, the problems of transference are not confined to the client, for the therapist may also have a mixture of feelings toward the client. This counter transference, wherein the therapist reacts in accord with the client's transferred attributions rather than objective, must be recognised and handled properly by the therapist. For this reason, it is considered important that therapists have a thorough understanding of their motives, conflicts, and "weak spots" (Carson, et al., 2011). According to Gross (2010) counter-transference refers to the therapist's feelings of irritation, dislike or sexual attraction towards the client. It is suggested that all psychoanalysts should undergo psychoanalysis themselves before they begin independent practice. The next focus is on interpersonal therapy.

3.3 Interpersonal Therapy

Interpersonal therapy was first articulated by Harry Stack Sullivan. Its central idea is that all of us, at all times, involuntarily invoke schemas acquired from our earliest interactions with others, such as our parents, in interpreting what is going on in our current relationships. Where these earlier relationship have had problematic features such as rejection or abuse, the "introjections" characteristics of those earlier interaction partners may distort in various ways the individual's ability to process accurately and objectively the information contained in current interpersonal transactions. Thus the formerly abused or rejected person may come to operate under the assumption that the world is generally rejecting

and/or abusive. This mistrust stemming from this belief is bound to affect current relationship negatively.

Interpersonal therapy seeks to expose, bring to awareness, and modify the effects of the remote developmental sources of the difficulties the client is currently experiencing.

4.0 Conclusion

In this unit, you have learnt about psychodynamic therapies with emphasis on Freudian psychoanalysis and interpersonal therapy. The original version of psychoanalysis is not common in practice today. Psychologists see it as difficult, costly in time, money and emotional commitment. It may take several years before all major issues in the client's life are successfully resolved.

5.0 Summary

In this unit, you have studied important things about psychodynamic therapies. You learnt the concept of therapy, also Freudian psychoanalysis and under psychoanalysis the techniques used by Freud in his therapeutic treatment were analysed. These include free association, catharsis, interpretation, dream analysis, analysis of resistance and analysis of transference. Harry Stack Sullivan interpersonal therapy was briefly highlighted as a therapy that creates awareness about past internalised knowledge that affects our present behaviour and hence clients misinterpret the world as unsafe.

6.0 Self-Assessment Exercise

1. Explain psychoanalysis of Freud as a therapeutic technique in treating maladaptive behaviour.
2. What is catharsis in Freudian therapy?
3. Explain the concept of transference and counter transference.

7.0 References/Further Reading

Carson, R. C. (2011). *Abnormal Psychology.* (13th ed.). New York: Pearson Education Inc.

Myers, D. G. (2004). *Psychology.* (7th ed.). New York: Worth Publishers.

Nolen-Hoeksema, S. (2004). *Abnormal Psychology.* (3rd ed.). New York: McGraw-Hill Higher Education.

Passer, M. W. & Smith, E. S. (2001). *Psychology*. (1st ed.). New York: McGraw-Hill Higher Education.

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Unit 5 Marital and Family Therapy

1.0 Introduction

In the last unit, you studied psychodynamic therapies. The Freudian psychoanalysis was well discussed. The processes involved in psychoanalysis such as free association, catharsis, interpretation, dream analysis, analysis of resistance and analysis of transference were clearly explained.

In this unit, you will learn about marital and family therapy. This is an important issue to be discussed because most problems brought to therapists are clearly relationship problems.

2.0 Objectives

At the end of this unit, you should be able to:

- discuss marital therapy
- explain family therapy.

3.0 Main Content

3.1 Marital Therapy

The large numbers of couples seeking help with relationship problems have made coupled counselling a growing field of therapy. Typically the couple is seen together, and improving communication skills and developing more adaptive problem-solving methods are both a major focus of clinical concern. Although it is quite routine at the start of couple's therapy for each partner secretly to harbor the idea that only the other will have changing (Cordova & Jacobson, 1003 as cited in Carson *et al*., 2011), it is nearly always necessary for both partners to alter their reactions to the other.

For many years the gold standard for marital therapy has been traditional behavioural couple therapy (TBCT). TBCT is based on a social learning model and views marital satisfaction and marital distress in terms of reinforcement. The treatment is usually short-term (10 to 26 sessions) and is guided by a manual. The goal of TBCT is to increase caring behaviours in the relationship and to teach partners to resolve their conflicts in a more constructive way through training in communication skills and adaptive problem solving (Carson *et al.,* 2011).

However, this form of treatment (TBCT) does not work for all couples. Moreover, even among couples who show an improvement in relationship satisfaction, the improvement may not be maintained over time. The limitations of TBCT have led researchers to conclude that a change focused treatment approach is not appropriated for all couples. This in turn, has led to the development of integrative behavioural couple therapy (IBCT). Instead of emphasising change, TBCT 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. It does not mean that change is forbidden. Rather, within IBCT, acceptance strategies are integrated with change strategies to provide a form of therapy that is more geared to individual characteristics and the needs of the couple. Now, let us look at how family therapy has some similarities with marital therapy.

3.2 Family Therapy

Therapy for a family obviously overlaps with couple and marital therapy but has somewhat different roots. Whereas marital therapy developed in response to the large number of clients who come for assistance with couple's problems, family therapy began with the finding that many people who have shown marked improvement in individual therapy, often in institutional settings had a relapse when they returned home.

One approach to resolving family disturbance is called structural family therapy. This approach, which is based on systems theory, holds 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 organisation of the family in such a way that the family members will have to behave more supportively.

Structural family therapy is focused on present interactions and requires an active but not directive approach on the part of the therapist. Initially, the therapist gathers information about the family – a structural map of the typical family interactions patterns, by acting like one of the family members and participating in the family interactions as an insider. In this way the therapist discovers whether the family system has rigid or flexible boundaries, who dominate the power structure, who gets blamed when things go wrong, and so on. Structural family therapy has quite a good record of success in the treatment of anorexia nervosa.

4.0 Conclusion

In this unit, you have learnt about marital and family therapy. Large numbers of couples seeking help with relationships problem gave rise to both marital and family therapy.

5.0 Summary

In this unit, you have studied marital and family therapy. Marital therapy helps in improving communication skills and developing more adaptive problem solving styles. Both TBCT and IBTC are useful therapeutic approaches. The structural family therapy is a good approach in family therapy.

6.0 Self-Assessment Exercise

1. What is marital therapy? Explain the two different forms of marital therapy.
2. What is family therapy? How does therapist use the structural family therapy?

7.0 Reference/Further Reading

Carson, R.C. *et al.* (2011). *Abnormal Psychology.* (13th ed.). New York: Pearson Education Inc.