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SECTION 1: TEST CONSTRUCTION

TAKING THE EXAM

If you're a Jungian, forget the collective unconscious for this exam. If you think Gestalt’s the cat's meow, throw the baby out with the bath water. If you believe Freud’s the way to “self-enlightenment”, perhaps you're still dealing with father figure issues. If you're eclectic, you might consider bartending as a career choice! Whatever your "orientation" for working with clients is, check it at the door when you come to take the exam. It will only get in the way of you passing. The same goes for all that wonderful "professional experience" you've gained since your college days. Park your job experience outside and focus on what the case study is asking. You may be the most confident clinician in your field, but chances are your personal experience is not going to help you take and pass this examination. The fact is, many times personal experience prevents test-takers from answering the case study questions correctly. You may have some particular belief or values that will get in the way. When pondering exam questions think of the lowest common denominator; the most common experiences most people have as clinicians and as clients. Answer in terms of how things should be, not how they are. To pass the licensure exam, remember those naive days when the world was perfect, you had unlimited funding and resources were available with just a simple call!

During the exam you may assume that as the therapist, you have total access to support staff and services. Your access is not tomorrow or the next day, but NOW! You need to answer the questions and case studies in terms of what "should be" as opposed to "what is."

You will have enough time in the approximately four hours to answer all of the 170 multiple-choice questions on the exam. Give it your best shot the first time around and answer the question even if you don't know the correct answer. Flag “iffy questions” so you can go back to them. Something later in the exam may jog your memory, or you may see a question that gives you additional information to help you answer a ‘flagged’ question. Either way, answer the question the first time through. Trust me, after 3 or 4 hours, your mind will turn to mush; you won’t be able to make clear decisions.

Linton's Helpful Hint #1

If you can, take these items with you into the exam:
- A watch
- Bottle of water
- Cough drops for you or the annoying cougher next to you
- Energy bar
- Ear plugs
- Kleenex
- Scratch paper
Who Are You?
For the purposes of the exam, you are a Social Worker. You need to always be aware of your perceived or required ROLE as you answer the questions and case studies.

Linton’s Helpful Hint #2

🌟 When you take the exam, read the questions and answers out loud! Why? Because if you read the questions out loud it will slow you down so you won’t miss the question because you didn’t see the NOT or FIRST or BEST or other qualifiers you might’ve missed if you read the question silently. Do not be one of the hundreds that fail the exam by one point because they didn’t see a NOT in the question!

Practice Decisions
When you’re working on these case studies, you need to think of them as representing the status quo. Don’t try to answer the case study by identifying an option that is an exception to the rule. There are so many exceptions to the rules that it’s truly difficult to ask a question and expect to get only one correct response! But that's exactly what this exam expects. You must be able to read the case study, distinguish between the choices, and come up with an answer that would most completely and best benefit the client. Always look for the most universally and/or socially accepted response; don't forget to bring along your common sense!

The diagnosis or action you determine for the client is not dependent upon insurance billing or reimbursement. In fact, none of your decisions or actions with the client will be financially based UNLESS specified.

Your practice with clients has three identifiable stages:

- BEGINNING - The preparatory stage
- MIDDLE - The working stage
- THE END - The termination, transfer or referral stage

Spend some time knowing what activities and client responses are appropriate for each stage of practice.

Linton’s Helpful Hint #3

🌟 Take earplugs! Very important! Why? Others in the exam room will be reading the questions out loud! Tell me that won’t be distracting! And yes, YOU SHOULD BE one of those people reading the questions out loud! Distractions are road-blocks. Ten to one, the gardeners will be mowin’ and blowin’ right outside; the person next to you will have a hacking cough and be blowing his nose incessantly; the proctor will be talking on the phone... yada yada..., you get the picture. You need to pass this exam! Any slight distraction can make that one point difference!

Non-Case Study Questions
There will be a fair number of questions on the exam that don’t require analysis, synthesis or evaluation. These are the MEMORIZATION questions. They’re based on factual information that
you either know or don't know. You aren’t asked how you would apply the information, just what the correct answer is. If you happen to know the information, finding the correct answer will be a piece of cake. These "meat and potato" questions are also used in conjunction with application and reasoning case studies, so they’re critical to your success on this exam. If you have no clue or draw a blank, then guess. There’s no penalty for guessing.

Linton’s Helpful Hint #4

**Guessing.** That’s a sticky wicket! You will probably be able to eliminate two of the answers right away. Then you have at least a fifty-fifty chance of getting it right! Use the following principles for guessing:

1. Eliminate an answer if it would be obvious to a lay-person
2. If the question is general, pick the general answer
3. If the question is specific, pick the specific answer
4. If none of the above applies, choose the longest answer
5. If you haven’t a clue and can’t eliminate any of the choices, choose “C” … don’t ask why, it’s simply good odds

Case Study Information

The case studies are the most difficult type of questions on the examination. They’re long, involved and many times include extra information you don’t need for answering the question. These are the questions that require the ability to analyze, synthesize and evaluate. They can be divided into two different types of case study questions: APPLICATION and REASONING. These will require significant work during your subscription time with us. You will need to develop a cognitive map to address these types of questions to make sure you won’t have to take the exam a second or even third time.

Linton’s Helpful Hint #5

**Dress in layers.** I’d count on the testing room being too hot or too cold. It’ll drive you to drink if you are physically uncomfortable when testing. And remember: This is NOT a fashion show! You need to wear clothes that are comfortable and loose fitting. Leave the "Who will be the next top model?" for later or when you go clubbing with Britney on the weekend.

Address And Treat Everything "AS TRUE" In The Case Study

Everything that’s written in the case study is true. There will be no deceptions or setups. If it says “Sally is a single parent with eight kids whose husband just died, and she’s doing well as are the kids”, then this is a true statement. Sally IS NOT in denial but is doing well as stated in the case study.

Don’t infer or add anything into a question that is not specified. This confuses the issue and might lead you down a wrong road. For example, if the question talks about an unemployed worker, if it doesn’t specify what type of job, don’t make assumptions. Being an unemployed steel worker is totally different than being an unemployed actor.
Linton's Helpful Hint #6

🌟 I don't care how high your IQ is, you need to stay for the ENTIRE time you've been given to complete this exam. Check your EGO at the door and concentrate on passing the exam. I know it looks impressive to walk out of the exam after two hours or so, and it WILL have a shock effect on everyone else taking the exam. When someone does this (and someone ALWAYS DOES, you'll see what I mean!!), you will start to get anxious thinking you are running out of time, don't know what you are doing, etc. You can fail by 1 point just as easily as 20 points. So do yourself a favor, STAY THE ENTIRE TIME. Pace yourself. Take breaks. You'll thank yourself later. Your EGO might not like it, but who's running this ship anyway?

STEP ONE: CLASSIFY THE TYPE OF QUESTION

The first step in processing any case study is to CLASSIFY the question. As mentioned previously, the three major classifications of questions are: Memorization, Application and Reasoning.

A Memorization question asks for factual information. Usually, this is a simple question without a case study, though occasionally the question associated with a case study will be asking for factual information. The case study may have many twists and turns, but in the final analysis, the case study will ask for a cognitive answer based on your ability to recall only the facts.

Linton's Helpful Hint #7

🌟 Make sure you read each possible answer before making your choice. There is usually more than one correct answer for an Application or Reasoning question, so don't just pick the first correct answer you see. It may be a correct choice, but it may not be the best correct choice. Read all of the other choices, as you may find one that's more complete.

An Application case study is more complicated than strictly memorization. They apply the "meat and potatoes" - procedures, theoretical models and concepts TO the specific case study presented. They require the ability to analyze. How do you analyze a case study?

- **Behaviors**: Determine the behavior the client is exhibiting. (How are they acting?)
- **Factors**: Identify contributing factors responsible for the client's actions or primary problem.
- **Concepts**: What procedures, concepts, legal issues, theoretical models or ethical considerations will determine your interactions with the client?
- **Actions**: What should your actions be taking into consideration: Concepts, Behaviors and Factors?

This type of case study will ask you to take an action. It will be in the format of: “WHAT SHOULD YOU DO FIRST?”

4
Linton’s Helpful Hint #8

In MOST case studies, before you take an action, make an assessment. For example, if you are asked, “What should you do?” (meaning, what you would do FIRST) look at the options that deal with assessing the client.

A Reasoning case study will require analysis, synthesis and evaluation. In the end, they will usually ask for a “thinking answer” rather than a doing answer. You will be required to make a judgment or evaluation. They will usually be in the form of: “What is the (MOST or LEAST) LIKELY, SIGNIFICANT, INSIGNIFICANT, IMPORTANT, APPROPRIATE?” “What PRIORITY?” “What is the BEST?”

Linton’s Helpful Hint #9

With ethical questions, the principles are:
- Do no harm
- Do not act in isolation
- Take problems to supervision

These answers are more complex than memorization or application case studies. You are looking for the response that’s best and most complete for that particular case study. It’s critical you focus on what you are being asked. This can be accomplished by:

- **Modifiers**: (Most or least) likely, significant, insignificant, important, appropriate, priority, best
- **Situation**: Intervention, diagnosis, characteristic, facilitate, referral, resolving, describing

Linton’s Helpful Hint #10

The BEST choice when a number of correct choices are given in order of correctness:
- The answer is Correct and Applies to all aspects of the question
- The answer is Correct and Applies to only a portion of the question
- The answer is Correct but Applies only to one example of the question

Summary - Ask yourself three questions:

1. **Am I being asked for some factual information?**
   - MEMORIZATION - (factual) Know it or guess
2. **Am I being asked to take an action?**
   - APPLICATION - (doing) What should you do first?
3. **Am I being asked to make a judgment or evaluation?**
   - REASONING - (thinking) What’s the best?
STEP TWO: IDENTIFY THE CASE STUDY FOUNDATIONAL FACTORS
The second step in processing any case study is to identify FOUNDATIONAL FACTORS. Foundational Factors are the broad Social Work areas that the case study may fall under. There can be multiple foundational factors all influencing the direction and correct responses required. Knowing the foundational factors will further focus what rules, processes and theories you will need to apply to the case study.

List Of Foundational Factors
- Group
- Administrative
- Diversity
- Ethics
- Diagnostic
- Treatment
- Social Work Role
- Counseling
- Developmental

Linton’s Helpful Hint #11
- When all else fails:
  - Absolutes are usually incorrect responses (always, never)
  - Qualifiers are usually correct responses (usually, sometimes)
  - Correct choices may be noticeably longer or shorter than incorrect answers
  - If two choices are opposites, one of them is probably correct
  - If choices are numerical, the correct answer may be the middle value
  - Correct answers may be more precisely worded than incorrect choices

STEP THREE: FILTER THE CASE STUDY USING CONTEXTUAL CODING
The third step in processing any case study is to filter using CONTEXTUAL CODING. Contextual Coding is a filter that consists of Social Work principles applied to the case study. Go through the case study and see what guiding principles need to be taken into consideration. Though the case study will contain multiple answers that are correct, only one answer will be "preferred" because it’s more complete than the others. The more complete answer provides the basic services for the client AND addresses a universal principle that the other correct answers do not take into consideration.

List of Contextual Coding
- Protection of Life
- Report legal violations - do not evaluate
- Responsibility to client supersedes all other responsibilities
Deal with the client's here-and-now
Treat clients with unconditional positive regard
No signature, no service
Evaluate before proceeding
Eliminate possible physiological causes
Clients determine interventions
Confirm 2nd party evaluations with client
Stabilize crisis first through actions
Implement least intrusive solution

**Linton's Helpful Hint #12**

The following Information will make the difference between passing and failing your exam: WRITE THIS DOWN AND REFER TO IT OFTEN!! When faced with the dreaded "What do you do NEXT/FIRST" questions - know these seven tasks in order. Always look for these within the answers and given two options, choose the one closest to the top of the list:

- Feelings - acknowledge clients
- Assess
- Refer
- Educate
- Advocate
- Facilitate
- Intervene

...this is how you remember them in order from Choosing First to Choosing Last with this mnemonic:

Feelings Assess Refer Educate Advocate Facilitate Intervene
Farmer Aladdin Raises Expensive Apples From India

AGAIN THIS IS CRITICAL INFORMATION YOU WILL NEED TO KNOW TO PASS YOUR EXAM!!!!!!

**STEP FOUR: FIND THE CASE STUDY ALERTS**

The fourth step and probably the easiest, is to identify ALERTS.

Alert words should automatically stimulate a chain of thoughts and associations. These associations will help you key into thinking about initial actions a therapist might take and further considerations for the client. As you read the case study and spot one of these alerts, bells and whistles should go off in your head. You need to follow the implications associated with them.

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<td>Adolescent</td>
<td>Legal parent - School, family, friends</td>
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<td>Age appropriate behavior</td>
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<td>Rapid Change in Situation</td>
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<td>Depression</td>
<td>Cognitive therapy - Substance abuse - Suicide Grieving</td>
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**EXAM CONTENT**

The national exam has 4 levels of exams for Social Work: Bachelor, Masters, Advanced Generalist and Clinical. All exams are based on a specified clinical outline with content weighed by percentage of questions in each category. As an example, the Clinical Level Exam breaks down as follows:
I. **Human Development and Behavior in the Environment** 22%
   A. Theories of human development and behavior
   B. Human development in the lifecycle
   C. Human behavior
   D. Impact of crises and changes
   E. Family functioning
   F. Addictions
   G. Abuse and neglect

II. **Issues of Diversity** 6%
   A. Effects of culture, race and/or ethnicity
   B. Effects of sexual orientation and/or gender
   C. Effects of age and/or disability

III. **Diagnosis and Assessment** 16%
   A. Assessment
   B. Information gathering
   C. Diagnostic classifications
   D. Indicators of abuse and neglect
   E. Indicators of danger to self and others

IV. **Psychotherapy and Clinical Practices** 16%
   A. Intervention theories and models
   B. The intervention process
   C. Treatment planning
   D. Intervention techniques
   E. Intervention with couples and families
   F. Intervention with groups

V. **Communications** 8%
   A. Communication principles
   B. Communication techniques

VI. **The Therapeutic Relationship** 7%
   A. Relationship theories
   B. Relationship practice

VII. **Professional Values and Ethics** 10%
   A. Value issues
   B. Legal and ethical issues
   C. Confidentiality

VIII. **Clinical Supervision, Consultation and Staff Development** 4%
   A. Social work supervision
   B. Consultation and interdisciplinary collaboration
   C. Staff development
IX. Practice Evaluation and Utilization of Research 1%
   A. Evaluation techniques
   B. Utilization of research

X. Service Delivery 5%
   A. Policies and procedures of service delivery
   B. Processes of service delivery

XI. Clinical Practice and Management 5%
   A. Advocacy
   B. Finance
   C. Management and human resource issues

THE FINAL WORD
Just a reminder, this is the 21st Century, so these tests are computerized. Know how to work with computers or your knowledge about counseling is not what’s going to be tested - it’s your patience. You will wish you’d asked your five-year old whiz kid as you fight to figure out how to make the little arrow (“It’s called a what?? I thought a mouse was a rodent…”) click on the icon (“isn’t that a Catholic symbol?”) to get to the instructions (“wait, if I can’t get to the next page, how can I find out ‘how’ if the instructions are on the next page I can’t get to?”) … Ahhh!! By the time you raise your hand to ask for directions from the Proctor, your 4-hour exam will be over and you will be bald. Face it, you are up the creek without a paddle and you haven’t gotten to a single question yet. So learn the basic ‘how to’s’ of computers before exam day!

By the way, if you have technical problems with the equipment while testing, call the Proctor immediately for help so you are not penalized.

Your exam will begin with a tutorial opportunity, however, your 4-hour exam time will not begin until you click that ‘start’ button. After you’ve finished, the computer will tally your results and you will walk out knowing whether you passed or will need instructions on how to register for taking the exam again. So be totally prepared, go in there to do your very best and knock ‘em dead.
SECTION 2: SCHOOLS OF PSYCHOTHERAPY

BEHAVIORAL THERAPY

- **Key Figures:** Ivan Pavlov, B.F. Skinner, John Watson, Joseph Wolpe, Edward Thorndike
- **Theory:** Although its basic hypothesis has remained unchanged since the 1960s, continuing behavioral research has brought four main types of behavior therapy: Applied behavior analysis, neuro-behavioristic stimulus-response, social learning theory and cognitive-behavior modification. Encouraged to choose goals, the client is an active participant. The counselor’s first job is to identify the existing concern; therefore, assessment techniques such as psychological tests, behavioral observations, self-reports/monitoring, role-playing and imagery may be used.
- **Treatment:** Techniques may include training in social skills, assertiveness training, self-control exercises (such as progressive relaxation and biofeedback), as well as performance-based techniques applied outside therapy (for example, behavior modification programs used in classrooms).
- **Relevance:** In any form of behavioral therapy, the client's commitment to change, along with effective client/counselor interaction, determines success. Since such classical conditioning creates both behavioral and emotional responses, it is used to explain and treat phobias, anxieties and aberrant behavior.

Behavioral therapy holds that the environment provides two types of situations for an individual to determine behavior: positive or negative. Learning occurs when there is either positive or negative reinforcement.

**Operant Or Classical Conditioning Techniques**
- Premack Principle
- Assertiveness Training
- Autogenic Training
- Baseline Biofeedback (i.e., EMG, EEC or Temperature) Covert
- Experiment with Peter
- Flooding of Implosive Therapy
- Law of Effect
- Jacobson Method
- Little Albert vs. Little Hans

**Behavioral Theory**
To explain personality development, behaviorists aim to describe how people think, perceive and learn (learning theory).

Of course, Ivan Pavlov looms large in the behaviorist pantheon. His theory of classical conditioning confirms the crucial part that antecedents play in learned behavior. Unconditioned stimuli produce unconditioned or natural responses, such as Pavlov's dogs salivating at the smell of meat powder. By combining a known stimulus and a natural response with a neutral stimulus
such as a ringing bell, Pavlov found dogs would begin to salivate upon hearing the bell alone, a conditioned stimulus producing a conditioned response.

Briefly, the key classical conditioning phenomena of stimulus generalization, extinction, and counter conditioning may be explained by the following:

- **Stimulus generalization** – A conditioned stimulus is repeated along with another like stimulus until the latter alone produces the response
- **Extinction** – A conditioned response fades over time as a conditioned stimulus is repeated without the unconditioned, natural stimulus
- **Counter conditioning** – A conditioned stimulus is coupled with another stimulus to evoke a response contrary to that produced by the original stimulus

Two pioneering behaviorists in the United States were John Watson (known as the first American behaviorist) and Joseph Wolpe. Watson contended that conditioning has power to mold people's behavior and treated patients' phobias with classical conditioning. Wolpe applied classical conditioning theory to psychotherapy, originating **reciprocal inhibition** and **systematic desensitization**. To treat anxiety, he joined relaxation with an anxiety-causing stimulus to render the stimulus harmless. Another behavioral approach is **operant conditioning theory**, which concentrates on consequences rather than antecedent causes. Early in the 20th century, Edward Thorndike proposed his law of effect, whereby the strength or weakness of conditioning is seen as dependent upon resultant satisfying or annoying degrees of reward or punishment. B.F. Skinner called Thorndike's finding the principle of reinforcement and coined the term “operant conditioning”.

People learn by experiencing reinforcement (encouraging recurrence) or punishment (discouraging recurrence) following their behavior. Consequences are positive if added and negative if withdrawn. By regulating response consequences, reinforcement schedules greatly affect the speed and strength of operant conditioning. Continuous reinforcement happens every time a behavior occurs; partial or intermittent reinforcement occurs occasionally. As any gambler can attest, intermittent reinforcement can be very powerful. The four intermittent schedules are:

- **Fixed interval**: Reinforcement is repeated at timely intervals (eg, every 10 secs)
- **Variable interval**: Reinforcement interval changes (such as reinforcement after 2 seconds, then after 7 seconds, then after 4 seconds and so on)
- **Fixed ratio**: Reinforcement occurs at fixed response intervals (for example, giving reinforcement after every fifth response)
- **Variable ratio**: Reinforcement happens at a rate tied to the number of responses (the actual number of responses to each reinforcement may fluctuate like payments on a capped variable rate mortgage, but the ratio, on average, stays constant)

**Other Salient Techniques Of Operant Conditioning**

**Token Economy**: This method rewards desired behaviors with tokens such as poker chips, stars and scrip that can be saved and traded for another reinforcement, such as an outing to a restaurant or a movie.

**Shaping**: This conditioning is used to encourage specific behavior by rewarding actions that come increasingly closer to the desired behavior.
**Extinction**: Unwelcome behaviors receive no reinforcement. This is most effective when all reinforcers of a behavior are eliminated all the time.

**Differential Reinforcement**: This program combines extinction of unwanted behavior with positive reinforcement for desirable behavior.

**Vicarious Conditioning**: Dismissed by Thorndike and Watson, vicarious conditioning or learning by observation was later demonstrated by Albert Bandura's work with children. Bandura discovered a child could learn by observing another's experience with classical or instrumental conditioning.

**Primary Vicarious Conditioning**: Occurs when an observer sees the model's behavior reinforced then he/she performs the same behavior. On flipside, in **Vicarious Punishment**, an observer watches the model get punished for a particular behavior and chooses not to do the same thing.

**Secondary Vicarious Conditioning**: Occurs when symbolic representations of behavior and its consequences are absorbed through reading, looking at maps or other images or from a verbalized description. Direct classical and/or operant conditioning can modify behaviors received from observational learning.

**Operant Conditioning - B.F. Skinner**
Based on the behaviorist theory that the environment determines behavior by providing either positive or negative situations, Skinner believed people exhibit or inhibit behaviors due to the ramifications given to those behaviors.

**Techniques Of Behavioral Therapy**
- Biofeedback Contingency Contracts Extinction
- Over-Correction Positive Reinforcement Premack Principle
- Response Cost Shaping Time-Out
- Token Economy

Behavioral modification derives from operant conditioning/instrumental learning. With the objective of increasing desirable behaviors or reducing objectionable behaviors, behavioral therapy holds to an educational model of human development combined with an adherence to scientific methodology. In treating abnormal and/or maladaptive behavior, the focus is on present causes of behavior rather than prior thought and unconscious conflicts. In diverse situations, the same unwanted behaviors may be treated differently because of the client’s needs. Although its basic hypothesis has remained unchanged since the 1960s, continuing behavioral research has brought four main types of behavior therapy:

- Applied behavior analysis
- Neuro-behavioristic stimulus-response
- Social learning theory
- Cognitive-behavior modification

Focusing on actual behavior rather than cognitive processes, **applied behavior analysis** sees behavior as a function of its consequences. This approach uses the behavior modification techniques of stimulus control, reinforcement, punishment and extinction.
Through systematic desensitization and covert conditioning, **neuro-behavioristic stimulus-response** therapy is concerned with extinguishing causes of anxiety. This approach assumes the same laws of learning apply to both overt and covert processes.

Viewing current behaviors, cognitive processes and the environment as working together to influence behavior, **social learning theory** stresses the processes of mediation, external stimuli and external reinforcement. In this approach, the client determines which behaviors to change using his/her self-directing abilities.

**Cognitive-behavior modification therapy** aims at cognitive restructuring - a process for understanding how the client interprets the experiences affecting behaviors. The emphasis is on altering irrational ideas, perceptions and interpretations of individual experiences.

**Behavioral couples therapy** has been the most researched. It attempts to reduce substance abuse both directly and through restructuring the dysfunctional couple’s interactions that frequently help sustain it.

### COGNITIVE-BEHAVIORAL THERAPY MODELS

- **Key Figures**: Aaron Beck, Donald Meichenbaum, Albert Ellis, Leon Festinger, George Kelly, Steve de Shazer, Insoo Kim Berg, Bill O’Hanlon
- **Theory**: Maladaptive behavior is associated with patterns of thinking and response that do not result in mentally healthy outcomes. The focus of therapy is on the present rather than the past. The central premise is that behavior is maintained by its consequences:
  - Consequences that accelerate behavior are called reinforcers
  - Consequences that decelerate behavior are called punishers
- **Treatment**: The goal of cognitive-behavioral therapy is to change or substitute these patterns with more realistic and useful thoughts and responses.
- **Relevance**: It is used to treat Depression, anxiety disorders, phobias and other forms of mental disorders. Medication is often used in conjunction with this approach to treat mood disorders and more severe forms of mental disorders.

### COGNITIVE THERAPY

**What Is Cognitive Therapy?**

Cognitive therapy is a widely used form of psychotherapy that focuses on changing dysfunctional cognitions (thoughts), emotions and behavior. This computerized learning program emphasizes the form of cognitive therapy developed over the last thirty years by **Aaron T. Beck** and his coworkers. Cognitive therapy is based on the theory that individuals with depression, anxiety and other emotional disorders have maladaptive patterns of information processing and behavioral-related difficulties.

One of the primary targets of cognitive therapy is the identification of negative or distorted automatic thoughts. These cognitions are the relatively autonomous thoughts that occur rapidly while an individual is in the midst of a particular situation or is recalling significant events from the past. Patients with depression and anxiety have many more negative or fearful automatic thoughts than control subjects, and these distorted cognitions stimulate painful emotional
reactions. In addition, negative automatic thoughts can be associated with behaviors (e.g., helplessness, withdrawal or avoidance) that make the problem worse. In depression or anxiety disorders, there is often a "vicious cycle" of dysfunctional cognitions, emotions and behaviors.

Automatic thoughts are frequently based on faulty logic or errors in reasoning. Cognitive therapy is directed, in part, at helping patients recognize and change these cognitive errors (sometimes called cognitive distortions). Some of the commonly described cognitive errors include: all or nothing thinking, personalization, ignoring the evidence and overgeneralization. In cognitive therapy, patients are usually taught how to detect cognitive errors and to use this skill in developing a more rational style of thinking.

Another focus of cognitive therapy is on underlying schemas. These cognitive structures are thought to be the templates, or basic rules, for interpreting information from the environment. Schemas (sometimes termed core beliefs) can be either adaptive or maladaptive. Cognitive therapists assist patients in modifying problematic schemas. Generally, cognitive therapy for dysfunctional schemas is more complex and demanding than therapeutic work with automatic thoughts.

Cognitive therapy also includes a number of behavioral interventions such as activity scheduling and graded task assignments. These procedures are used to reverse behavioral pathology and to influence cognitive functioning. The relationship between cognition and behavior is considered to be a "two-way street". If behavior improves, there is usually a salutatory effect on cognition. In a similar manner, cognitive changes can lead to behavioral gains. Thus, cognitive therapists often combine cognitive and behavioral techniques in clinical practice.

**What Is The Research Background Of Cognitive Therapy?**
Cognitive therapy is the most heavily researched form of psychotherapy. Multiple, well-controlled outcome studies have shown cognitive therapy to be an effective treatment for Depression. Also, cognitive therapy has been found to be a particularly useful intervention for Panic Disorder and Social Phobia. Other conditions for which cognitive therapy has been proven useful include: psychophysiological disorders, Bulimia Nervosa and cocaine abuse. Research on cognitive therapy for a wide variety of disorders was reviewed by Wright and Beck (1995).

**How Is Cognitive Therapy Conducted?**
Usually cognitive therapy is a short-term treatment lasting from 10-20 sessions. Therapists are more active than in many other types of treatment for emotional disorders. A strong therapeutic relationship is encouraged between the clinician and patient. This relationship has been termed collaborative empiricism because therapist and patient work together as a team to examine: 1) the validity of cognitions, and 2) the effectiveness of behavior patterns.

In the early phase of cognitive therapy, emphasis is placed on establishing a good working relationship and teaching the patient the basic principles of this treatment approach. Examples from the patient's current life situation are usually used to demonstrate the effects of automatic thoughts and cognitive errors. Therapy is most often focused on the "here and now" and is directed at specific problems or areas of concern. Homework assignments are used from the beginning of treatment to reinforce learning and to encourage behavioral change.
The middle portion of therapy is devoted to modifying dysfunctional patterns of information processing and behavior. Frequently used cognitive interventions include: thought recording, identifying cognitive errors, examining the evidence and developing rational alternatives. A number of behavioral techniques may also be employed, such as activity scheduling, graded task assignments or desensitization procedures. The therapist asks frequent questions designed to stimulate a more rational cognitive style. Also, self-help is encouraged by in vivo therapeutic exercises and a continuation of homework assignments.

The final phase of treatment is concerned with reinforcing skills learned earlier in therapy and in preparing patients for managing problems on their own. One of the goals of cognitive therapy is to learn methods that will have positive effects in reducing the risk of relapse. Thus, many cognitive therapists help their patients prepare for stressful situations that might trigger the return of symptoms. During the later portions of therapy, more intensive work may be needed to revise deeply held schemas. Change in these underlying attitudes is thought to be an important factor in the long-term effects of cognitive therapy.

**Cognitive Therapy - Aaron Beck**

The cognitive therapy, developed by Aaron Beck, involves the identification of automatic thoughts (similar to preconscious). Both cognitive therapy and the Beck Depression Inventory utilize a client’s thought patterns or cognitive schemas. The negatively oriented internal dialog of depressed individuals results in low self-esteem and negative self-concept. Beck believed a client's difficulties are a result of a distorted construction of reality on three levels:

- View of Self
- View of Experiences
- View of the Future

When a client’s thinking is modified, biochemical changes occur in the brain relieving feelings of depression. This therapy is most effective for clients with phobias and/or depression.

**Cognitive-Behavior Therapy - Donald Meichenbaum**

Working to move clients from self-defeating thoughts to coping ones, Donald Meichenbaum’s cognitive-behavior therapy includes the technique termed “self-talk” in which a client examines automatic illogical thoughts with the intent of changing the underlying assumptions responsible for beliefs and therefore for actions. Stress inoculation is the practice of making positive self-statements. The client keeps a daily journal of dysfunctional thoughts, noting situations and emotions that trigger the irrational beliefs and learning to counter irrational beliefs with rational responses.

**Rational Emotive Behavior Therapy - Albert Ellis**

Rational emotive behavior therapy (REBT) is a cognitive-behavioral therapy. Believing individuals have potential for rational thinking, the REBT therapist views self-talk as the source of emotional disturbance, using the ABC framework:

- A Activating event
- B Belief
- C Consequent affect
Disputing of the irrational belief

Developed by Albert Ellis in the 1950s, rational emotive behavior therapy envisions emotional consequences as being created by an individual's belief system rather than by significant causal events. The individual’s intrapersonal and interpersonal life are viewed as the source of growth and happiness. Each person is born with abilities to create or destroy, to relate or withdraw, to choose or not choose and to like or dislike, all affected by culture/environment, family and social group. By using rational emotive behavior methods, the counselor aims to help the client desire rather than demand, positively changing those aspects the client wants to change and working toward acceptance of what cannot be changed.

According to Ellis, people possess innate capacities for self-preservation/self-destruction and rationality/irrationality. Since the influence of others is strongest during the early years, an individual’s early family environment is of major importance. As individuals perceive, think, emote and behave simultaneously, cognitive, connotative and motoric behaviors coexist. Yielding both normal and abnormal behaviors, perceptions, thoughts, emotions and actions are key elements in the REBT client/counselor relationship. Although remaining accepting of a client, the counselor may need to be critical of that client's negative behaviors, illustrating deficiencies as needed. If the client remains dependent, the counselor must emphasize independent self-discipline. Because of its cognitive core, rational emotive behavior therapy does not require a warm relationship between counselor and client.

Employing various methods to help clients achieve basic cognitive changes, rational emotive behavior therapy aims to alter an individual's belief system and values. Among the techniques used are:

- Didactic discussion
- Behavior modification
- Bibliotherapy
- Audiovisual aids
- Activity-based homework
- Role-playing
- Assertion training
- Desensitization
- Humor
- Operant conditioning
- Suggestion
- Emotional support

Usually, general rational emotive behavior therapy (learning appropriate behaviors) is included in preferential rational emotive behavior therapy (internalizing logic and empirical thinking to counter irrational ideas and behaviors). In this model, the true cause of an individual's problems is viewed as adherence to dogmatic and irrational beliefs. Therefore, the individual needs to see what difficulties result from those beliefs instead of focusing upon antecedent causes and conditions. Although problems will not go away by themselves, they can be minimized through
rational emotive thinking and action. The active-directive approach of rational emotive behavior therapy treats the client holistically with emphasis on the biological factors of personality development. In order to help the client replace a self-defeating outlook with a realistic and acceptable worldview, a REBT therapist identifies and strongly challenges the client’s irrational beliefs.

**Treatment**
- REBT uses a cognitive psychological approach to treat the client
- The underlying belief in this treatment is that the client has developed incorrect thinking that has led to destructive and unacceptable behaviors and/or psychological disorders
- Changing the illogical thinking will lead to successful behavior and a cure
- The therapist acts as a teacher helping the client replace dysfunctional thinking patterns with rational cognitions
- The therapist challenges the thinking of the client and offers more logical, rational ways of looking at the world
- The client learns to see the world and himself/herself in a different light, which gives hope and a practical way to deal with the world

**Relevance**
- Relatively healthy individuals who are not suffering from psychosis or brain impairment may gain from the rational emotive behavior therapy
- Satisfaction with life and a more effective way of gaining needs and desires are the goals of this treatment

**Solution-Focused Therapy - de Shazer, Berg, O’Hanlon**

Solution-focused therapy was pioneered by Steve de Shazer and Insoo Kim Berg and further developed by Bill O’Hanlon who termed his theory, solution-oriented or possibility therapy. It is a form of brief therapy. They believed therapy should focus on what the person wanted to accomplish through therapy, not the issues that drove them there. They saw therapy as a conversational process by which the therapist helps the client shift their thinking from negative to positive using creative tasks to engage the client in actions that lead to new perspectives and behavior. The art of solution-focused therapy then becomes a matter of helping clients not only to see their problems have exceptions, but also to realize these exceptions are solutions they already have in their repertoire.

**Theory Concepts**
- de Shazer and Berg postulated three rules of thumb:
  - If it isn’t broken, don’t fix it
  - If it’s working, do more of it
  - If it’s not working, do something else
- Look for exceptions – “When was the problem not a problem?”
- The client’s effectiveness has been blocked by a negative mindset
  - Drawing their attention to times when they were doing well helps clients to see things differently
Therapists look to the future when problems can’t be solved
  • Changing the way people talk about their problems
  • Language creates reality
    1. Go from problem talk to solution talk

Normal Behavior Development
  ➢ Therapists do not impose their view of “normality”
  ➢ There are no absolutes

The Goal Of Treatment
  ➢ Help the client shift from talking about problems to talking about solutions
  ➢ Therapist and client work to build on the solutions which emerge from optimistic conversations
  ➢ The therapist must be careful to create modest, concrete and reachable goals
  ➢ Assessing future goals:
    • “What do you think the problem is now?”
    • “How will you know when the problem is solved?”
    • “How will you know when you don’t have to come here anymore?”
    • “What will have to be different for that to happen in terms of your behavior, thoughts and feelings?”
    • “What will you notice is different about others involved in the situation?”

Treatment Process
  ➢ Therapist needs very little intake information
  ➢ Assess the client’s stage:
    • Complainant
      1. They aren’t willing to work on solving problems
    • Customer
      1. Someone motivated to change
  ➢ First session tasks
    • Ask the client to observe what happens in their life which they want to continue to happen
    • Ask the “Miracle Question”
      1. “A miracle happens over night and your problem is solved, you wake up… how do you know, what would be different?”
    • Exception questions
      1. Ignore the picture of the problem the client presents, then redirect attention to a time when they didn’t have the problem
    • Scaling questions
      1. Help clients talk about vague problems such as communication and depression
      2. Help the clients quantify their confidence so they can maintain their resolve
      3. Ask the client how they can increase their chances for success
  ➢ Anticipate and disarm resistance
  ➢ List the client’s strengths
• Compliments point out the person has already done something right
• Highlight the client’s successes and keep the client working
  ➢ Summary Message
  • Provide a new and more hopeful perspective on the problem while engendering confidence and positive expectations

Cognitive Dissonance - Leon Festinger
Leon Festinger called actions or feelings at odds with a consistent self-concept, cognitive dissonance. People try to maintain a steady view of themselves by avoiding or reducing unwelcome incongruities, which can call for some pretty deft mental maneuvering. Reduction of Cognitive Dissonance (RCD) is the three-card-Monte of self-concept.

George Kelly
George Kelly proposed that people make sense of the world by creating constructs. Decisions and behaviors are influenced by "constructive alternativism," the ability to choose options. Kelly's Role Construct Repertory Test (Rep Test) helps show structuring of interpersonal life, level of cognitive complexity and some kinds of personality and cognitive variables. We are reminded that in counseling, clients sometimes need to abandon some constructs and adopt new ones.

Cognitive Theory - Lewin
Cognitive theories hold that people react to different things and events according to different individual perceptions of them.

Kurt Lewin saw behavior arising from the individual and his or her psychological environment, or life-space.

COGNITIVE - COUPLE’S THERAPY
Treatment focuses on deconditioning anxiety and helping clients resist negative thoughts.

➢ Disorders of desire range from “low sex drive” to sexual aversion
➢ Arousal disorders include:
  • Decreased emotional arousal
  • Difficulty achieving and maintaining an erection
  • Dilating and lubricating
➢ Orgasm disorders include:
  • Timing of the orgasm
    1. Premature
    2. Delayed
  • Quality of the orgasm
  • Requirements for the orgasm

Limitations Of The Approach
➢ The behaviorist focus on modifying the consequences of the problem behavior, accounts for the strengths and weaknesses of this approach
➢ Behaviorists rarely treat whole families:
• Instead, they only see those subsystems they consider central to the targeted behavior
• Unfortunately, failure to include the entire family could be disastrous
• Furthermore, if the whole family isn’t involved in the change, new behavior may not be reinforced and maintained

**BRIEF THERAPY**

- **Key Figures:** Milton Erickson, Richard Bandler
- **Theory:** Seeing the history of the problem as less important and the present as the primary focus, the brief therapist is interested in focusing on specific problems and taking a much more involved role. Spontaneous and generative change happens as the client sees the present in a wider context and develops more functional ways to interact with it. The therapist is a helper who encourages the client to find the solutions from within.
- **Treatment:** Using a wide range of approaches adapted to the particular client’s unique situation, the therapist actively goads the client to examine behaviors that work, while concentrating on successes rather than failures.
- **Relevance:** Brief therapy is used in a wide range of situations including individual, marital and family therapy. Anger management, relationship mending, communications skills, adolescent and children issues, behavior problems and substance abuse are all areas of concern. This therapy is best suited for individuals who are relatively intact in their reasoning and communication abilities. Brief therapy is an umbrella encompassing several theoretical models.

**EXISTENTIAL – LOGOTHERAPY**

- **Key Figures:** Rollo May, Gordon Allport, Viktor Frankl, Abraham Maslow, Irving Yalom
- **Theory:** Psychological dysfunction and mental illness are nonexistent in existential thinking. Any manifestation of “being” is simply an expression of how one chooses to live. The important issues for existential therapists are exercising choices and coming to terms with the resulting anxieties. Focus is on the here-and-now.
- **Treatment:** Four major themes are relevant to the therapeutic process: death, freedom (& responsibility), isolation and meaninglessness. The therapist guides the client through confrontations with his/her anxieties about these four themes. Making choices and taking full responsibility for these choices are central to becoming a healthy individual.
- **Relevance:** This form of therapy works best with high functioning individuals with little or no psychopathology. Problems or issues relating to the DSM Codes most commonly react well with this form of therapy.

Phenomenology is the basis of existential therapy, a therapy that views a person’s awareness as more important than genetics. Logotherapy, as founded by **Viktor Frankl**, finds healing through the discovery of meaning. The goal of existential therapy is for the client to comprehend his/her own being and work to know the meaning of life’s situations. In addition to Viktor Frankl, **Rollo May** and **Irving Yalom** were leaders in the movement.

To grasp existential therapy, three words must be understood:

- **Mitwelt:** Refers to one's relationship with other people
- **Umwelt:** Refers to one's relationship with the environment
- **Eigenwelt:** Refers to one’s relationship with himself/herself (In German, the word literally means self-world)

**Phenomenology** is the direct study of experiences taken at face value. Each person is viewed as having freedom to make decisions as well as being responsible for those decisions.

**Goal Of Existential Therapy**
- Increase the client's awareness and understanding of goals, purposes and responsibility for personal actions
- Acceptance of freedom
- Use of normal anxiety to promote growth

**Techniques Of Existential Therapy**

Since there are no set techniques, the existential therapist can use any approach that meets the needs of the client; therefore, therapists show wide latitude in techniques employed. Humor and paradox are both used.

Best considered as an approach to understanding humans, existential therapy is basically experiential. An authentic relationship between the client and the therapist is necessary, and the therapist’s authenticity is considered the crucial quality in building an effective therapeutic relationship. In the therapeutic process:

- Subjective understanding of the client is primary
- Techniques are secondary

The central theme running through the works of Viktor Frankl is the will to meaning. According to **Jean-Paul Sartre**, existential guilt is the consciousness a person has of evading commitment to make personal choices.

As a reaction against both psychoanalysis and behaviorism, the existential approach views humans as being free and responsible. According to the existential view, anxiety is a part of the human condition. A limitation of the existential approach in working with culturally diverse client populations is the focus on personal responsibility rather than on social conditions.

**Theory Foundation**

- The modern person has the means to live, but often has no meaning to live for - this is the malady of our times, meaninglessness or existential vacuum
- Purpose of therapy is to challenge people to find meaning and purpose through suffering, work and love
- It takes courage to “BE”
  - Our choices determine the kind of person we are
    - We are in constant struggle with:
      1. Our want to grow toward maturity and independence
      2. Realizing expansion and growth is often a painful process
      3. Struggling between security and dependence, and delights and pain of growth
- Phenomenological approach
• People’s perceptions or subjective realities are considered to be valid data for investigation, no matter what their origin
• Phenomenological discrepancies
  1. Two people perceiving the same situation differently

➢ Non-Deterministic approach
• Existentialists argue it is an oversimplification to view people as controlled by fixed physical laws
• They encourage theories that consider individual initiative, creativity and self-fulfillment
• Focus is on active, positive aspects of human growth

➢ I-Though Dialogue vs. I-It Dialogue

  I-Though Dialogue
  1. Human confirms the other person as being of unique value
  2. Direct mutual relationship

  I-It Dialogue
  1. Person uses others but does not value them for themselves
  2. Focuses on self-fulfilling or self-serving

Utilitarian
  1. Self-disclosing of the therapist’s emotional response to the client’s demonstration of valuing the client’s feelings and perspective

Basic Dimensions Of The Human Condition

➢ The capacity for self-awareness:
  • The greater our awareness, the greater our possibilities for freedom
  
    Awareness is realizing:
    1. We are finite - time is limited
    2. We have potential - the choice to act or not to act
    3. Meaning is not automatic - we must seek it
    4. We are subject to loneliness, meaninglessness, emptiness, guilt and isolation

➢ The tension between freedom and responsibility:
  • People are free to choose among alternatives and have a large role in shaping personal destinies
  • The manner in which we live and what we become are a result of our choices
  • People must accept responsibility for directing their own lives

➢ Creation of an identity and establishing meaningful relationships:
  • Identity is the courage to be
  • We must trust ourselves to search within and find our own answers
  • Our greatest fear - we will discover there is no core, no self
  • Aloneness
    1. We must tolerate being alone with self
    2. We must have a relationship with ourselves first
  • Struggling with identity
    1. We are trapped in a ‘doing’ mode to avoid the experience of being
  • Relatedness
1. At their best, our relationships are based on our desire for fulfillment, not on our deprivation

- The search for meaning:
  1. Finding meaning in life is a byproduct of a commitment to creating, loving and working
  2. Life is not meaningful in itself, the individual must create and discover meaning

- Goals deal with:
  1. Discarding old values
  2. Coping with meaninglessness
  3. Creating new meaning

- Accepting anxiety as a condition of living:
  1. Anxiety arises from striving to survive and maintain our own being
  2. Existential anxiety is normal - life cannot be lived, nor can death be faced without anxiety
  3. Anxiety can be a stimulus for growth as we become aware of and accept our freedom
  4. We can blunt our anxiety by creating the illusion there is security to life
  5. If we have the courage to face ourselves and life, we may be frightened, but we will be able to change
  6. Neurotic anxiety creates guilt

- The awareness of death and nonbeing:
  1. Awareness of death is a basic human condition which gives significance to our living
  2. We must think about death if we are to think significantly about life
  3. If we defend against death, our lives can become meaningless
  4. We learn to live in the “now”
  5. One day at a time results in a zest for life and creativity

Aim Of Existential Therapy

- Rejects the deterministic outlook on mankind
- People are free and responsible for their choices and actions
- People are the authors of their own lives
- Existential therapy encourages clients to:
  1. Reflect on life
  2. Recognize range of alternatives
  3. Decide among them

Goal

- Help clients recognize ways they passively accepted circumstances and surrendered control
- Help clients to start to consciously shape their own lives by exploring options for creating a meaningful existence

Tasks Of The Therapist

- Invite clients to recognize how they have allowed others to decide for them
- Encourage clients to take steps toward autonomy
The Question:
- “Although you have lived in a certain pattern, now that you recognize the price of some of your ways, are you willing to consider creating a new pattern?”

Relationship between therapist and client
- Therapy is a journey taken by BOTH therapist and client
  1. The person-to-person relationship is key
- The relationship demands therapists be in contact with their own phenomenological world
- The core of the therapeutic relationship
  1. Respect and faith in the client’s potential to cope
  2. Sharing reactions with genuine concern and empathy

FAMILY THERAPY MODELS

- **Key Figures**: Nathan Ackerman, Gregory Bateson, Jay Haley, Milton Erickson, Murray Bowen, Carl Whitaker, Virginia Satir, Ludwig von Bertalanffy
- **Theory**: The family is seen as an emotional unit and any changes in an individual impact the functioning of the whole family. The functioning of one member of the family is predictable, and a change in behavior will result in the family unit compensating in some way for the modification. The family is seen as the psychological unit, so treatment is not necessarily aimed at the symptomatic person.
- **Treatment**: The individuals involved in the family system are encouraged to think of issues such as conflict, difficult relationships, loneliness, communications, etc. in terms of a multigenerational family or system. This method of problem solving focuses on individual responsibility and downplays blaming. Individual, couple and family counseling are used to identify and exercise solutions to problems.
- **Relevance**: It is most often applied to family therapy situations. Although the individual may be identified as having the problem, the whole family or parts of the family are treated as a group and enlisted to help change the situation.

FAMILY SYSTEMS THERAPY - MURRAY BOWEN

**Murray Bowen** was interested in a system theory way of thinking.  He felt we have less autonomy in our emotional lives than we assume. Most of us are more dependent and reactive to one another than we would like to think.

Bowen’s success at differentiation within his family convinced him a single, highly motivated individual could be the fulcrum for changing an entire family system.

- Family systems therapy was conceptualized by Murray Bowen
- Began at Meninger Clinic in late 1940s working with schizophrenics
- Bowen was stuck by the emotional sensitivity between patients and their mothers
- At the heart of the problem was anxious attachment, a pathological form of closeness
- Family systems therapy is a form of brief therapy

**Normal Family Development**

- Optimal family development occurs when:
• Members are well differentiated
• Anxiety is low
• Partners are in emotional contact with their own families

Development Of Behavior Disorders

➢ Result from the stress that exceeds a person’s ability to manage when the level of anxiety created by the behavior of the individual exceeds the system’s ability to handle it
➢ It is not the crisis, but the response to it that creates the behavior disorder
➢ The underlying factor in the beginning of psychological problems, is emotional fusion passed down from one generation to the next
➢ Emotional fusion is based on anxious attachment which may be manifested either as dependency or isolation

The Goal Of Therapy

➢ Help individuals learn more about themselves and their relationships so they can assume responsibility for their own problems
➢ Increase parents’ ability to manage their own anxiety and thereby become better able to handle their children’s behavior
➢ Fortify the couples’ emotional functioning by increasing their ability to operate independently from their families-of-origin
➢ Understanding, rather than action, is the vehicle of cure
➢ Change occurs as anxiety is lowered within the current family and between the current family and the families-of-origin

A) Assumptions

Bowen describes how the family, as a multi-generational network of relationships, shapes the interplay of individuality and togetherness using Eight Interlocking Concepts:

➢ Differentiation of the Self - Ego Strength:
  • Differentiation is the process of freeing oneself from one's family
  • Realizing one's own involvement in problematic relationship systems as opposed to blaming others, while still being able to be emotionally related to members
  • The capacity to think and reflect, instead of responding automatically
  • The ability to think and act wisely in the face of anxiety

➢ Triangulation:
  • Anxiety is a major influence
  • The family member with the least differentiation (the most vulnerable) will often be the person most likely to get triangulated within the family
  • A two-person system is unstable because it tolerates little tension before involving a third person
  • Two people in a conflict will draw in a third person to try and fix the problem or take sides
  • A triangle allows the tension to spread
    This lets off steam, but freezes conflict in place
  • As anxiety increases, people experience a greater need for emotional triangles
Nuclear Family Emotional System:
- Undifferentiated family ego mass
- FUSION = families that are emotionally stuck together
- Especially noticed in schizophrenic families
- Existing family emotional patterns passed on to each generation
- They can include:
  1. Overt conflict
  2. Physical or emotional dysfunction in one spouse
  3. Reactive emotional distance and projection of problems onto one or more of the children

Family Projection Process:
- The method by which emotional projections are passed on from one generation to another
- It describes the primary way parents transmit their emotional problems to a child
- For example:
  1. The child that receives projection will have trouble differentiating
  2. This will, in turn, effect his interactions with his own spouse and/or children
- The parent focuses on a child out of fear that something is wrong with the child
- The parent interprets the child's behavior as confirming the fear
- The parent treats the child as if something is really wrong with the child

Emotional cutoff:
- The way people manage anxiety between generations
- People manage their unresolved emotional issues with parents, siblings, and other family members by reducing or totally cutting off emotional contact with them
- The greater the emotional fusion between parents and children, the greater likelihood of a cutoff
- A person may believe being cut off from the family has solved their issues, however, the problems are dormant and not resolved

Multigenerational transmission process:
- The way family emotional processes are transferred and maintained over several generations
- Passing chronic anxiety from generation to generation

Sibling position:
- The order of birth on the sibling totem pole
- People who grow up in the same sibling position predictably have important common characteristics
- For example:
  1. Oldest children tend to gravitate to leadership positions
  2. Youngest children often prefer to be followers.
- Each child has a certain position in the family, which may make them more or less likely to fit some projection of the family

Societal emotional process:
The effects of social expectations about classes, ethnic groups, race, gender, sexual orientation, etc. on the family
- Used early in the field of family therapy to acknowledge the influence of societal pressures/influences
- Later used by feminist Bowenians Monica McGoldrick and Betty Carter who added gender and ethnicity

B) Why People Do What They Do? (What Motivates Them?)
- Bowen spoke of people/families functioning on a single continuum, and there are no different "types" of families
- Optimal development occurs when:
  - Members are differentiated
  - Anxiety is low
  - Parents are in good emotional contact with their families-of-origin
- Each family member plays a different role in each of the subsystems they belong to
- A differentiated self is able to be guided by thoughts or emotion
  - They recognize they need others
  - But they depend less on the acceptance and approval of others
- Individuals who are differentiated:
  - Are able to stay rational, clear headed and able to critically assess the situation without being clouded by emotion even when faced with rejection, conflict or criticism
  - These family members are confident in their own thinking and they make their decisions thoughtfully (not because they are giving in to relationship pressures)
  - They can either support another family member's point of view without becoming wishy-washy or reject another's viewpoint without becoming hostile

C) How Do People Get In Trouble?
- Bowen felt problems within the family unit stem from a multigenerational transmission process, whereby levels of differentiation among family members become progressively lower from one generation to the next
- Unproductive family dynamics of previous generations are transmitted by marriage of undifferentiated individuals
- Issues also occur when "vertical" problems passed on from parent to child interact with "horizontal" problems caused by environmental stressors or transition points in the family development
- Disorders are seen as resulting from emotional fusion - an increase in the level of emotion and anxiety within the family
- Individuals with "low differentiation" are more likely to become fused with predominant family emotional patterns
  - They either conform themselves to others in order to please them
  - Or attempt to force others to conform to themselves
- With a need for self-identify while still belonging to one’s family, they may physically be able to leave but unable to leave emotionally
People who cut off from their original families are more likely to repeat the same patterns in their own relationships
Problems arise when there is an upset to a triangulated relationship that has formerly kept the triad stable

D) How To Help People
- Increase individual family member’s level of differentiation
- Change in one part of the family system affects the whole system, so the therapist’s goal should be to change the individuals within the context of the system
- The therapist must define the presenting problem within a multigenerational framework
- Help to lessen anxiety and increase the parents’ ability to control their own anxiety
- Open closed ties and create the detriangulation of family members
- Put an end to generation-to-generation transmission of problems by resolving emotional attachments

E) What Techniques And Skills Are Used?
- The therapist must attend to:
  - Process (patterns of emotional relations)
  - Structure (interlocking triangles)
  - But not to details
- The therapist must remain neutral
- Bowen did not like to focus on technique; however, he felt therapists should look for fusion within the family by asking questions
- Questions should help to foster self-reflection and be directed to family members one at a time
- Process questions that are:
  - Designed to slow people down
  - Diminish anxiety
  - Start them thinking, not just about how other are upsetting them, but about how they participate in interpersonal problems
- Couples therapy:
  - A triangle is formed - avoid taking sides
  - Couples need to be forced to deal with each other
  - The therapist takes an “I” position
  - Makes non-reactive observations and statements of opinion
  - This technique makes it easier for family members to define themselves and each other
- Individual therapy:
  - Goal is to develop the person-to-person relationships
  - See family members as people rather than emotionally charged images
  - Learn to recognize triangles
  - Detriangle oneself
- The therapist should use relationship experiments by asking the clients to try new behaviors and then pay attention to the processes
The therapist should teach speaking and listening skills to the family

- Coach them how to interrupt arguments and tackle the skill of using the “I-Position” teaching family members how to state their needs and thoughts without over-reacting
- The therapist should emphasize saying what you feel is more productive than commenting on what other family members are doing

Use genograms to look at the family over three generations to help determine critical turning points in the family emotional process, characteristics of family members and provide an evolitional picture of family

Incorporate displacement stories where the therapist narrates an anecdote or recommends movies that can help minimize the defensiveness within a family

F) What Are The Limitations On Those Skills Or Techniques?

- The therapist must be highly differentiated to prevent getting caught in triangulation with the family or couple
- Therapists must be able to tolerate anxiety
- Differentiation requires the therapist to cultivate a personal relationship with everyone in the extended family – which may not be able to take place
- The therapist cannot allow open conflict to occur in sessions
- If underlying conflict is not properly addressed, it can worsen

G) What Are The Professional Implications?

- A well-differentiated "self" is an ideal that no one realizes perfectly
- If the therapist cannot remain free of emotional entanglements, it may lead them to avoid feelings of being stuck or stalemated
- The family may not allow the therapist to keep the emotional tone under control, so therapy may be too anxiety provoking for the family
- Family members may feel the therapist is taking sides (even if that is not the case)
- Although the entire family does not need to be in therapy, treatment requires the therapist to develop an accurate awareness of the entire family
- Feminist critics contend this theory needs to also address the power differentials that can occur between couples

Key Terms

- **Detriangulation:** The process by which an individual removes himself from the emotional field of two others
- **Differentiation of self:** Psychological separation of intellect and emotions, and independence of self from others - opposite of fusion
- **Emotional cutoff:** Bowen’s term for flight from an unresolved emotional attachment
- **Family life cycles:** Stages of family life from separation from one’s parents, to marriage, having children, growing older, retirement and finally death
- **Family of origin:** A person’s parents and siblings
- **Fusion:** A blurring of psychological boundaries between self and others
- **Genogram:** Schematic diagram of the family system
I-Position: Statements that acknowledge one’s personal opinions rather than blaming others

Multigenerational transmission process: The concept of passing on chronic anxiety from one generation to the next

Process questions: Questions designed to help family members think about their own reactions to what they are doing

Triangle: A three person system

Triangulation: Caused by anxiety, a release person is brought into conflict between two people, however, this only freezes that conflict

Undifferentiated family ego mass: Emotional stuck-togetherness or fusion of the family - prominent in schizophrenic families

EXPERIENTIAL FAMILY THERAPY - CARL WHITAKER

Foundation

- Humanistic: Here-and-now
- Gestalt: Role-playing, emotional confrontation
- Psychodrama: Sculpting, family drawing

Cark Whitaker’s basic model stated the cause and effect of family problems is emotional suppression. The tendency in family therapy is to confuse the instrumental and expressive functions of emotion by:

- Trying to regulate children’s actions by controlling the child’s feelings
- Dysfunctional families are less of the emotions that signal individuality
- Children grow up estranged from themselves

The concept was to help families uncover their honest emotions and forge more genuine family ties from enhanced authenticity.

A) Assumptions

- Carl Whittaker’s idea of experiential family therapy was based on a pragmatic stance with the belief that theory can hinder clinical work
- Each family member has the right to be themselves
- Based on the belief of the family being an integrated whole, not as a collection of discrete individuals
- Familial togetherness and cohesion are associated with personal growth
- Emphasis is on the importance of involving extended family members in treatment (especially the expressive and lively spontaneity of children)
- Basis of this bold and inventive approach to family therapy was the result of Whitaker’s spontaneous and creative thinking
- He stressed the importance of genuineness
- Techniques are secondary to the therapeutic relationship
- Whitaker believed in this atheoretical approach based on the assumption that many times, theory is a way for the therapist to create distance from clients
• It also helps to control the anxiety of therapists by allowing them to hide behind their “theory”

B) Why People Do What They Do? (What Motivates Them?)
  ➢ To be authentic and able to freely express oneself
  ➢ Being autonomous while also feeling they are a part of the family
  ➢ To have intimacy
  ➢ Self-determination
  ➢ Self Actualization
    • A term for the innate human tendency for each of us to seek what is best for us
    • This gets subverted by the need to please, but can be released again in the presence of unconditional positive regard

C) How Do People Get In Trouble?
  ➢ Symptoms and interpersonal problems stem from the lack of emotional closeness and sharing among family members
  ➢ The needs of the family may be suppressing the rights of the individual
  ➢ Keeping family secrets can lead to the dysfunction of family members
    • This may also get subverted by social pressures
    • Society enforces repression to tame people’s instincts and make them fit for group living
      1. Families add their own controls to achieve peace and quiet
      2. Family myths
    • Set of beliefs based upon a distortion of historical reality and shared by all family members that help shape the rules governing family dysfunction
      1. Mystification
      2. Concept that many families distort their children’s experience by denying or re-labeling it
  ➢ The family infringes upon its individual members’ growth and freedom
  ➢ Personal choice has been comprised
  ➢ Families put on a façade, which restrains its members from being authentic

D) How To Help People
  ➢ The therapist’s active and forceful personal involvement is the greatest way to bring about change in families, with the goal of promoting flexibility among family members
  ➢ A goal of therapy is to help family members open up and more fully be themselves by freely expressing what they are thinking and feeling
  ➢ The therapist conducts a family therapy session with the intent of it being a growth experience for him/herself, thereby inspiring the family to do the same
    • Therefore, the therapist helps family members focus on the here-and-now by the therapist “being with” the family
  ➢ Focus on expanding immediate personal experiences and increasing the family’s awareness by achieving a higher level of intimacy
  ➢ Unmask pretense, create new meaning and liberate family members to be themselves
Aim for authenticity, as there is no right or wrong way to be
Attempt to unmask and tap into family secrets
Guide the family through three specific phases:
  • **Engagement** (the most powerful)
  • **Involvement** (dominant parent figure, adviser)
  • **Disentanglement** (more personal, less involved)

E) What Techniques And Skills Are Used?
  ➢ Whitaker pioneered the use of co-therapists as a way to maintain objectivity
  ➢ Whitaker believed in doing therapy with a “crowd” in the room
  ➢ Whitaker - Psychotherapy as Absurd
    • Augmenting the reasonable qualities of patients response to absurdity (calling one’s bluff) like sarcastic teasing
    • The hope is that patients will get objective distance by participating in the therapist distancing
    • The danger is, patients will feel made fun of or get hurt
  ➢ This type of therapy incorporates highly provocative techniques or interventions intended to create turmoil, turn up the emotional temperature and intensify what is going on here-and-now in the family, while then coaching the family how to get out of the turmoil
  ➢ The therapist is active and directive to help create an intensified effective encounter for family members, which allows for the family’s own healing and self-actualizing processes to take hold
  ➢ The therapist takes an atheoretical stance as a way to intensify what the family members are presently experiencing and encourage them to reach into their unconscious to understand what is really going on in the family
  ➢ Facilitation of individual autonomy and a sense of belonging in the family
  ➢ Encourage spontaneity, creativity, the ability to play and the willingness to let go and be “crazy”
  ➢ The therapist's role is more of a facilitator; through the use of reflection, he/she exposes the process of family interaction while joining the family process as a genuine and non-defensive person

F) What Are The Limitations On Those Skills Or Techniques?
  ➢ The greatest limitation of Whittaker’s approach: it deemphasizes theory opting for the “one-size fits all” technique
  ➢ Therapy follows a subjective focus and centers around the subjective needs of the family members, which leaves room for bias or skewed perceptions
  ➢ This approach relies on a highly involved therapist model where the therapist must be visible, take risks and get involved with the family in their sessions

G) What Are The Professional Implications?
  ➢ Whitaker typically relied on his own personality and wisdom rather than any fixed therapeutic techniques to stir things up in families, so it is a hard theory to “teach” in terms of technique
Whitaker believed in a confrontive approach, which may not work well with fragile families.

This method incorporates an intuitive form of therapy, which lower-functioning families/family members may not grasp.

He also acquired the reputation as the most disrespectful among family theorists since he often attacked or sought to overthrow traditional or popular ideas in family theory.

Some families may not appreciate the unrestrictive, intuitive, non-interventionist and sometimes, outrageous nature of this approach.

Rather than focusing on alleviating symptoms, this approach focuses on enhancing the quality of life of the family members:

• Although some focus on changing the family system may develop, it is not the primary goal.
• Therefore this method may not be well suited for families who are looking for crisis management.

CONJOINT FAMILY THERAPY - VIRGINIA SATIR

Virginia Satir’s novel approach to family therapy centered on her idea that usually the problem at hand was not the real issue, instead, she believed it was the manner in which the person dealt with the issue that actually created the underlying problem. Whitaker and Satir had theoretical differences in their approaches: Whitaker believed self-fulfillment depends on family cohesiveness, whereas Satir felt the importance of good communication among family members.

A) Assumptions

• Virginia Satir’s approach is based on congruence and openness in communication.
• Emotional experiencing.
• Families have many spoken and unspoken rules.
• Relies on the validation process.
• Emphasis is on family roles where the role played by each family member is based on one’s behavior:
  • Peace-keeper
  • Victim
  • Hard-working caregiver
  • Disciplinarian
• Focus on emotional honesty, congruence and systemic understanding.
• Stuck families follow broken rules.
  • Pathology is considered a deficit in growth.
  • In a dysfunctional family, symptomatic behavior makes sense and is also covertly rewarded.
• People rely on a “Nurturing triad” (or a primary triad) that consists of the two parents and child where the child is nurtured as their source of identity.

Satir believed in **Five Styles of Communication**. She considered four as dysfunctional and one as functional:

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Dysfunctional:
- **Placater**: Fearing rejection, they want to please, becoming dependent
- **Blamer**: To cover their own inadequacies and emptiness, they attempt to control others by bullying and attacking their faults
- **Super Reasonable**: (coined Computers) Keeping others at a ‘safe distance’, they depend upon detachment to protect their own feelings skirting emotional issues with intellectual rationalization
- **Irrelevant or Distractor**: Rather than face the situation, they will make the problem go away, pretend it doesn’t even exist, hoping others involved will do the same
  1. Often the youngest child falls into this category

Functional:
- **Leveler or Congruent**: Telling it like it is, they are honest and genuine

B) Why People Do What they Do? (What Motivates Them?)
- Strive for honesty and openness in family communication
- Family members are considered “functional” when they are given the opportunity to be an individual
  - This entails the family member having a life separate from the family
  - With freedom and flexibility in their skills to communicate with other family members
- When family members allow their similarities to unite them and use their differences to help them grow
- The core of a healthy “self” embodies eight levels:
  1. Physical
  2. Intellectual
  3. Emotional
  4. Sensual
  5. Interactional
  6. Contextual
  7. Nutritional
  8. Spiritual

C) How Do People Get In Trouble?
- Self-esteem is lowered due to family not respecting its members’ needs.
- Family members adopt defensive stances for coping with stress such as:
  - Placating-enabler
  - Acting out
  - Entertainer
  - People pleaser
  - Rescuer
- When family members start operating under unspoken, absolute rules that are impossible in nature
  - For example: always look happy, never be mad at your mother, etc.
  - A child will adhere to these rules to survive within the family, yet they become burdensome as an adult
When members in a family begin to act, think and feel the same way due to dysfunction

- This can also stem from family members being controlled by punishment, guilt, fear or dominance

Family members are considered “dysfunctional”:

- When the poor self-esteem of the parents leads to closed communication
- When members become incapable of establishing autonomy from one another
- Family members’ relationships become strained with little room for individuality or intimacy
- The establishment of rigid patterns emerge

There are three parts to every communication: me, you, context; dysfunctional communications only account for two at a time

D) How To Help People

- Encouragement of growth by acknowledging differences
- A goal of therapy is to enhance the self-esteem of family members by basing family decisions on individual needs
- Transform extreme family rules into useful and functional rules
- Focus on enhancement and validation of self-esteem
- Assess, strengthen and enhance coping skills
- Identify family roles; help to transform family roles into relationships, and family rules into guidelines

The overall goal is to liberate the family, so they adhere to the 5 Freedoms:

- To see and hear what is here instead of what should be, was or will be
- To say what one feels and thinks, instead of what one should
- To feel what one feels, instead of what one ought
- To ask for what one wants, instead of always waiting for permission
- To take risks in one's own behalf, instead of choosing to be "secure" by not rocking the boat

E) What Techniques And Skills Are Used?

- This approach stresses the involvement of the therapist with the family
- Family mapping and chronologies
- Create new meaning and liberate family members
- Encourage open communication, where individuals are allowed to honestly report their opinions and perceptions
- Help family members construct a mind, soul, body triad as a current basis of self-identity
- Use of the Intergenerational Model of Family reconstruction:
  - A psycho-dramatic reenactment of a significant event used to help unlock the point from which the dysfunctional patterns stem
- Use of touch or connection to demonstrate empathy/compassion and “not-so-friendly” touch
- Co-therapy to balance out transference and prevent being inducted (drawn into families)
- Uses of self as catalyst of change
Don’t leave the family to work it out
Encourage them to share what they are feeling with each other when you see something going on inside one of them

Family Sculpting
- Can be used to demonstrate current family interactions or past members of the family to arrange others
- Graphic means of portraying each person’s perceptions of the family and his/her place in it
- Virginia Satir uses ropes and blindfolds to dramatize constricting roles families get trapped in

Family puppet interviews
- Make up a story using puppets as a vehicle for highlighting conflicts and alliances
- This can be difficult to use, resistance is often found as adults struggle to tell a story

Family art therapy
- Produce a series of drawings
- Joint family scribble - each person makes a quick scribble and everyone incorporates their own
- Conjoint family drawings - warm families up and free them to express themselves

Draw a picture of how you see yourself as a family
- Reflect on disclosure of perceptions that haven’t been discussed
- May stimulate person drawing to realize something once unrealized

Gestalt therapy techniques
- Empty chair
- Speak to another or oneself in an opposing chair

Role Playing
- Experience, in order to be real, must be brought to life in the present
- Recollection of past events and consideration of hoped for or feared future events can be immediate by role-play

Satir’s 4 Family Games:
- Rescue Game: One family member placates (agrees), one blames (disagrees) and one is irrelevant (distracts)
- Coalition Game: Two people always agree and a third disagrees, or two disagree and one agrees
- Lethal game: All agree with everyone else at the expense of their own needs
- Growth Game: People either agree or disagree according to their experiential reality, while remaining a part of the system

F) What Are The Limitations On Those Skills Or Techniques?
- This approach relies on the utilization of sight, sound, touch, metaphor, demonstration, dialogue and group exercises in the process of change and learning
- Some therapists may not be comfortable with the experiential basis of Satir’s ideas – aiming for the goal that families attain an effective, emotional therapeutic experience
The therapist must be well versed in family reconstruction (an exercise where roles in significant family historical events are directed by the therapist) and competent in being able to analyze how family members handle differences.

G) What Are The Professional Implications?

- Techniques are secondary, therefore some therapists who rely on technique may have difficulty embracing this approach.
- This approach includes ideas/viewpoints from all the schools of family therapy:
  - For example, the emphasis on triads and sculpting deal with boundary and hierarchical issues occurring within the family (this touches upon both structural and strategic tenants).
  - A therapist not knowledgeable with all of these schools of thought may have difficulty embracing Satir’s model.
- Strong weight is placed on intergenerational issues – this may not apply to all families.
- This approach includes fostering a greater awareness and has family members participate in exercises of both the mind and body:
  - Families with a more concrete nature may not benefit from some of the more symbolic therapeutic techniques of sculpting, drama, metaphor and story-telling.

- Goals for the family:
  - Improved communication and reduced conflict.
  - Growth, not stability: symptom reduction is secondary to greater freedom of choice.
  - Increased personal integrity (congruence between inner experience and outer behavior).
  - Less dependence.
  - Expanded experiencing.
  - Emphasis on the feeling side of human nature.
  - Improved autonomy for each member.
  - Improved agreement about roles.
  - Merger of needs for individual growth and strengthening the family unit.

**STRATEGIC FAMILY THERAPY - ERICKSON, HALEY**

Based on Bateson’s model, strategic family therapy is a form of brief therapy. Milton Erickson and Jay Haley are attributed as the founders. Erickson stressed a strategic approach to therapy, pragmatic and problem solving in conjunction with hypnotherapy. Haley developed his own brief therapy model focusing on context and possible function of symptoms. He instructed clients to act in a manner contradictory to their maladaptive pattern. Along with Cloe Madanes, he founded the Family Therapy Institute.

**Basic Principles**

- Three different models:
  - Mental Research Institute (MRI)
  - Haley and Madanes approach
  - Milan Model – Concentrating on Anorexia Nervosa and Schizophrenia
- Strategic family therapy focuses on the process.
- It is clever, prescriptive and systematic.
• It can also be considered manipulative

- The basic belief: People are always communicating
  • Communication is either:
    1. "Report" (what happened) or
    2. "Command" (do something)
      a. Command messages are patterned as family rules

- Family Homeostasis
  • Rules maintain family homeostasis and keep things the same
  • Negative Feedback: Conservative efforts to keep things from changing

- Circular Causality
  • Does not look for underlying motives for behavior
  • Instead, points to circular causality (a change of communication patterns) in the form of feedback loops

- Feedback Loops
  • Are chains of stimulus and response
  • Problems are made worse when a problem behavior elicits a response that makes it continue or worsen
  • "Positive feedback loop" is the center-piece of the strategic model

- Types of change include:
  • First order change: When a behavior in the system changes
  • Second order change: When the rules that affect a behavior change
    • Rules are changed by re-framing interpretation of a behavior

- Family rules around hierarchical structure are often a cause of family problems

Normal Family Development
- Normal families depend upon two important processes:
  • Maintaining integrity in the face of environmental changes through negative feedback
  • Adapting to changing circumstances when remaining the same (staying rigid) doesn't work
    1. Adapting to change utilizes positive feedback

Development Of Behavior Disorders
Because the basic function of a family is to maintain homeostasis through negative feedback loops (staying the same) and positive feedback loops (adapting to change), a family experiences disorder when their patterns of interaction become too rigid or dysfunctional.

- Metacommunication
  • Communicating about the communication
  • Required to solve a problem a new way that will correct the dysfunction

- Dysfunction messages include:
  • Paradoxical injunctions
    1. Demanding a behavior that by nature can only be spontaneous
    2. For example: "You should love me."
  • Double binds
1. A result of paradoxical injunction
2. Created when two contradictory messages are given at the same level of importance
3. For example: You demand someone tell you how they feel and then yell at them when they do

**Explanations For Malfunction**

- **Cybernetic**
  - Difficulties are turned into problems by using misguided solutions and forming positive feedback escalations

- **Incongruous Hierarchies**
  - A structure that doesn't work (parents ruled by a child)

- **Function**
  - Symptoms serve a function
  - For example: Mom isn't leaving abusive dad, so the child becomes sick to give mom a chance to be strong

**Goals Of Therapy**

- Define resolvable complaints
- Identify attempted solutions
- Understand the client’s language for describing the problem
  - Haley believed symptomatic behavior is voluntary
  - Milan Group believed preliminary hypothesis about the assumption that the identified patient’s problems are serving a homeostatic or protective function for the family
  - The idea is to apply techniques to manipulate and solve the problem with or for the family
  - Paradoxical directives are used to break down resistance and address symptoms

**The Counseling Process**

- Introduce treatment setup
- Inquire about and define the problem
- Estimate the behavior maintaining the problem
- Set goals for treatment
- Select and make behavioral interventions
- Terminate therapy

**Techniques**

- Identify behaviors that maintain problems
  - They are generally tried solutions that did not work because they deny the problem exists
  - An attempt to solve something that isn't really a problem makes a solution impossible
  - For example: A father buys a child toys when what the child wants is attention
- Reframe the problem for the family
• For example: Explain to that particular child, “Your Daddy doesn't know how to tell you he loves you, so he buys you toys instead.”

➢ Interrupt problem-maintaining sequences by doing something that runs counter to common sense
  • This is a paradoxical intervention
  • For example: Tell a child, when Mom starts fussing over you, act over dependent until she can’t maintain the behavior

➢ Prescribe the symptom
  • Ignore someone's depression to get attention

➢ Directives are used as thoughtful suggestions targeted to specific requirements of the case

**STRUCTURAL FAMILY THERAPY - SALVADOR MINUCHIN**

Developed by Salvador Minuchin, structural family therapy divides family problems into those relationships within a family unit or those in what he termed the ‘subsystems’ of the family.

**A) Assumptions**

➢ Structural changes must take place within a family before an individual’s symptoms can be diminished

➢ Family interactions reveal the structure and organization of the family

➢ Family structure is defined as an invisible set of functional demands or rules that organize relationships family members have with one another

➢ Symptoms are a by-product of structural failings

➢ Families can be divided into subsystems:
  • Spousal (husband and wife)
  • Parental (father and mother)
  • Sibling (children)
  • Extended (grandparents and other relatives)

➢ Boundaries (“emotional barriers”) are formed in each family and serve to protect and develop the integrity of individuals, the subsystems and the family itself

**B) Motivation**

➢ Family members strive for clear and healthy boundaries
  • Each member needs to establish a personal identity while also feeling a sense of belongingness within the family system

➢ Each family member plays a different role in every subsystem of which he/she is a member

**C) Dysfunction**

➢ Structural difficulties emerge when one subsystem takes over or encroaches upon another

➢ When boundary extremes take place, the family system is no longer healthy or clear

➢ When family members become enmeshed:
  • Each member becomes overly involved with others and roles seem to overflow and merge
  • This type of system encourages dependency on the parents

➢ Problems also arise when family members become excessively detached from one another
• When such disengagement has occurred within the family, its members become rigid and inflexible
  ➢ Faulty structures consist of subsystems that have inappropriate functions and tasks as well as those with diffused or rigid boundaries

D) Intervention
  ➢ The therapist observes the family to determine its structure by assessing who says what to whom, how it is said and what results
  ➢ A goal of therapy is to decrease symptoms of dysfunction
  ➢ The therapist should strive to create change in the family structure by:
    • Helping the family to create more appropriate boundaries
    • Modify its transactional rules
    • Establish a successful hierarchical structure
  ➢ The therapist intervenes in ways designed to transform an ineffective structure into a more effective one
  ➢ To begin structural change, the family as a unit must be actively engaged

E) Techniques
  ➢ Techniques are active, directive and carefully thought out
  ➢ In family mapping, the therapist draws a diagram to identify boundaries, underlying structure and transactional styles
  ➢ When using enactment, a therapist has the family re-create, in therapy sessions, conflict situations that typically occur at home
  ➢ When a therapist supports the family in a leadership position while developing and maintaining a therapeutic alliance with them, the technique of joining is being employed
  ➢ In reframing, a therapist helps the family to understand problems by defining the problematic situations in a new light or giving them a different interpretation

F) Limitations
  ➢ Since the therapeutic goal is to challenge rigid transactional patterns, the family may not be willing to accept the changes or able to successfully implement them
    • Desirable changes include:
      1. Increased flexibility in family interaction
      2. Clearer boundary definitions
      3. Alteration of dysfunctional family structures
  ➢ The family may easily fall back into the original patterns of dysfunction
  ➢ There is a high reliance on change occurring within the context of the therapy session
  ➢ Structural family therapists place little importance on the past history of the family focusing more on the here-and-now, which may hamper resolution of certain difficulties

G) Implications
  ➢ The emphasis on the nuclear family lessens stress on the wider system
    • Critics say the influence of interactions with greater environmental systems (socio-cultural contexts including school, employment and healthcare) receives inadequate attention
This type of therapy is not suited for families with active domestic violence or with a member threatening harm to himself/herself. An individual’s symptoms cannot be reduced until structural changes are successfully implemented within the family. Because of focus upon the family as a unit, psychological factors affecting individual family members may be ignored. Incorporating a traditional gender role mentality, this theory may ignore power and vulnerability issues of men and women.

Key Concepts
There are three constructs of structural family therapy: Structure, Subsystems and Boundaries.

- **Family Structure**
  - The functional organization of families that determines how family members interact.

- **Hierarchical Structure**
  - Family functioning based on clear generational boundaries, where the parents maintain control and authority.

- **Subsystems**
  - Smaller units of families determined by generations, sex or function.

- **Boundaries**
  - A concept used in structural family therapy to describe emotional barriers that protect and enhance the integrity of individuals, subsystems and families.
  - Can be diffused (enmeshed), rigid (disengaged) or clear.

- **Disengagement**
  - Minuchin’s term for psychological isolation that results from overly rigid boundaries around individuals and subsystems in a family.

- **Enmeshed**
  - Minuchin’s term for loss of autonomy due to a blurring of psychological boundaries.
  - **Enmeshment** encourages somatization, disengagement and acting out.

- **Accommodation**
  - Elements of a system automatically adjust to coordinate their functioning.
  - People may have to work on it.

- **Ecological context**
  - The family's church, schools, work and extended family members.

- **Sick child**
  - Family conflict defuser.

- **Generic and idiosyncratic rules**
  - That regulate transactions and govern structure.

- **Power**
  - Determined by authority and responsibility for acting on it.

- **Coalitions**
  - Can be stable or detouring.
Sets
- Repeated family reactions to stress

Normal Family Development
- A normal family has the structure to deal with their problems
  - This is accomplished with accommodation and boundary making

Development Of Behavior Disorders
- In the face of external pressures and developmental transitions, less adaptive families increase the rigidity of structures that are no longer functional
  - Disengaged families or subsystems
    - Boundaries are rigid and the family fails to mobilize support when it’s needed
      - Enmeshed families or subsystems
    - Boundaries are diffuse and family members become dependent upon one another
      - Cross-generational coalition
- An inappropriate alliance between parent and child, who side together against a third member of the family

Goals Of Therapy
- Structural treatment is designed to alter the organization of the family so its members can better deal with their own problems
- The therapy goal is structural change
  - Problem solving is a byproduct
- The family is changed by the therapist joining the family, probing for areas of flexibility and then activating dormant structural alternatives
  - Joining gets the therapist into the family
  - Accommodating to their style gives the therapist leverage
  - Restructuring maneuver transformations in the family structure
    1. The first task is to understand the family’s view of the problem
    2. Then the therapist reframes these formulations into one based upon an understanding of the family structure
    3. The therapist works with the structure they see, not what the family members describe

Techniques
- Joining and Accommodation
  - The therapist works to build an alliance of understanding with each member of the family
- Working with Interaction
  - Using enactments to view the family’s interactions
- Structural Mapping
  - Preliminary assessments are based on interaction in the first session
  - In future session, these interactions are later refined and revised
- Highlights and Modifying Interaction
Recognizing problematic transaction between family members
• Interactions can be modified by using empathy, shaping, competence and intensity

➤ **Boundary Making**
• For enmeshed families, interventions are designed to strengthen boundaries

➤ **Unbalancing**
• The goal is to change relationships within a subsystem in order to realign the relationships between subsystems

➤ **Challenging Unproductive Assumptions**
• Changing the way family members relate to each other
• Offers alternative views of their situation

**SYSTEMS THEORY**
A form of brief therapy, this concept was originated by **Ludwig von Bertalanffy**. It offers the framework to explore a group of organisms to describe how they work together to accomplish one result. How they thrive or die in accordance with their openness to their environment. **Margaret Mead** and **Gregory Bateson** furthered Bertalanffy’s theory by incorporating the concepts of positive and negative feedback. Other theorists who also used this view in their structural concepts were **Jean Piaget** and **Noam Chomsky**.

**The System**
➤ Focus changed from linear causality to circular causality
➤ Idea that events are related through a series of interacting loops or repeating cycles
➤ A set of elements standing in interaction
➤ Each element is affected by whatever happens to any other element
➤ System is only as strong as its weakest part
➤ System is greater than sum of its parts
➤ Boundaries are more or less permeable depending upon the amount and type of feedback received

**Key Terms**
➤ **Homeostasis**: Defined as “relationally stable state of equilibrium”
  • In the family system, it is the way of dealing with issues and change by keeping things the same so as not to face problems
  • It is safer not to rock the boat
➤ **Negative Feedback**: (homeostasis monitor) Behavioral reactions that stabilize a process system returning it to its equilibrium state
  • E.g., When there is an issue causing a scene, one glance at dad, his arms crossed and that ‘look’ will bring the disruptive family member under control
➤ **Positive Feedback**: Pro-active behavior that rocks the equilibrium of the family system and causes issues within the system
  • Designed to cause an imbalance in the family unit and redefine it in a positive way
  • E.g., A man who is self-employed agrees to work from home and take care of the kids so his wife can get a job changes the way the family operates
- **Calibration:** The normal or standard operational system of the family
- **Wholeness:** Refers to all individual family members combined into the one family system and their interdependence
  - Idea that working on one individual within the family system will have a ripple effect causing change in the rest of the family members within the system
- **Equifinality:** States the same results can be accomplished by different family systems
  - The therapy process and what is currently happening within the family is more important than the what or whys of the actual family exchanges
- **Equipotentiality:** Conversely, that same family system can also wind up with several different results
  - E.g., Incest within a family system can lead individual family members to several different possible problems in adulthood such as promiscuity or fear of sex
- **First Order Change:** Refers to transformation happening *inside* a family system but having no effect on the family system itself, leaving it unchanged
- **Second Order Change:** These are changes that actually effect the structure of the family system and how it ultimately functions
- **Non-Summativity:** Being the ‘sum of its parts’, a family system can be therapeutically treated as a unit, not simply as individual members

**Interventions**
- Help clients identify past conflicts which may be emerging and effecting current situations
- The therapist helps the family recognize defense mechanisms and shows them ways to deal with maladaptive family behavior

**Techniques**
- **No-fault:** Within the family system no individual is blamed for existing problems
- **Reframing:** The difficulty is not assigned to an individual or identified patient, the family is the problem and is the focal point of the therapeutic intervention
- **Focus:**
  - Belief systems
  - Rules, regulations and roles
  - Expectations and value system
  - Support system
  - Family hierarchy

**Feminist Family Therapy**

**Foundations**

Feminist family therapy emerged in the late 1960’s continuing into the 1970’s.

- Betty Carter
  - In 1977, was the first woman to found a major family therapy training institute
- Rachel Hare-Mustin
  - One of the first women to challenge the family-therapy establishment
• In 1978, wrote, "A Feminist Approach to Family Therapy"

- Marianne Walters
  • In 1980, founded The Family Therapy Practice Center in Washington D.C.

- Peggy Papp
  • One of the first women to gain recognition and prominence in the field of family therapy

- Olga Silverstein
  • Returned to school in her fifties after spending thirty years as a housewife and mother
  • She was refused admission on the basis that she was "too old" to make contributions to the field
  • But later, she was accepted at Hunter College School of Social Work, where she met Betty Carter who was earning her Masters in Social Work

- Carter, Papp, Silverstein and Walters formed a collaborative relationship in the seventies
  • Workshop "Women as Family Therapists"
  • Formed what is known as, The Women’s Project in Family Therapy

- Thelma Jean Goodrich
  • Wrote books on the issues of gender in family therapy

- Bepko & Krestan
  • "Too Good For Her Own Good"

- The Family Institute of Westchester
  • One of the leading training facilities in the United States
  • Curriculum where gender sensitivity is interwoven into all aspects of training

- The strategies used in this theory are intended to lead to the recognition and validation of inequality and what changes can be made to end it

- It acknowledges gender roles and socialization effect:
  • Each individual in the family system
  • Interpersonal relationships in the system
  • Relationships between the family and society
  • The client and therapist exchange

- Originally, family theories simply ignored sexual stereotyping in families
  • Complementary
    1. Systemic concept that suggests a temporary inequality between partners
    2. The inequality is complementary and serves to stabilize the relationship
    3. Does not take into consideration that women are ultimately at a disadvantage living in a society which keeps the women in a disadvantaged position

  • Neutrality
    1. A position recommended that encourages the therapists to maintain a position of neutrality with the couple or family
    2. The goal is to have all members of the family feel sided with and not against
    3. However, the relationship is unequal to begin with, so it is maintaining a position of inequality by siding equally

  • Circularly
1. Suggests that responsibility for interactional dyads is equal
   a. For example: It would suggest that even in cases of domestic violence, she is equally as responsible for the abuse as he is
2. The therapist who remains neutral by means of silence in a clinical situation like this, is encouraging the unequal distribution of power in the system

The Therapist Must Remember There Are Socialized Gender Differences
- Men are socialized to be task focused
- Women are socialized to be emotional caretakers
- Masculinity is defined through separation
- Femininity is defined through attachment
- The male gender is threatened by intimacy
- Females are threatened by separation

You Must Learn To Incorporate The Gender Lens In Therapy
- In order to treat the system effectively, therapists must address the socially prescribed role
  - For example:
    1. Many men have not been taught how to have a closely connected emotional relationship
    2. Moving an “uninvolved” father closer to his children and pushing the “overly involved” out does not serve to connect the couple on a more intimate level, rather it mimics the emotional distance the couple started out with
- In cases of decreased sexual vigor, it is important to know and discuss in the therapy room the sexual oppression of women in this country
  - Women are taught to be "good girls"
  - That they are not to enjoy sex, discuss sex and absolutely should not be sexually aggressive
  - In the cases of a lesbian couple with low sex frequency, both women may be awaiting the other to initiate sex
- There may be mixed messages:
  - In the case of families with children who are involved in the larger system, that very system encourages dependence upon helpers and yet it pushes for autonomy between mother and especially sons
  - The female, usually the mother, is expected to model dependent relationships while letting her children go
  - This does not set up a positive paradigm for interdependent relationships

Humanistic Therapy
- **Key Figures**: Abraham Maslow, Carl Rogers, Fritz Perls (Gestalt), Eric Berne, Clark Moustakas
- **Theory**: Rejecting determinism and putting an emphasis on subjective meaning and positive growth, humanistic therapy departed from the psychodynamic and behavioral based schools of psychotherapy. Growth and self-fulfillment are the primary focus in
humanistic therapy. The unconscious and environmental issues are considered, but freedom of choice in creating one’s experience is the key.

- **Treatment**: The therapist interacts with the individual in a genuine and non-judgmental manner. Using empathy, open-ended responses, reflective listening and hypothetical interpretations, the therapist guides the client to a place where his perceptions of self are more consistent with his actual self.

- **Relevance**: Effective for high functioning individuals who are experiencing problems dealing with inner struggles and conflicts, primarily V-Codes and mild adjustment disorders.

If a lower level need is no longer met, the individual regresses to satisfy that basic need. This is called "Satisfaction progression." After an individual meets a lower level need, they progress to attempting to satisfy the next higher level need. Unsatisfied needs are basic motivational forces.

**Abraham Maslow** and **Carl Rogers** are among those humanist theorists who set aside the perspectives of testers, behaviorists and psychoanalysts in favor of a belief in basic human goodness combined with people's natural desire to do better.

**PERSON-CENTERED THERAPY - CARL ROGERS**

First called non-directive, then client-centered, Rogerian therapy (after psychologist **Carl Rogers**) is now termed person-centered and has become the third force in psychology. In person-centered therapy, the counseling process is determined by the client rather than the therapist. Based on the belief that individuals are rational, good and responsible, Rogerian therapy is humanistic. Self-acceptance is a basic construct of this approach. Congruence occurs when what a person would like to be is in accordance with the perception of how he/she actually is.

**Goals Of Person-Centered Therapy**

- Deal with the here-and-now
- Help clients grow so they can better cope with present situations and future problems
- Rather than looking to solve the client’s problems, the person-centered therapist wants to encourage the client to move towards self-actualization

**Characteristics Of A Person Progressing Toward Self-Actualization**

- Openness to experience
- Self-trust
- Internal source of evaluation
- Willingness to continue growing
- Since the process is ongoing, one is never completely self-actualized

**Techniques Of Person-Centered Counseling**

- Since it is the client/therapist relationship that brings about the growth, there is no set technique

**Common Factors Of Gestalt And Person-Centered Therapies**

Sharing a respect for the client’s subjective experience and a trust in the client’s capacity to make positive and constructive choices, both are experiential and relationship oriented. Both therapies...
emphasize a vocabulary of freedom, choices, values, personal responsibility, autonomy, purpose and meaning.

Significant differences are also present. Gestalt takes the position that humans are faced with the anxiety of creating a never-secure identity in a world that lacks intrinsic meaning. In contrast, humanistic therapists stress self-actualization.

The person-centered counseling of Carl Rogers is grounded the goal of self-actualization, which is the innate predisposition to develop all of one's capacities for the maintenance and growth of personality. Assuming faith in the client's problem-solving abilities, the therapist uses the "if - then" principle. If a client believes in the counselor's genuineness, empathic understanding and unconditional positive regard, then the client will approach positive change and self-actualization. To convey genuineness, Rogerian counselors draw upon their inner experiences during counseling.

An empathetic understanding of the client's feelings comes through the counselor's genuine experience of his/her own feelings. Unconditional positive regard is acceptance of and respect for the client's individuality, stemming from trust in the client's self-directing capacity for positive change. Since present experience provides the means to personal growth, the person-centered counselor serves as facilitator, helping the client to find meaning in inner experiences. By freely showing responsive warmth, meanwhile avoiding evaluative judgments and probing questions, the therapist encourages a permissive atmosphere without pressure or coercion.

Person-centered counseling often refers to the counselor as "helper" and the client as “the other.” The therapist assumes a client has potential to develop self-regard and to differentiate between positive and negative inner experiences. Affected by the reactions of others and by introjection of external conditions, an individual encounters conflict when personal needs and desires run counter to needs and desires of significant others in the environment. Intervention is needed when environmental needs routinely eclipse self-regard needs. Person-centered counseling seeks to allow conflicted individuals to incorporate these negative organismic needs, once denied, into their self-concepts.

**Theoretical Foundation**

Focus is on the person, not the presenting problem.

- **Humanism**
  - Philosophical movement that emphasizes the worth of the individual and the centrality of human values
  - Attends to matters of ethics and personal worth
  - Gives credit to the human spirit
  - Emphasis is on the creative, spontaneous and active nature of humans
  - Optimistic
  - Human capacity to overcome hardship and despair

- **Non-Deterministic**
  - Belief that it is an oversimplification to view people as controlled by fixed physical laws
• Encouragement of therapy that considers individual initiative, creativity and self fulfillment

➤ **Self Actualization**
  • Innate process by which a person tends to grow spiritually and realize potential
  • Change occurs through self-actualization

➤ **The Experiencing Person**
  • Important issues must be defined by the client
  • Special concerns are discrepancies between what a person thinks of himself and the total range of things he experiences
  • The individual is not sick in a medical disease sense - pathology stems from the dissonance between three selves existing in each individual:
    1. **The self-concept** - The way in which one sees himself/herself
    2. **The real self** - The actual person
    3. **The ideal self** - The way in which one wants to be or ought to be
  • The closer (more congruent) the three selves are, the healthier the individual

**Techniques**
➤ Listening
➤ Accepting
➤ Respecting
➤ Understanding
➤ Empathic Responding

**Six Conditions Necessary And Efficient For Personality Changes To Occur**
➤ Two persons are in physiological contact
➤ First, the client is experiencing incongruence
➤ Second, the therapist, is congruent or integrated in the relationship
➤ The therapist experiences unconditional positive regard or real caring for the client
➤ The therapist experiences empathy for the client’s internal frame of reference and endeavors to communicate this to the client
➤ The communication to the client is, to a minimal degree, achieved

**Three Requirements For Therapy**
➤ **Genuineness**
  • Accurate empathic understanding
  • Genuineness or realness in relations between therapist and client
  • Being oneself in the therapeutic relationship with the client

➤ **Unconditional positive regard**
  • Acceptance and caring
  • NOT approval of all behavior

➤ **Congruence**
  • Understanding of client’s frame of references
  • Ability to deeply grasp the client’s subjective world and communicate this to the client
Role Of The Therapist

- To focus on the quality of the therapeutic relationship
- Serve as a model of a human being struggling toward greater realness
- Be genuine, integrated and authentic, without a false front
- Can openly express feelings and attitudes that are present in the relationship with the client

Treatment

- The individual is seen as a person, not a patient
- The process of treatment is a two-way relationship with the counselor creating an atmosphere of unconditional positive regard for the person
- The counselor uses reflection (rewording fragments of the client’s speech) and clarification (suggesting a core or essence to a grouping of remarks made by the client) to aid the client in his personal development
- The client must be reasonably verbal and free of psychosis or delusions
- The ability to bond with the counselor is important

GESTALT THERAPY - FRITZ PERLS

Based on existential principles, Gestalt therapy was founded by Fritz Perls, wife Laura Perls and Paul Goodman. It includes the concepts of personal responsibility, unfinished business and the here-and-now. The goal is to become complete and whole individuals.

During therapeutic encounters, the therapist needs to be "fully present." Similar to Rogerian therapy, Gestalt views growth as occurring due to genuine contact between two people rather than by the imposition of techniques. Neither is growth fostered by the therapist’s interpretations. In fact, interpretation is made by the client rather than by the counselor. While encouraging the client to believe that growth is possible, the therapist has to be creative in helping the individual deal with the here-and-now as well as with unfinished business.

- Gestalt asks “What?” or "How?" rather than "Why?"
- Gestalt relies on the concept of layers of neurosis
- Dreams are considered important

Foundations

- Existential and Phenomenological
  - Grounded in the client’s “here-and-now”
- Initial goal is for clients to gain self-awareness of what they are experiencing and doing now
- Promotes direct experiencing as opposed to the abstractness of discussing situations
- Rather than talking about childhood trauma, the client is encouraged to become the hurt child
- Holistic approach to personality vs. mechanistic approach of Freud
- Value of examining present situations vs. repressed intrapsychic conflicts from early childhood
- Focus on:
• Process vs. content
• Presently experienced vs. what is revealed by the client from memory
- Self-understanding comes from the individual’s behavior in the present vs. why they behave as they do
- The therapist’s goal: Create experiments for the client to assist their self-awareness of what they are doing and how they are doing it
- Development of skills necessary to satisfy needs without violating rights of others or personal moral standards
- Acquisition of morals
- Development of willingness to help others and to ask for help when needed

Concepts Of Human Nature
- Clients are manipulative
- Avoid self-reliance
- Avoid taking on personal responsibility
- Clients have to stand on their own two feet to deal with life problems themselves
- Move the client from environmental supports to self-support
- Help the client reintegrate disowned parts of their personality

Major Principles
- Holism
  • Interested in the whole person
  • Emphasis is on integration of thoughts, feelings, behaviors, body and dreams
- Field Theory
  • Organism must be seen in its environment or its context as part of a constantly changing field
    1. Relational
    2. In flux
    3. Interrelated
    4. In progress
- Figure Formation Process
  • How the client organizes the environment from moment-to-moment
  • Background
    1. The undifferentiated field or ground
  • Figure
    1. The emerging focus of attention
- Organismic Self Regulation
  • Restore equilibrium or contribute to growth and change

Therapy Process
- The Here-and-Now
  • Power in the present
  • Nothing exists except the now
  • The past is gone and the future has not yet arrived
• For many people, the power of the present is lost
  1. They may focus on past mistakes or engage in endless resolutions and plans for
     the future

➢ **Unfinished Business**
  • Feelings about the past are unexpressed
  • These feelings are associated with distinct memories and fantasies
  • Dealing with the feelings that are not fully experienced in the background and interfere
     with effective contact
  • Preoccupation, compulsive behavior, wariness, oppressive energy and self-defeating
     behavior
  • “I take responsibility for…”

➢ **Layers of Neurosis**
  Perls likens the unfolding of adult personality to the peeling of an onion:
  1. **Phony layer** - stereotypical and inauthentic
  2. **Phobic layer** - fears keep clients from seeing themselves
  3. **Impasse layer** - giving up power
  4. **Implosive layer** - fully experiencing deadness
  5. **Explosive layer** - letting go of phony roles

**Techniques**

➢ The experiment in Gestalt therapy
  • To assist client’s self awareness of what they are doing and how they are doing it
  • Expand awareness of the client
  • Opportunity to “Try on” new behavior
  • Experiments bring struggles to life, inviting client to enact them in the present
  • Major emphasis is placed on preparing clients for experiments though trusting
     relationship
  • Making rounds: going around in a group and saying something to everyone

➢ **Confrontation:**
  • **Imposing Stance**
    1. Therapist meets their own agenda for the client
    2. Acts as the expert, giving power and control to the therapist
  • **Competing Stance**
    1. Therapist promotes rugged individualism with negotiation, compromise and
       confidence
  • **Confirming Stance**
    1. Therapist acknowledges the whole being of the client

➢ **Client’s needs and experiences are the center of relationship**

➢ **Ideal type of stance for confrontation**

➢ Invites the client to look at incongruities in verbal and nonverbal language, in words vs. action

➢ **Internal Dialogue** - Identifies the struggle for control in a person, fragmented between:
  • Controller and controlled, through introjection of aspects of others
  • Top dog and underdog
• Critical parent shoulds and oughts
• Passive recipient without responsibility and with excuses

➤ Empty chair technique
• Shift client between two chairs for dialogue role play
• Let them experience the conflict from both sides
• The hot seat

➤ Reversal technique
• Play the projection and the reversal: strategy for dealing with retroflection
• Role play the opposite of symptoms and behaviors the client suffers
• Client tries the very thing fraught with anxiety, therefore submerged and denied
• Help the client to accept personal attributes they have tried to deny

➤ Rehearsal exercise
• Behavioral rehearsal: role-play a planned exercise for a new behavior with a person or people in the client’s environment
• Reduce stage fright, anxiety or fear
• Encourage spontaneity and willingness to experiment with new behaviors

➤ Exaggeration/Repetition Game
• Exaggerate a movement or gesture repeatedly to intensify feelings attached with the behavior to make inner meaning clear, such as:
  1. Trembling hands or feet
  2. Slouched posture
  3. Bent shoulders
  4. Clenched fists
  5. Tight frowning, etc.

➤ Staying with Feelings
• Keep the client from escaping fearful stimuli and avoiding unpleasant feelings
• Encourage them to go deeper into feeling or behavior they wish to avoid
• Facing, confronting and experiencing feelings makes them able to unblock and make way for new levels of growth
  1. That will take courage and pain

➤ Dream work

The Five Major Channels Of Resistance

➤ Introjection
• The tendency to uncritically accept other’s beliefs and standards without assimilating them to make them congruent with who one is
• To passively incorporate what the environment provides, spending little time on becoming clear about what one personally needs or wants

➤ Projection
• Disown aspects of self by assigning them to the environment
• Trouble distinguishing between inside and outside world
• Disown attributes of oneself that are inconsistent with self image and put them onto other people
• Avoid taking responsibly of feelings and the person one really is
• Keeps self powerless to initiate change

- **Deflection**
  • A way of avoiding contact and awareness by the process of being vague and indirectly using distraction
  • It makes it difficult to sustain a sense of contact with reality
  • May lead to overuse of humor, abstract generalizations and asking questions rather than making statements resulting in emotional depletion
  • It may also lead to diminished emotional experience as one seeks to live vicariously through others

- **Retroflection**
  • One may do something to oneself they really wanted to do or would have done to someone else

- **Confluence**
  • Blurring the boundaries between self and environment
  • Fitting in, which alleviates all conflict, and the belief that all people feel and think the same way
  • The high need for acceptance and approval
  • Stay safe, never express one’s own feelings
  • Therapist uses W’s questions, the who, what, where and why to get client to open up

**Other Forms Of Resistance**

- **Control of environment**
  • Resistance to contact
  • Boundary disturbance

- **Blocks to energy manifested by:**
  • Tension in part of the body
  • Posture
  • Keeping body tight and closed
  • Not breathing deeply
  • Looking away from people when speaking
  • Numbing feelings
  • Speaking with restricted voice

Although the underlying theories are criticized as being incongruent, Gestalt and TA form a popular eclectic therapeutic mix.

**Wolfgang Kohler's** studies with the great apes also help explain Gestalt principles. Fritz Perls was analyzed by **Wilhelm Reich**, author of *Function of the Orgasm*.

**Transactional Analysis (TA) - Eric Berne**

The basis of transactional analysis is that each person possesses the three independent and observable ego states of Parent, Adult and Child. In the 1960s, the founder of transactional analysis, **Eric Berne**, asserted these states are marked by experiences and emotions that relate to behavior patterns.
TA theory emphasizes Parent-Adult-Child (PAC) concepts roughly similar to Freud’s Super-ego, Ego and Id. In TA, ego states are viewed as observable, conscious and segregated from each other. “Tapes” recorded from early relationships are observed and their ramifications addressed. **Parent Ego State** tapes deal with the subject’s paradigms of caring and rules based on childhood experiences. Using information and calculations to solve problems, the **Adult Ego State** is the here-and-now, a logical awareness of the outside world. The **Child Ego State** is comprised of behaviors, thoughts and feelings (whether appropriate or not) replayed from childhood.

In the Child ego state, an individual acts emotionally, regardless of his or her chronological age; and in the Adult ego state, the individual responds unemotionally, using logic and facts. The Parent ego state includes behavior essentially reproducing the real parent and is the purview of morals, beliefs and values. Someone operating in this state may want to influence, control or judge the development of others.

TA calls units of communication between individuals, **transactions**, of which there are two different levels:
- The Overt Social level
- The Covert Psychological level

Counselors chart these transactions which show both counselor and client how the client interacts with significant others. This pictorial didactic device depicts circles containing P(parent), C(child), and/or A(adult) connected by arrows illustrating the transaction.

Transactional analysis posits that people’s social interactions are seated in their need for recognition, satisfied by **strokes**. Indispensable to personal growth, strokes are learned. The system of stroking learned through familial interaction creates a person's sense of wellbeing and determines how he/she evaluates others. Since families vary from positive and approving to negative and disapproving or apathetically absent, these strokes are seen as shaping personality. This patterning is called the **life script**.

**TA Key Words**
- Adapted Child
- Critical Parent
- Crossed Transaction
- Ego States
- Karpman's Triangle - Role Playing Games
- Life Position
- Life Scripts
- Little Professor
- Natural Child
- Nurturing Parent
- Parallel Transaction
- Rackets
- Stamps
- Strokes
Role Of The TA Therapist

Therapist and client are equal partners. The therapist brings knowledge and the client brings life and openness to insight.

Goals Of TA Therapy

The most important goal of TA is change in the direction of the client's life. First, the client benefits by recognizing the ego state (Parent, Adult, Child) in which he functions. Change can then be accomplished by gaining awareness of how the client’s present life script is influenced by old decisions. TA therapists attempt to make clients autonomous and increase awareness and spontaneity. They want clients to create appropriate life scripts based on new decisions.

Techniques of TA

- Contracts
- Teaching Concepts
- Diagnosis
- Confrontation
- Empty Chair
- Role Playing
- Family Modeling

REALITY THERAPY - WILLIAM GLASSER

Rejecting the concept of mental illness, reality therapists do not bill using the DSM because they do not believe in the pathology model. As might be inferred from the name reality therapy, this approach encourages the client to face reality without excuses or explanations. The client is helped to identify what he/she really wants and whether or not he/she is behaving in a manner to achieve those goals. Rewards are created and given upon desirable behavior.

With the view that individuals have psychopathology because they cannot control their environments in ways that satisfy their basic needs for survival (belonging, power, fun and freedom) reality therapy sees individuals as possessing two psychological needs:

- The need to love and to be loved
- The need to feel worthwhile to themselves and to others

Contracting

- Eight Steps with Focus on the Here-and-Now
- Failure Identity
- No Excuses
- No Punishment
- Positive Addiction
- Success Identity
- Book - Schools Without Failure
- Individual has a "Success" or "Failure" Identity
Developed by William Glasser, reality therapy proceeds on the theory that the brain functions as a system to control behavior by fulfilling needs created by the environment. When an individual is unable to control or effectively act on such environmentally based needs, problems result. By this model, behavior is an integration of a person's feelings, thoughts and actions. Relating personal needs to behaviors of others, action comes from within and is dependent upon the needs it means to satisfy.

In addition to societal standards, every person is assumed to have a set of personal standards. When a client is operating contrary to personal or societal standards, more effective behaviors must be chosen. Therapy is an exercise aimed at greater fulfillment of the individual’s needs. Since the focus is upon helping the client to make more effective behavior choices in the present, reality therapy considers antecedent experiences and outside forces to be of little import.

**Eight Basic Steps Of Reality Therapy**
- Having established a friendly relationship, the counselor finds out from the client what he/she wants
- Counselor and client determine what the client is doing to achieve the desired end
- The counselor helps the client evaluate how effective his/her behavior is to achieve the goal
- The counselor helps the client make a plan to gain effective control over the situation/environment
- The counselor exacts a commitment to follow through on the plan
- Excuses for failure are not accepted
- If possible, the counselor imposes reasonable consequences if the plan is not carried out, such as temporary restrictions of freedom or temporary removal of privileges
- The client is not allowed to control the counselor by simply giving up
  - If one plan does not work, the counselor and client amend it or create another, until the client implements a plan and begins to take control of his/her life

Though Glasser conceded such individual control can take a long time to achieve, he argued it would succeed, in that it is the individual who controls the environment, rather than the converse.

**Here-And-Now!**
- The content involves immediate events in the meeting, not past occurrences or even current outside events
- The process is cognitive, a self-reflective loop determined by the nature of the relationship between interacting individuals
- How and why meanings are sought
- The content process includes:
  - Abstract
  - Specific
  - Generic
  - Personal information
  - As guided by the needs of the group at any given time
Process Focus

- Not socially sanctioned, but content is
- Why it is not socially sanctioned:
  - Socialization Anxiety
    1. Evokes memories of early parental criticism (introjections)
  - Social Norms
    1. Becomes self-conscious, complex and conflicted (Freud and Jung)
  - Fear of Retaliation
  - Power Maintenance
    1. Power maintenance hierarchies

Here-And-Now Tasks Of The Therapist

- First stage: Activating phases aim to move group into the here-and-now
  - As an example, it is the leader who sets the norms for interpersonal confrontation, emotional expression, self-monitoring and who demonstrates the value placed upon the group as a source of good information
- Second stage: Process illumination is employed
  - The counselor acts as observer-participant and group historian
  - In this role, the therapist should comment on the process
  - Eventually helping members to process as well
- Past events of the group become part of the here-and-now
- Uncovering should not be used to understand the past, but toward understanding the present
- Here-and-now (content) and process should overlap

Techniques Of Here-And-Now Activation

- “What's going on?”
- Realizing resistance is natural, focus on positive interaction. (“Who in the group is most like you?”)
- “There is valuable information here if we only could excavate it.”
- Accuracy doesn't matter as much as guidance of group toward here-and-now
- The therapist models by sharing personal feelings toward individuals in the group

Research has shown the more structured the group, the more competent the leader appears to be. However, better results are often achieved with less structure. Educational systems and facilities with confinement, such as juvenile detention centers, use reality therapy in modifying antisocial behavior and preparing individuals for reentry.

Techniques Of Process

Stages

- Members must recognize what they are doing with others
  - Therapist needs to recognize non-verbal message
- It is crucial to attend to what is said and what is omitted
  - Therapist should observe here-and-now process changes when a member is absent
- Appreciate the impact of the process
- Determine satisfaction
- Exercise the will to change

**Common Group Tensions**
- Struggle for dominance
- Primary task and secondary gain
  - Primary task is determined by what the client wants to gain
  - Secondary gain - blocks to gain occurring within the group
    1. Freud: desire to remain in therapy outweighs desire to be cured
    2. Tension between primary task and secondary gain
    3. Resistance ordinarily refers to pain avoidance
    4. Share feelings with the group, especially if feeling shut out

**Feelings Of The Therapist**
In helping patients assume a process orientation, the therapist must:
- Be a mature leader who resists the temptation to make brilliant interventions
- Help clients accept process-illuminating comments such as “I am not sure what’s happening with Bill.”
- Realize clients are always more receptive to observations delivered supportively
- Love the group members
- Don’t make global accusations
  - Instead of saying someone is dependent, make a statement that indicates an observation of times of closeness and other times of aloofness

**Process Comments**
- “Your behavior is like….”
- “Your behavior makes others feel….”
- “Your beliefs influence the opinions others have of you by…."
- “Your actions effect self-esteem by…."

**Existentialism**
- Ask, “Are you satisfied with the world you have created?”
- The client must make the decision to change
- Realizing independent will is the primary motivator, the therapist must be careful not to insist upon change

**Beliefs**
- “Only I can change the world I have created for myself.”
- Change does not present danger
- “To attain what I really want, I must change.”
- “I can change.”
- “I am potent.”
MULTIMODAL THERAPY (BASIC I.D.)

- **Key Figure**: Arnold Lazarus
- **Theory**: Centered around what is perceived to be best for the individual, multimodal therapy tailors an intervention plan to each client, based upon analysis of interactions among modalities in the client's BASIC I.D. which encompasses the whole person.
- **Treatment**: Listing the client’s problems and possible interventions using a Life History Questionnaire designed by Lazarus, a modality profile results from the first client/counselor session. Bridging and tracking procedures then allow the counselor to gradually steer the client from his/her preferred modality to problem areas. Direction and techniques (called the firing order) depend upon the client's preferred modalities, varying from client to client. The counselor helps the client to understand how his/her behavior is affected by antecedent causes. Continued assessment of the client's progress permits adjustment of the modality profile as needed.
- **Relevance**: Due to the framework of the BASIC I.D., multimodal therapy’s approach allows for a much more complete assessment of the client and provides insight into treatment goals and evaluation of successes. This enables the client to be a part of the therapy process and progress. It is ideal for dealing with issues of stress management and anxiety disorders. This method claims to help eliminate relapses more than other therapies.

Multimodal therapy is a holistic approach with behavioral components broken down into seven classifications of a person’s personality termed by the acronym BASIC ID:

- **B** Behavior (habits, actions, reactions)
- **A** Affective response (emotions and moods)
- **S** Sensation (taste, touch, smell, sight, hearing)
- **I** Images (self-concept, memory, dreams)
- **C** Cognitions (constructs, ideas, insights)
- **I** Interpersonal relationships (interactions)
- **D** Drugs (nutrition, biological functions)

Multimodal therapy posits abnormal behavior results from an array of problems including conflicts, unhappy experiences and social defects; and these problems should be treated with a variety of intervention techniques. Developed by Arnold Lazarus in the 1960s and 70s, this approach expands behavioral psychology to include assessment techniques and interactions between sensory, imaging, cognitive and interpersonal factors. After determining an individual’s needs by using the BASIC I.D., therapy proceeds. Included within the category of behavior are habits, reactions and actions; effective processes include both emotions and reactions to them. Within sensation are included:

- The awareness of sensory perceptions and responses such as pain and pleasure
- Imaging which deals with the role of the imagination
- Cognition covers analytical, planning and reasoning skills

The interpersonal relationship component considers relationships with others and the degree of importance they have. Lastly, drug/biological functioning concerns general health and physical
wellbeing, including such biochemical and neurophysiological factors as personal hygiene, exercise, diet and medication.

Some multimodal techniques are:

- Biofeedback
- Imagery
- Bibliotherapy
- Audiotherapy
- Assertiveness training
- Role-playing

NEURO-LINGUISTIC PROGRAMMING (NLP)

- **Key Figures:** John Grinder, Richard Bandler, Gregory Bateson
- **Theory:** Focused on creativity, learning and change, it seeks to evaluate the construction of reality. Modeling skills are at the heart of NLP.
- **Treatment:** Help the client to see his/her own perceptions of problems and work to change them creatively adapting from the perceived to reality.
- **Relevance:** Used as a therapeutic theory, it is increasingly being used to cultivate skills of outstanding performance in training, business, management, sales, coaching, counseling, education, sports and the performing arts.

NLP, associated with John Grinder, Richard Bandler and Gregory Bateson, is one of the fastest growing fields of applied psychology.

The Origins Of NLP

In the mid-seventies while Grinder and Bandler were exploring strategies for excellence at the individual level, Tom Peters popularized similar strategies for excellence in organizations. Under the influence of the profoundly original British thinker Gregory Bateson, Grinder and Bandler modeled the skills of some of the leading masters of communication and personal change, calling the result Neuro-Linguistic Programming.

Neuro refers to the neurological processes of sight, hearing, touch, smell and taste, which form the basic building blocks of a person’s experience.

Linguistic refers to the ways language is used to represent experience and to communicate with others.

Programming refers not to computer programming, but rather to the strategies used to organize inner processes to produce results.

By developing a practical understanding of how learning occurs, tactics can be developed to achieve results that often seem magical. Put simply, the world each person experiences is not the real world. It is a model of the world that he/she creates unconsciously and lives in as though it were real. Most human problems derive from the models in people’s heads rather than from the world as it really is. As someone develops a practical understanding of how these inner models work, that person can learn to exchange habits, thoughts, feelings and beliefs which are not
helpful for more useful ones. NLP offers specific and practical ways of making desired changes in behavior. Allowing a person to redesign life for maximum personal and professional achievement, NLP is the know-how that works for human behavior!

How Does NLP Work?

Modeling skills lie at the heart of NLP. From the study of human excellence, patterns emerge: patterns of similarity and patterns of difference. Modeling enables people to discover the difference between competence and excellence in any given area of human activity. Within each field, the NLP modeling process is producing many techniques and ways of thinking that significantly improve bottom-line results.

NLP increases awareness and choice. The skills offer a practical way of achieving a highly generative learning ability to produce better results in any area a person chooses. Learning to learn more effectively is one of the best investments anyone can make in a changing world.

Presuppositions Of NLP

- No one is wrong or broken
- People work perfectly to accomplish what they are currently accomplishing
- People already have all the resources they need
- Behind every behavior is a positive intention
- Every behavior is useful in some context
- The meaning of a communication is the response received
- If the response is not as desired, the person must do something different
- There is no failure; there is only feedback
- In any system, the element with the most flexibility exerts the most influence
- The map is not the territory
- If someone can do something, anyone can learn it
- A person cannot fail to communicate

Psychoanalytic and Psychodynamic Theories and Models

- **Key Figures:** Sigmund Freud, Carl Jung, Alfred Adler, Erik Erikson, Karen Horney, Harry Stack Sullivan
- **Theory:** Freud saw neuroses as the result of unconscious sexual and aggressive conflicts. The repression of unacceptable thoughts and desires caused psychological symptoms and neuroses. He divided the psyche into three parts:
  - The “**ID**” is the most primitive state and is involved with the primitive desires (hunger, sex, rage)
  - The “**SUPEREGO**” in one sense might be considered the conscience. It is made up of the internalized societal morals and taboos.
  - The “**EGO**” is the mediator between the id and the superego. It is often thought of as the center of self or awareness.
- **Treatment:** The patient is encouraged to free associate and say whatever comes to mind while in a relaxed state such as lying on a couch. The therapist mostly listens with a
nonjudgmental attitude, commenting only to make interpretations of patterns and inhibitions. Treatment is normally meeting intensive (several times per week) and takes a very long time continuing on for years (three to seven years).

- **Relevance:** Many experts consider psychoanalysis to be counter-indicated in extreme psychological situations. Psychosis, suicidal depression or severe untreated drug addiction need faster, more relevant-to-the-moment types of psychotherapy. Psychoanalytic treatment of clinical depression and personality disorders is thought to be more apropos. Cases of neurosis are the common recipients of this therapy.

Although few today follow him strictly, Sigmund Freud's profound influence upon psychology continues. The work of his followers, especially Carl Jung, Alfred Adler, and Erik Erikson more immediately inform psychodynamic therapy.

As everyone knows, libido (sexual energy) is at the center of the Freudian theory of human growth and development. Other personality structures described by Freud have long been part of popular parlance: the **Id** (seeking immediate gratification and acting on the pleasure principle), the **Ego** (the thinking self regulating the id) and the **Superego** (conscience, ideal self and standards). An individual’s response to the dynamic tension between **Eros** (life force) and **Thanatos** (death or destructive force) strongly effects personality.

In contrast to Freud, Carl Jung came to view libido as a generalized psychic energy, not necessarily sexual. From the Jungian psychoanalytic perspective, people instinctually push toward individuation and wholeness as they develop psychologically. Seeking to become one's true self is an endeavor common to humanity. Jungian interpretations focus on a person’s present state and potential growth rather than on antecedent causes. Looking to dreams, fantasies, connections between inner and outer realities and other windows to the unconscious, increases awareness and personal growth.

Individual psychology is the holistic developmental approach proposed by Alfred Adler. Both nature and nurture hold less importance than the process of “becoming” through striving toward individual goals. Differences between the real and ideal selves cause normal feelings of inferiority. As pointed out by Harold Mosak, such differences can lead to a pathological inferiority complex.

Adler saw social influence as key to early development. Growing up, children learn to master their surroundings and seek significance by acting on conclusions (healthy or otherwise) derived from the family constellation. If the early environment is deficient, therapy can help create the trust and love that are lacking.

**Theory Of Reciprocal Inhibition**

The basic concept: an individual cannot be both anxious and relaxed at the same time.

**Systematic Desensitization**

Reducing anxiety by associating negative stimuli with positive events, systematic desensitization is a behavioral intervention for counter conditioning.
Techniques
- Brief Psychodynamic Therapy (BPT) - treating selective disorders within an established time
- Hypnosis
- Dream Interpretation
- Free Association
- Projective Techniques
- Freudian Slips

Foundations
- Rooted in the “psychological self”
- It emerged in the 1980s in response to object-relations theory as a way to probe beneath family dialogues to explore individual family member’s fears and longings
- Based in Freudian concepts (intrapsychic)
- Expanded by Nathan Ackerman
- Grew in proportion at the National Mental Health Institute in the 1950s.
- Brought to prominence by Jill and David Scharff in the 1980s at the Washington School of Psychiatry

How It Works
- It is a method of therapy to discover some of the basic wants and fears that keep individuals from acting in a mature way, based in the interpretation of unconscious impulses and the defense against them
- Human interaction is rooted in depth and complexity of psychic organization
- Psychodynamic theory is useful to understand the self in the family system
- The balance of this conflict should be shifted by either strengthening defenses or relaxing them to permit some gratification
- Self psychology
  - Human beings long for appreciation
  - Acceptance from parents leads to strong self-confident personalities

Normal Family Development
- Average environment is sufficient for healthy development
- Includes “good mothering”
- To a young child, parents are seen as “self objects”
- Two essential qualities to create secure and cohesive self are:
  - Mirroring
    1. Understanding plus acceptance “I see how you feel”
  - Idealization
    1. Image of strong and powerful parents

Development Of Behavior Disorders
- Rooted in childhood transference
- Projective identification
• Defense mechanism where unwanted aspects of self are attributed to another person and that person is induced to behave in accordance with these projected attitudes
  ➢ Failure of parents to see their children as separate beings results in severe psychopathology
  ➢ Idealization
    • Exaggeration of the virtues of another
  ➢ False self
    • Defensive façade that leads to domination
  ➢ Narcissism
    • Exaggerated self regard
  ➢ Fixation
    • Partial arrest of attachment
  ➢ Regression
    • Return to less mature level of functioning during stress

Treatment Process
  ➢ Fosters insight by looking beyond behavior to hidden motives
  ➢ Less concerned with system, more concerned with individual
  ➢ Therapist creates a climate of trust and safety in which the family can explore old wounds
  ➢ Key techniques:
    • Listening
    • Empathy
    • Interpretations
    • Analytic neutrality

Limitations
  ➢ In dealing with families in which there had been severe trauma and abuse, it is clear that the damage from the past needs to be clarified, elaborated on and confronted in the present
  ➢ This has led to a re-examination of the adequacy of a past-time approach as the exclusive therapeutic modality

The Therapeutic Process For Couples
  ➢ Therapy starts with exploring the conflict between couples
  ➢ Focus is primarily placed on helping couples to recognize the source of emotional reactions
  ➢ Psychoanalytic couples therapists explore along four channels:
    1. Internal experience
    2. History of that experience
    3. How the partner triggers that experience
    4. How the session and the therapist contribute to what’s going on between the partners

SIGMUND FREUD
With a negative view of humans, Sigmund Freud believed people are inherently selfish, impulsive and irrational; that behavior is a result of unconscious processes, the biological and
instinctual needs and drives, both determined by sex and influenced by psychosexual states. A finite quantity of libido is stored in the id. Freudian drive psychology proposed anxiety as a central concept, rooted in unexpressed sexual and aggressive drives that children are taught to repress. When the id, ego and superego clash, anxiety results. Freud proposed we then turn to **Ego Defense Mechanisms** to deal with and reduce our anxiety.

**Personality Structure**

- **Ego**: The ego is viewed as the reality that mediates between the id and superego
  - Reality principle - maximize gratification, minimize punishment
  - “Traffic Cop”
- **Id**: A primitive, selfish aspect of the personality, the id demands immediate gratification through increased pleasure and reduced tension
  - Pleasure principle
  - “Demanding Child”
  - Deterministic - problems are rooted in the first six years of life and trapped in unconscious motivations
  - Unconscious
  - Satisfy basic survival
- **Superego**: Providing motivational instincts, the superego is an internalization of parental interjections
  - Moral Principle
  - “The Judge”
  - Strive for perfection
- **Libido**: Comprised of the sexual and ego drives found in the id, libido effects aggression and instinctual behaviors
- **Neurosis**: When the superego imposes guilt on the ego to limit the impulses of the id, neurosis results
  - Neuroses stem from childhood conflicts that occur when the relationship between the libido and ego mechanisms becomes unbalanced

**Freud's Psychosexual Stages Of Development**

Freud's stage theory of human development proposes basic personality formation by about age five. His **Five Psychosexual Stages of Development** are:

- **Oral** (birth to about age 2)
- **Anal** (about ages 2 to 3)
- **Phallic** (about ages 3 to 6)
- **Latency** (about 6 to puberty)
- **Genital** (puberty to old age)

**Key Freudian Terms**

**Manifest Latent Dreams**: Dreams are composites of symbols derived from recent and remote memories and formed by the current feelings, attitudes and motivations of the individual. Shaped
by the immediate psychological needs of the sleeper, manifest latent dreams are distortions of life experiences in accordance with the regressive thinking processes that prevail during sleep.

**Manifest Content:** Formed as a composite of recent and distant memories, this is the apparent content of the dream. Actually it provides a mask for events that conceal the latent meaning of a dream.

**Latent Content:** Underlying thoughts, desires and fantasies related to the emotional reactions of early infancy, latent content gives a dream its fundamental meaning.

**Dream Work:** This is a process whereby latent dream content becomes apparent. An individual gains understanding of the fundamental meaning of a dream by exploring early experiences, attitudes toward parents and siblings, and defenses and conditionings, as well as emotionally charged current life experiences, interpersonal dynamics and repressed unconscious impulses.

**Defense Mechanisms:** Although the individual is unaware of them, defense mechanisms provide protection against negative feelings associated with painful events. The events may be physical or mental.

**Compensation:** If an activity viewed as rewarding is substituted for one that produces tension, compensation has occurred.

**Denial:** A person in denial refuses to acknowledge a situation that causes anxiety or distress.

**Displacement:** When an emotion felt toward an individual or an object is transferred to a similar person or object, displacement is the result.

**Projection:** An unconscious process, projection is the assignment of unacceptable thoughts and behaviors found within oneself to another person.

**Rationalization:** Rationalization is giving to behavior a socially acceptable motive.

**Reaction Formation:** When behavior is opposed to unconscious desires, reaction formation is said to have resulted.

**Regression:** Regression is a retreat to an earlier stage of development where the individual feels more comfortable.

**Repression:** The determinate of all defense mechanisms, repression occurs when a person forces painful perceptions, constructs and feelings into the unconscious.

**Sublimination:** Dealing with inappropriate social impulses, the individual channels them into socially acceptable behaviors.

**Suppression:** In suppression, the individual undoes various levels of consciousness, preconsciousness or unconsciousness.

**Counter transference:** The irrational reactions therapists have toward their clients
ERIK ERIKSON

Erik Erikson’s theory views maturity as proceeding through eight stages, which are both psychosocial in nature and genetically determined:

- Trust vs. mistrust (birth through 18 months)
- Autonomy vs. shame and doubt (18 months to 3)
- Initiation vs. guilt (ages 3 to 6)
- Industry vs. inferiority (ages 6 to puberty 12)
- Identity vs. role confusion (ages 12 to 20)
- Intimacy vs. isolation (ages 20 to 40)
- Generativity vs. stagnation (middle adult years, about 40 to 65)
- Ego integrity vs. despair (Later adult years, 65 on)

A) Assumptions

- Being a consciously experienced sense of self, ego identity is derived from transactions with a person’s reality
- People must strive to reach and maintain a strong sense of ego identity
- The desire for competence is a motivating force behind people’s actions
- Although a psychosocial crisis is a turning point with potential for growth, it leaves a person vulnerable.
  - In this sense “crisis” indicates a level of importance rather than a specific event
- Conflict arises from the struggle between attaining some psychological quality versus failing to obtain it
- Conflict never ends; issues are simply re-confronted in different forms throughout a person’s life
- People experience eight stages of psychosocial development, each stage focusing on:
  - A particular transaction with the social environment
  - Some conflict and/or crisis to resolve
- Individuals must negotiate each stage by developing a balance between the characteristics that give the stage its name
- This theory rests on the principle of “epigenesis” which means the focal issue at any given stage exists in some form in every other stage
- Basic trust is necessary for adequate human functioning

B) Motivation

- Successful management of a stage enhances a person’s feelings of competence
- The goal of each stage is to reach a successful balance between the two extremes it presents with resolution closer to the positive side than the negative
- When people successfully emerge from a crisis, they have a positive orientation toward future events pertaining to that conflict
- Successfully emerging from a stage establishes ego quality, ego strength and virtue, all of which become permanently ingrained in the personality
C) Dysfunction

- The absence of a strong ego identity is a major cause of poor adjustment
- Lacking trust in relationships or fearing the loss of relationships distorts and damages people’s lives
- If a person does not manage a stage well, increased feelings of inadequacy result
- Unsuccessful negotiation of a crisis results in a destructive emotional or psychological tendency that corresponds to one of the two opposite extremes of the particular crisis

D) Intervention

- Since Erikson’s model asserts that change and development continue throughout life and personality continues to develop beyond childhood, the client can be encouraged to see the future as an opportunity for positive change and development instead of looking back with blame and regret
- People of any age should be assisted in understanding the connections between life experiences and human behavior
  - Adults can be shown how to help rather than hinder the development of emotional maturity in children
- Clients need to understand how to apply these concepts in their day-to-day lives
- A therapist should affirm the client’s “actuality” (i.e., the world of his/her participation) and emphasize the healing role play or work may provide
- The goal of treatment is the restoration of mutuality by helping the client’s ego to become stronger and to heal itself

E) Techniques

- Treatment should focus on helping the client balance the demands of:
  - Unconscious internal pressures (instincts and effects)
  - Pressures of the external world (social reality and relationships)
- Therapists should be aware of obligations to others, both for their clients and for themselves
- The therapeutic exchange, in itself, should be the essence of study
  - The therapist needs to be committed to continuous conceptual revision as new information emerges from the client
- Establishing the basis of trust is the core element of the therapeutic relationship
- Dream analysis and free association are included in therapy
- Transference is a factor
  - Clients transfer onto the therapist significant issues from past interactions with meaningful people
  - The therapist, through his/her responses, must clarify the appropriateness or inappropriateness of the client’s past interactions
- Self-awareness and relationship to the world are integrated
- The therapist should recognize if clients have passed or not passed through various lifestyle stages and assess self-growth based on whether or not various crises have been met
F) Limitations
- Erikson’s theory may be more applicable to boys than to girls
- Greater attention is focused on infancy and childhood than adulthood
- Erikson’s belief in identity formation ignores those adults who rediscover themselves and develop a different understanding of their lives due to particular experiences

G) Implications
- An implication of epigenesis is that a person’s initial orientation to a crisis is influenced by all preceding stages, so one’s resolutions from previous conflicts will reshape each new conflict
- Erikson’s theory may be too simplistic
  - Research has demonstrated parent-child reactions are more complex than his stages suggest
- Not everyone may face the challenges in the exact order presented by Erikson
- Erikson’s claims are not universal
  - Those in other cultures or at other times in history do not necessarily define a successful life in the same terms

ANALYTIC THERAPY - CARL JUNG
Stressing the significance of racial and historical influences on personality, Carl Jung believed individuals generally move toward wholeness and individuation. Jungians see culture as having great influence on personal development and view therapy as a healing process. The test based on Jung’s work is the Myers-Briggs.
- Introvert/Extrovert
- Anima – The feminine side of men
- Animus – The masculine side of women
- Archetypes – Universal response patterns
- Collective Unconscious – Determined by evolution of the human species
- Individuation
- Mask
- Persona – Public mask
- Shadow – Negative side of an individual

Jung's analytical psychotherapy stresses the dynamic interplay between the conscious and unconscious minds that together comprise the human psyche and govern behavior. A keener awareness of the unconscious provides the key to analytical psychology, which sees the unconscious as a means to conscious direction and creativity.

According to Jung, individual behavior comes from compensating conscious and unconscious subsystems with strongly held beliefs and attitudes playing point/counterpoint, conscious/unconscious. Observation of interpersonal relationships, work habits, communication skills and the interpretation of dreams all reveal this phenomenon.
Analytical psychologists believe the instincts of hunger, thirst, sex and aggression are universal, as is the need to achieve a whole, true self that has been grounded in conscious and unconscious elements (*individuation*). A person’s actions are influenced partly by present experience and partly by expectations of response. Revealed through symbols contained in dreams and external reality, unconscious forces provide guiding messages that help the client resolve conflicts and overcome difficulties.

The analytical model of psychological counseling deals with the client's directing the psyche - present and future.

This psyche is comprised of the conscious ego, the personal unconscious (accessible elements that were once conscious) and the non-personal unconscious (archetypes which influence behavior but are not available to consciousness).

**Some Jungian archetypes**
- Rebirth
- Hero
- What one does not wish to be
- Feminine/masculine
- The need for wholeness and meaning

Making the client as aware as possible of unconscious influences and their connections with behaviors, both present and future, is the touchstone of analytical therapy. After analyzing the client’s conscious experiences, client and counselor explore unconscious messages, especially through interpretation of dreams and then work toward the client's achievement of a true, positive self.

**Therapeutic Goals**
- Reintegration
  - Merging past and present
  - Explore the conscious/unconscious
  - Develop self knowledge
  - Individualization - reclaiming undeveloped parts of self through reflection on life/past

**Key Ideas**
- View of Man
  - Man’s behavior is conditioned not only by his individual/racial history (causality) but also by aims and aspirations (teleology - explanation of behavior based on future goals)
- Collective Unconscious
  - Shared by all, but modified by personal experience
- Personal Conscious
  - Unique life experiences and perceptions
- Theory of Personality
  - Psyche
    1. Conscious/unconscious
• Personal Conscious
  1. Only understood through dreams and analysis
  2. Makes itself known through complexes and emotions
• Personal Shadow
  1. Archetypal representing thoughts, feelings and actions that disown by projecting them outward
  2. Contains everything that could or should be part of the ego that the ego denies or refuses to develop, either positive or negative
  3. Reclaiming is an essential task for mature personality
• Archetype
  1. Pathway of communication between unconscious and conscious
  2. Understanding archetypes (images of unconscious) helps one to understand the self
• Principles of Opposites
  1. Animus vs. Over Characteristics
  2. Conscious vs. Unconscious
  3. Personal vs. Shadow
  4. Mind vs. Body

THE NEO-FREUDIANS

KAREN HORNEY

According to the view of Karen Horney, (pronounced Horn-eye) neurosis results from the child's difficulty in dealing with a potentially hostile world.

As strategies of coping, individuals choose to:

- Go towards others
- Go against others
- Go away from others

Horney's theory does not contain the Oedipus Complex; instead, her view declares people are moving toward (feeling), moving against (acting) or moving away (thinking).

Early in the life of Karen Horney, she was pushed into a state of depression. An outstanding student, she was trying to finish her medical studies. Coupling this with the responsibilities of motherhood and the death of her mother, she began to experience difficulties in her marriage. After entering therapy, she became very disappointed with the whole process and the basic principles of psychoanalysis. (By the way, it is recommended that all therapists try the process of therapy. Going through therapy increases awareness of fears and expectations clients may have.)

Becoming actively outspoken against the primary canons of psychoanalysis, Horney came out against Freud and what he labeled as “penis envy”. The Freudian view of development leads to the unequivocal conclusion that women are inferior to men. According to Freud, many of the abnormalities seen in women can be directly related to their frustrated wishes to become men. He surmised the most disturbing aspect of female development is the discovery that boys have
penises and girls do not. This leads to an inferiority complex that is actually contemptuous of womanhood.

In short, Horney rejected Freud’s concepts of the Oedipal conflict and penis envy as being responsible for the development of female character as well as his theory of female masochism. Horney did agree that penis envy derived to a degree from anatomical differences between men and women, but saw the reason as cultural and social forces of a patriarchal society that indoctrinates male superiority and female inferiority. According to Horney, anatomy is not necessarily destiny, but it plays an important role. Further, she maintained women must realize their inferiority complexes are based on unconscious acceptance of male superiority. Not until society as a whole becomes more democratic and egalitarian will change occur. Out of her departure from Freudian psychoanalysis, Horney determined and described ten neurotic needs:

- The need for affection and approval
- The need for a partner who will take over one’s life
- The need to restrict one’s life within narrow borders
- The need for power
- The need to exploit others
- The need for social recognition and prestige
- The need for personal admiration
- The need for personal achievement
- The need for self-sufficiency and independence
- The need for perfection and unassailability

Because she perceived commonalities among several of the needs she described, Horney grouped them into three distinct categories:

- **Compliant types**
  - Their needs are connected with moving toward people
  - Having neurotic needs for affection and approval, they seek partners to control their lives and desire to live within restricted borders

- **Aggressive types**
  - These people who have neurotic needs for power typically move against people
  - Believing others are hostile and untrustworthy, they are highly competitive and driven to demonstrate strength and/or intelligence continually
  - The main reason for associating with others is to enhance their own prestige, wealth or power

- **Detached types**
  - They have neurotic needs for self-sufficiency and perfection, needs that are associated with moving away from people
  - Tending to operate in total secrecy, they are reluctant to reveal even trivial details of their lives
  - Most activities are solitary
  - On a positive note, they are not conforming robots
    1. They will fight to retain their beliefs and their integrity
2. Since they aim to avoid being influenced or obligated, their independence can also become negative

**HARRY STACK SULLIVAN**

Harry Stack Sullivan built his approach to psychiatry on the study of personality characteristics that can be directly observed in the context of interpersonal relationships through the lifespan. Personality is viewed as being formed by the interpersonal relationships an individual has during his entire lifetime, especially with those closest to him. Although patterns of behavior are modified during the aging process, the basic core remains.

According to Sullivan, four levels of Insight exist:

- **Interpersonal Presentation**: Clients gain a more objective perspective about how they appear to others
- **Complex Insight**: Clients gain understanding of interactional patterns of behavior
- **Motivational Insight**: Clients understand why they act in certain ways
- **Genetic Insight**: Clients understand why they are the way they are

**Sullivan's Concepts Of Interpersonal Relationships**

“Anxiety”, a term Sullivan employed in a special way, is one of the central concepts of interpersonal psychiatry. Broadly viewing anxiety, Sullivan basically placed all types of emotional suffering including guilt, shame, dread and feelings of personal worthlessness into the category of anxiety. Within this framework, anxiety can be viewed as a warning signal. All causes of anxiety share one commonality: they threaten the individual's feelings of personal worth and competence, eroding his/her concepts of capability and self-esteem. Because of these factors, anxiety tends to bind a person in whatever unhealthy interpersonal patterns are already present.

Arising from short or long-term unhealthy relationships with others, anxiety is always interpersonal in origin. To facilitate healthy adjustments, the major task of psychiatric treatment is to decrease the various kinds of emotional discomforts grouped under the term anxiety. Eventually the individual develops a concept of himself called **self-dynamism**. This is accomplished by stressing and developing characteristics which meet with approval from significant others and de-emphasizing aspects which meet with disapproval.

**Security And Security Operations**

The opposite of anxiety, security is a state of relaxed comfort in which an individual feels no apprehension, self-doubt, guilt, inadequacy or any other emotional distress. People seek security as a result of the prolonged period of helplessness experienced in infancy.

A **security operation** is any interpersonal action or attitude (of which the person is often unaware) used in the attempt to abolish anxiety and to increase emotional ease.

A healthy security operation achieves its goal of diminishing anxiety and increasing security without interfering with the individual's interpersonal competence. On the other hand, an unhealthy security operation reduces anxiety, but with certain cost to the individual. Costs vary extensively. They may be limitations in the person's interpersonal capacities, or they may consist
of some other emotional discomfort. Unhealthy security operations cause a large number of the states labeled as “psychiatric illnesses”.

Every security operation, whether healthy or unhealthy, is interpersonal in nature and occurs in the context of an individual's relationship with another person or with a group of people. It is never an unobservable mental process.

One of the most common and easily defined healthy security operations is **sublimation**. In sublimation, a person discharges uncomfortable feelings by giving them expression in interpersonally acceptable ways.

Often working in a healthy way, another security operation is **selective inattention**. Here, an individual simply fails to observe a stressful or emotionally repulsive event that is occurring. Although he/she is not aware of the failure to observe, the stressor has simply been blocked from perception.

Another security operation, which may operate in healthy or unhealthy ways, was termed the "as if" process by Sullivan. In this security operation, an individual behaves as if he were someone other than himself. He adopts and acts out a role; the role is false, but it nevertheless renders an otherwise painful interpersonal situation comfortable.

**The Self-System**

The word **self-system** is more accurately conveyed by the term self-protecting system. Composed of all security operations a person uses to defend against anxiety and to seek emotional security, the self-system is the entire arsenal of interpersonal devices for self-protection. Sullivan acknowledged the self-system is not observable (the black hole); however security operations are. Most people get along fairly well with many others much of the time. Thus, Sullivan stated, there is a basic tendency toward emotional health and sound interpersonal functioning. If other things do not interfere, personalities tend to grow in healthy ways and interpersonal relationships tend to proceed in a sound manner.

**Awareness And Unawareness**

Differing greatly from the concepts of consciousness and unconsciousness put forth by Freud, Jung and others, awareness and unawareness are fundamental concepts in Sullivan’s system of psychiatry. Sullivan viewed the unconscious mind as a metaphorical concept invented by Freud, the existence of which, can no more be demonstrated than the existence of other metaphorical concepts. However, a person's awareness or unawareness of something can be objectively demonstrated through conversation and by other means.

Additionally, it is a matter of common understanding that every person is continuously unaware of many aspects of his/her behavior. Only a person who has a high awareness of his personality structure and how it was influenced by the experiences of his early life may, in essence, be able to say, "I am aware that the way I was brought up leads me to be tense and irritable when things go wrong and I feel my self-confidence and self-esteem have been undermined."

A person who is unaware of the nature of his interpersonal experiences learns nothing from them; according to Sullivan, a person who is unaware of something in his interpersonal life simply does not experience it. The cause of unawareness is anxiety. Abrupt confrontation with things excluded
from awareness usually brings on anxiousness, guilt, shame, self-loathing or other emotional discomfort.

**Parataxic Distortions**

A *parataxic distortion* occurs when an individual treats another person as if he were someone else, usually a significant, close person from the individual's past life.

**Consensual Validation**

This is the process by which unhealthy interpersonal patterns are corrected. In *consensual validation*, a person arrives at a healthy consensus with one or more people about some aspect of his feelings. Repeated experiences that emphasize its soundness validate this consensus.

**ADLERIAN THERAPY - ALFRED ADLER**

**Individual Psychology**

Individuals need to be viewed in the context of their social relationships. Psychopathology occurs when the individual develops inappropriate strategies to overcompensate for feelings of inferiority. Techniques include examination of family constellations, dreams and early memories. Assignment of homework, completion of life histories and paradoxical intervention provide key components to this approach.

**Notes Of Interest**

- Birth order influences the development of lifestyle
- Inferiority complex
- Lifestyle developed in childhood compensates for inferiority and weakness
- Superiority results from striving to overcome inferiority

**Alfred Adler's** theories are collectively known as Individual Psychology. Adler was one of the first to recognize the importance of children's birth order in their families of origin. The primary therapeutic approach is encouragement.

According to Adler, humans have an inborn social interest and are motivated by their social urges. Adler believed each individual is unique and that humans are conscious beings aware of their reasons for behaviors. His term “inferiority complex” refers to a sense of inadequacy. He theorized that every person has a sense of inferiority and strives for superiority. Established by age four or five, a style of life is the principle that explains the uniqueness of the individual. No two people have the same style of life. By creating a goal and the means to its achievement, creative self gives meaning to life.

**Childhood Experiences**

- Neglected children look for revenge on society
- Spoiled children expect society to conform to their self-centered needs
- Children with mental and/or physical weaknesses may develop feelings of inadequacy, however, with appropriate guidance they can transfer weaknesses into strengths
Goals Of Individual Counseling
- Identify and explore faulty assumptions and mistaken goals
- Re-educate clients toward constructive goals
- Challenge and change fundamental premises, life goals and basic concepts
- Help clients overcome inferiorities and understand themselves

Role Of The Therapist
- No set of techniques
- Therapeutic styles vary
- Functions as a diagnostician
- Focus on cognitive aspects of therapy

Diagnostic Tools
- Family constellation
- Early recollections
- Questioner
- Homework assignments
- Paradoxical interventions

Key Concepts Of The Adlerian Approach
- Holism
- Creativity and choice
- Teleology
- Social interest

Adlerian Therapists
- Alfred Adler
- T.J. Sweeney
- Rudolf Dreikurs - developed the Adlerian group methods

Other Adlerian Tidbits
- The lifestyle assessment includes information based on dreams
- Adlerians use only cognitive techniques
- An Adlerian counselor views personal problems of the client as an end result of a process of discouragement
- The principle of basic mistakes accounts for the consistency and directionality of an individual's psychological movement
- Adler stresses the unity of personality, reliving early childhood experiences, feelings of inferiority and a unique style of life that is an expression of life goals
- The phenomenological orientation attends to the ways in which people interact with each other
- Adlerians consider psychological position in the family, birth order, interactions among siblings and parent/child relationships to be influential in an individual’s life
According to Adler, childhood experiences in themselves are not as crucial as the person’s attitude toward such experiences.

By the Adlerian view, insights gained in therapy must be translated into a constructive action program to be of value.

Consciousness, not the unconscious, is considered to be the center of personality.

The approach is grounded on the medical model.

Feelings of inferiority can be the wellspring of creativity.

Early influences can predispose a child to a faulty lifestyle.

The Adlerian therapeutic goal is symptom removal.

The Adlerian approach is primarily a cognitive perspective.

Counseling is not best directed by the expertise of the therapist.

Insight is best defined as understanding translated into action.

Adlerians do interpret.

Adlerians confront faulty beliefs.

Fictional finalism refers to the central goal that guides a person's behavior.

Rather than focusing on past events, people are best understood by looking at their movement toward goals. Although they are influenced by their early childhood experiences, individuals are not passively shaped and determined by these experiences. People have a basic need to be superior, that is, to overcome their feelings of inferiority. Fictional finalism is an imagined central goal offering direction to behavior and unity to the personality - an image of what a person would be if he/she were perfect and perfectly secure.

The Adlerian notion of “Life Tasks” is that all humans must face and solve certain problems universal to human life, including the tasks of friendship, work and intimacy. Reorientation is the phase of the counseling process when clients are helped to redirect their mistaken goals and basic beliefs with more objective outlooks.

Adlerian psychology is not a form of ego psychology. The Adlerian psychologist feels that people remember only those past events that are consistent with their current views of themselves.

**Family Therapy**

Many of the Adlerian concepts relevant for group practice are concerned with the influence of one's family on current personality, review of one's past to determine its present impact, definition of goals that delineate a unique lifestyle and identification of ways to develop social interest. Insight and interpretation are basic aspects of Adlerian group counseling. An analysis of each member's family constellation is essential to successful group work. The impact this type of group has on an individual depends upon how much that person wants to invest his/her feelings and experiences in the group.

**A) Assumptions**

- Each family has its own unique Family Atmosphere, which consists of the climate of relationships that exist between family members.
- The family is considered to be a system with each member exerting influence on every other member.
Parents serve as role models defining relationships, work and participation in the world; additionally, they act as emotional role models for children.

Emphasis is placed on family value:
- This consists of the total value of all family members’ support and cannot be overlooked.

Family constellation defines each family system (parents, children and extended family) and determines:
- How each family member finds his/her place in family system
- How each relates to others
- The alignment of family members

Based on birth order, Adler observed five psychological positions:
- **Only Child** does not learn to share or cooperate with other children, but learns to interact well with adults.
- **Oldest Child** is generally the center of attention, receives more attention than others and may be spoiled.
- **Second of only Two** behaves as if in a race and often tries to be opposite to the first child.
- **Middle Child** often feels forced out.
- **Youngest child** acts like the baby and is treated accordingly.

B) Motivations
- Birth order encourages later behavior:
  - **First-born** children are accustomed to being favored, tend to be high achievers and they assume the role of pseudo-parents.
  - **Second-born** children learn to anticipate rivalry and live life as if it were a competition.
  - **Last-born** children expect to be pampered and readily assume the role of baby, tending to be creative, rebellious and forward thinking.
- Family members are motivated by goals.
- When it is not thwarted, the overall movement of children is toward growth; children strive to become more capable by increasing their skills and achieving success.

C) Dysfunction
- Children’s misbehavior arises from four goals:
  - **Attention-getting**: Consists of stop and go interaction plus annoyance or irritation.
  - **Power struggle**: Shows up as persistent or intensified interactions plus anger, defeat or challenge.
  - **Revenge**: Manifested as intensified interactions plus hurt.
  - **Demonstration of inadequacy**: Seen as no interaction or the child wanting to be left alone plus despair.
- Mistaken goals of parents’ behaviors when dealing with a child include:
  - Trying to demonstrate adequacy.
  - Attempting to display control.
  - Acting with revenge.
• Responding with a display of inadequacy

A family becomes stuck when:
• The parents assume roles based on their expectations of the children (due to birth order)
• Children’s behaviors then conform to patterns based on the parents’ expectations
• The whole family views these patterns as fixed and inevitable

D) Intervention

➢ Emphasize the family’s motivational patterns
➢ The therapist should try to unlock mistaken goals and patterns of interaction
➢ The main objective should be the reorientation of the family
➢ Assist each family member to reach Social Equality, the conviction that each person in the family has an equal right to be valued and respected within the family
➢ The therapist should help the children consider different options for current problems
➢ By using encouragement and consequences (natural and logical), the therapist should teach the parents how to increase their leadership abilities
  • This should allow parents to rediscover their ability to work together as leaders
➢ Generate new approaches that end mistaken interactions, leading to more democratic, harmonious and effective living within the family system

E) Techniques

➢ Conduct therapy as an open forum where the therapist functions as a collaborator who seeks to join the family
➢ Engage parents in a learning experience and a collaborative assessment through conducting a Parent Interview; objectives should include:
  • Acquiring problem descriptions and parental concerns
  • Identifying goals
  • Understanding patterns of interaction that occur in a typical day
➢ Use an educational model to counsel families with an emphasis on the family atmosphere and family constellation
➢ Create a genogram of the family as a starting point for family communication
➢ Conduct a Child Interview to assess whether the children are aware of their behaviors (goal disclosure) and to introduce alternative goals
➢ Using System Description, verbally reframe mistaken interactions in a manner that highlights difficulties
  • By describing these patterns aloud, the therapist helps the family take the first step to unlocking them
➢ The technique of Goal Disclosure is most effective if the therapist is aware of specific misbehaviors rather than generalities
➢ At the time of Reorientation, change is facilitated by highlighting the family’s strengths
  • The therapist should normalize relations within the family by validating that the interaction observed is typical of families with the same values and the same number of children
Between sessions, the therapist provides recommendations for the family to follow that usually involve redirecting mistaken motivations.

F) Limitations
- Techniques require the parents’ commitment to make changes.
- Since this process relies on changes that happen at home rather than in the therapy session, “lessons” apparently learned may not transfer to situations outside the therapist’s office.
- This approach relies on the therapist’s ability to correctly assess family interaction and to form accurate hypotheses about the children’s mistaken goals.

G) Implications
- Since Adlerian family therapy is based on the assumption that the child is not mentally disturbed, effects of this therapy may be limited if there is true mental dysfunction.
- This type of therapy is dependent upon mutual respect; some families may not feel comfortable being co-educators.
- Some families resist the democratic nature of this approach.
SECTION 3: HUMAN DEVELOPMENT

ABNORMAL BEHAVIOR

Much of professional therapy is helping medically "normal" people with developmental and/or environmental problems. Still a therapy setting, according to the medical model, calls for knowledge of abnormal development assessments based on the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM). Abnormal behavior can be either "a deviation from the social norms" or "maladaptive behavior that interferes with optimal functioning and growth of the individual and, ultimately, society." In addition to psychoses, neuroses and other customary listings, some disorders causing individual problems and group conflict are included as maladaptive behaviors. Behaviors such as violence, prejudice/discrimination, corruption and contribution to pollution may be considered maladaptive.

Biological Viewpoint

The idea of a causal, empirical link between mental disorder and brain malfunction appeared during the Age of Reason and was widely accepted in the 19th century. Spurring further classification of illnesses and research into their physiological processes, the work of William Griesinger and Emil Kraepelin influenced this biological view.

Psychosocial And Sociocultural Viewpoint

With the start of the 20th century, psychology became accepted as a recognized discipline. This promoted investigation of psychological causes for behavioral problems. According to Coleman, et al., five views of human mind and nature that reveal the psychological perspective are:

- Psychoanalytic
- Behavioristic
- Humanistic
- Existential
- Interpersonal

To explain maladaptive behaviors, the varied approaches deal with different primary causes. For example, those advocating the biological view stress genetics, chemical functions and diseases of the brain, along with more obvious causes such as physical handicaps and physical deprivation. Proponents of the psychosocial school see stress, childhood trauma and unhealthy parental and/or family relationships as causes of psychological distress. Others look to sociocultural components that can cause psychological problems. These include war and violence, prejudice and discrimination, and dislocation caused by economic, cultural or technological change.

COMMUNITY SYSTEMS

System Maladaptive Outputs

- Agency decisions and staff behaviors are detrimental to individual or family adaptation

Dysfunctional Process

- Ineffective management systems
Inadequate programming
- Lack of staff training program stemming from interpersonal staff programs
- In some cases, there is a major focus of interventions on developing interagency cooperation in producing ongoing support to weak families

Therapists may serve as go-betweens in working out a relationship between the two feuding agencies so that their handling of the case could be consistent and supportive. For example:
- With welfare workers to support keeping a child in the home
- With community agencies to provoke family crisis (such as signs of parental neglect, emotional instability or behavior difficulties) so that intervention might occur, including:
  - Protective Services
  - Justice Systems
  - School Systems

At times, necessary pressure by the Juvenile Justice System supported by documentation from the school can create enough of a crisis in the family to get parents to take action for the betterment of the family.

Relationships established with agencies through a case-by-case process can lead to interventions at the community level which are less related to individual cases, including:
- Training agencies to teach adaptive skills to families
- Developing new programs aimed at strengthening families

Systems-crisis approach provides a rationale for the use of interventions at a variety of levels and a means for differential decision making with regard to what intervention would best be used.

It is felt that the use of community systems allows for the successful treatment of a broad range of cases and leaves therapists helpless in fewer instances.

**Crisis Intervention Models**

There is a 4-step Crisis Intervention model covering cases of:
- Date rape
- School violence
- Substance abuse
- Adolescent suicide
- Marital abuse
- HIV positive
- Hospital intensive care clients

**Step #1: Listen**
- Establish therapeutic relationship
- Identify precipitating problems
- Explore the patient’s emotions
Step #2: Assessment

- Determine the severity of the crisis
- Suicide/homicide assessment, or assessing the potential danger or physical harm the patient might do to himself/herself or others
- Identify past coping skills, strengths and supportive resources
- Determine the patient’s perception of reality
- Discuss cultural beliefs about handling trauma
- Find out if family and social opinions are potential resources
  - Are the resources positive or negative

Step #3: Treatment Plan

- Selectively choose and use appropriate approaches to action planning
- Modify or eliminate past coping skills so they don’t interfere with your current plan of attack
- Create a contract or have the patient sign a treatment plan so you are both on the same page
- Identify useful referral resources
- Use three basic approaches:
  - Start by being non-directive – let the patient tell you why they have come to you
  - Be collaborative - by working together on a joint plan
  - Be directive - if the person does not or will not make a plan
- If they are currently in a major crisis, have only short-term objectives

Step #4: Termination

- Review progress on treatment plan
- Plan for expanding resources and support system
- Schedule a follow up session

DEVELOPMENTAL MILESTONES

Only during a baby’s first month is its cry purely physiologically linked; from then on emotions are involved. Emotional contagion has been observed in children as early as two days after birth.

Before age 5, an EEG is required to differentiate between REM and slow wave sleep. As the child continues to mature, the 50% of sleep that is REM is easier to distinguish from slow wave sleep.

Milestones of Development

- **1-3 months**: Infant gains the ability to raise his/her chin from the ground and can turn its head from side to side and play with hands and fingers
- **4-6 months**: Baby rolls over
  - At 5 months, the baby reaches and grasps while sitting on someone’s lap
  - At 6 months, the baby sits alone and may stand with support
  - First teeth appear between 5 and 9 months
- **7-9 months**: Coordination improves
• Creeping and crawling usually begin between 8 and 9 months

- **10-12 months:** Child pulls himself/herself to standing position with furniture and walks with help
- **15 months:** Baby stands alone then gains ability to walk
  - He/she throws things
- **18 months:** Toddler can walk sideways and backwards
- **2 years:** Child walks with a steady gait, jumps, runs in a controlled way and can climb stairs with help
- **3 years:** Typically toilet trained, child dresses and undresses with simple clothing and can scribble
- **4 years:** Child prints first name and has stable preference for right or left hand
- **5 years:** Youngster coordinates movement to music
- **Middle childhood:** Gender differences appear
  - **Girls**
    1. More physically mature than boys of the same age
    2. Superior in skills requiring flexibility, agility and balance
    3. Early maturation works against girls resulting in:
      4. Lowered self-concept
      5. Dissatisfaction with physical development
      6. Sexual precociousness
      7. Increased potential for drug and alcohol abuse
      8. Late maturing girls also are:
         a. Likely to be dissatisfied with their physical appearance
         b. And resent being treated as younger than they are
  
  - **Boys**
    1. Stronger than girls
    2. Perform better in activities that require gross motor movement
    3. Early maturation improves popularity and adjustment
    4. Late maturing boys:
      a. Lack confidence
      b. Perform more attention-seeking behaviors
      c. Are considered childish

Other factors making for good development are high socioeconomic status, a two-parent family, little visible disfiguration and healthy parental adjustment.

**IMPORTANCE OF BIRTH ORDER - ALFRED ADLER**

**Personality**

**Oldest child:** As a child, this individual suddenly has to share his parents’ attention when the second sibling arrives. If proper transition does not occur, the firstborn may become insecure and dislike people. However, if proper transition occurs, he/she will be responsible, dependable, hard working and achievement oriented. Generally, the firstborn child has more rapid language
acquisition, achieves better grades in school and higher scores on IQ tests, and is more achievement oriented and socially responsible than later born children. The later are usually less cautious, have better peer relationships and are more confident in social situations.

**Second child:** From the beginning of his/her life, this individual shares attention and competes with the older sibling. These individuals are often ambitious.

**Middle child:** Middle children often feel left out and develop "poor me" attitudes.

**Youngest:** The baby can be spoiled, easily influenced by others and often develops in directions not thought of by others. These individuals are often the most liked.

**Only child:** Being accustomed to center stage, these individuals may not learn to share and cooperate. They relate and deal well with adults.

**Psychological Positions**

Birth order motivates later behavior:

- **First born/ Oldest**
  - Favored pseudo-parents, usually high achievers
  - Received more attention, tend to be spoiled

- **The Second born**
  - Rivalry and competition
  - Second of only 2, behaves as if they are in a race, often opposite first child

- **Middle Child**
  - Often feels squeezed out

- **Last born**
  - More pampered, “baby,” they tend to be more creative, rebellious, revolutionary, avant-garde
  - Acts like the baby and is treated accordingly

- **Only Child**
  - Does not learn to share or cooperate with other children
  - Learns to deal with adults more easily

**ATTACHMENT THEORY**

Psychoanalytic theory defines attachment in terms of the satisfaction of oral needs, while learning theorists add the aspect of reinforcement.

**Harry Harlow's** research with monkeys and their need for contact comfort played an important role in the early development of attachment theory.

**John Bowlby’s** idea of critical periods explains the biological predisposition humans have that increases the likelihood of forming attachments. An infant is programmed to cry and smile while adults are programmed to respond to the infant. During the first few months of the child’s life, such attachments are indiscriminant. After six or seven months the attachments become
increasingly directed to caregivers. Signs of attachment include a selective social smile beginning at six months and the emergence of stranger anxiety and separation anxiety.

- Stranger anxiety – Very anxious and fearful of strangers at six months; typically disappears by age two
- Separation anxiety – Severe distress when separated from primary caregiver beginning at 6-8 months; peaks in intensity at 14-18 months, continues until about age two, then diminishes

Patterns Of Attachment (Ainsworth: "The Strange Situation")

**Secure Attachment:** A securely attached infant is mildly upset by the mother's absence and actively seeks contact with her when she returns. Mothers of securely attached children are emotionally sensitive and responsive.

**Insecure (Anxious/Ambivalent) Attachment:** The infant becomes very disturbed when left alone with a stranger but is ambivalent to mother’s return and may resist her attempts at physical contact. Mothers of these children are often moody and inconsistent in their caretaking.

**Insecure (Anxious/Avoidant) Attachment:** The child shows little distress when the mother leaves and ignores her when she returns. Mothers of these children are impatient and unresponsive or provide their children with too much stimulation.

**Disorganized/Disoriented Attachment:** Signs of fearing their caretakers, confused facial expressions and a variety of other disorganized attachment behaviors mark these children. Eighty percent of infants who have been mistreated by their caregivers exhibit this pattern.

Early attachment seems to affect subsequent development. By ages four to five, children who were securely attached as infants are usually more curious, more popular with peers and less dependent upon adults. As adults, they have high self-esteem and a strong sense of personal identity, although it does not appear that insecure attachment in infancy is necessarily linked with poor social adjustment or adulthood psychopathology.

Children usually develop the same kind of attachment to both parents. Attachment to the father is usually a function of play. There is some evidence that fathers have closer relationships with sons than daughters; fathers also stay home more when they have sons.

**Prolonged Separation**

Children separated from the mother prior to three months of age show negative consequences ranging from little to none. Those separated at nine months exhibit moderate to extreme reactions including feeding and sleeping problems, social withdrawal, increased stranger anxiety and either physical rejection or extreme attachment to the new mother. Early institutionalization has the most negative impact when separation of the mother and child occurs in the second half of the first year. In this case, the infant may develop anaclitic depression, a syndrome involving developmental delays, unresponsiveness and social withdrawal. Adverse effects are reduced if the child is given adequate attention and affection. In general, the longer the institutionalization, the greater the effects will be.
Stages Of Prolonged Separation (Bowlby)

- **Protest:** Refuses to accept separation demonstrated by crying, kicking and screaming
- **Despair:** Gives up all hope and withdraws
- **Detachment:** Seems less unhappy, accepts attention from others and may react with disinterest when visited by the caretaker

**OBJECT-RELATIONS THEORY**

Comparable with the psychosexual view of development, object-relations theory places emphasis on early development as a decisive factor influencing later development. It is rooted in infant/mother studies conducted by Margaret Mahler. Psychoanalytic theorist, Heinz Kohut, expounded upon her theories to say children who do not experience the opportunity to differentiate themselves from others may later develop narcissistic character disorders. Object-relations theorists focus on symbiosis, separation, differentiation and integration.

**STAGES OF DEVELOPMENT - MARGARET MAHLER**

Based on psychoanalytic concepts, Mahler presented 3 stages of development in the preoedipal phase of an infant (first 2 or 3 years) with the third stage broken down into 4 sub-categories:

- Autistic (newborn to 1 month)
- Symbiosis (Fusion with Mother)
- Separation-Individuation
  - Differentiation
  - Practicing motor skills
  - Rapprochement
  - Constancy of self and object


**HIERARCHY OF NEEDS - ABRAHAM MASLOW**

Based largely on his study of highly competent, self-actualized people, Abraham Maslow developed the hierarchy of needs. In Maslow’s proposal, the lower order needs of survival and safety must be met before higher order needs like love, dignity and self-actualization can be effectively sought. With the benefit of a supportive environment conditioned by creativity, happiness, autonomy and egalitarian regard, Maslow believed people seek self-actualization.

**HIERARCHY OF NEEDS**

Needs from high to low:

- Self-actualization
- Self-esteem
- Belonging
- Safety
- Physiological
STAGES OF COGNITIVE DEVELOPMENT - JEAN PIaget

Jean Piaget's conclusions from his work with children continue to exert the most lasting influence on cognitive developmental theory. This approach sees cognitive development as essential to moral, ethical and self-concepts. In Piaget’s structuralist view, humans develop by attempting to understand and adapt to their environments.

Piaget presented Four Cognitive Developmental Stages of experience and interaction with the environment:

- **Sensorimotor Stage** (birth to 2 years)
  - Knowledge gained through active interaction with the environment
  - Beginning awareness of cause and effect relationships
  - Learning objects exist even when not in view
  - Crude imitation of actions of others

- **Pre-operational Stage** (ages 2 to 6 years)
  - Initially very egocentric
  - Development of language and mental representations
  - Classification of objects by a single characteristic at a time

- **Concrete Operations Stage** (ages 6 to 12 years)
  - Understanding of conservation of volume, length, etc.
  - Organization of objects into ordered categories
  - Comprehension of rational terms (i.e., bigger than, above)
  - Beginning use of simple logic

- **Formal Operations Stage** (over 12 years of age)
  - Thinking becomes abstract and symbolic
  - Development of reasoning skills and a sense of hypothetical concept
  - **Stages**: Applies to all individuals and indicates a qualitative difference
    1. Object Permanence
    2. Egocentrism
    3. Conservation
    4. Abstract Thinking
    5. Concentration

**Adaptation Involves:**

- **Assimilation**: The process of adding new material/information to an existing schema
- **Accommodation**: The process of altering or revising an existing schema in light of new information
- **Equilibration**: Keeping balance by creating new concepts

**Assimilation vs. Accommodation (Equilibration)**

- **Object Permanence**: The appreciation that an object no longer in view can still exist and may reappear later (early in stage two)
- **Schema**: A system of organized general knowledge stored in long-term memory that guides the encoding and retrieval of information
Optimistically expanding Piaget's work, Lawrence Kohlberg included formation of a sense of justice in three levels:

- **Pre-conventional**: Acting from selfish rather than social motives
- **Conventional**: Acting according to social norms
- **Post-conventional**: Acting on moral, legal and ethical principles, irrespective of temporary social rules

Kohlberg also proposed **Three Stages of Gender Development**:

- Stage 1 *Gender Labeling*: The child has reached a point where he/she can recognize boy-ness or girl-ness in self and others, but does not understand it to be static over time.
- Stage 2 *Gender Stability*: The child now understands that his/her gender is stable and that he/she will grow up to be a daddy or mommy. The static aspect of gender that is that gender will not change with time no matter what appearance or activity choices are made. This concept is not fully understood.
- Stage 3 *Gender Constancy*: The child now has a full understanding of the unchanging nature of gender over time and across situations.

There are **Seven Stages** and two transitions in Jane Loevinger's theory of **Ego Development**. Defined according to character growth, ways of relating to others, thinking and conscious concerns, they progress as follows:

- Pre-social/symbiotic
- Impulsive
- Self-protective
- Conformist conscientious/conformist
- Conscientious individualistic
- Autonomous
- Integrated

Working with college students, William Perry devised **Three Stages of Intellectual and Ethical Development**:

- **Dualism** – Seeing things in terms of black and white
- **Relativism** – Abstract thinking leading to a rejection of easy absolutes
- **Commitment** – Taking personal responsibility for dealing with the right/wrong dichotomy

Robert Kegan saw people as involved in a continuing cognitive process that lasts a lifetime and promotes personal growth by assigning sense and meaning to things and events. This also is stage theory, and its stages are:

- Incorporative
- Impulsive
- Imperial
- Institutional
- Interindividual
**Freud’s Psychosexual Stages of Development**

According to Sigmund Freud, personality develops through several stages during the first five years of life; difficulty or dysfunction can create an adult personality mired in characteristics of the oral, anal or phallic stage. He proposed **Five Psychosexual Stages of Development** in which each stage has developmental causes and effects:

1. **Oral** (birth to about age 2): Greedy, mistrust, unable to form intimate relationships
   
   As the term ‘oral’ suggests, this stage primarily involves an infant’s pleasure stimulus via their mouth - everything finds its way into it. This includes sucking such as nursing, pacifiers or finding their thumb for pleasure and comfort, chewing on toys and spitting objects out of their mouth such as that pacifier we’re now bored with.

2. **Anal** (about ages 2 to 3) - Anal retentive, aggressive
   
   The infant phases from oral pleasures to the elimination independence stage. The joys of toilet training are the way parents deal with the infant’s newly discovered freedom - expelling feces.

3. **Phallic** (about ages 3 to 6) - Identity disturbance (Oedipal/Electra complex)
   
   As the child reaches almost four, they become aware of their own sexual identification, discovering pleasure when their genital areas are stimulated. They also become aware of differences in boys and girls. Freud felt a process of this stage was feelings of sexual bonding to their parent of the opposite sex. He categorized these as:
   
   - **The Oedipus Complex**: (castration anxiety) - Boys feeling sexually attracted to their mother and feeling competitive with father for her attentions
   - **The Electra Complex**: (penis envy) - Girls feeling sexually attracted to their fathers and jealous of their father’s attentions for their mother

   Freud theorized the central developmental undertaking the child faces in this stage would be to repress this sexual desire. Recognizing the need to compensate their relationship with the parent of the same sex, the child embraces their sexual identity developing their superego by bonding and adapting male role norms for boys and female role norms for girls.

4. **Latency** (about 6 to puberty) - Socialization stage
   
   Freud felt this was the one stage where sexual desires are overshadowed by the child’s need to adapt to their environment. Tending to avoid relationships with the opposite sex, they are drawn to authority figures (teachers and coaches at school or scout leaders and coaches of little league) further developing their superego.

5. **Genital** (puberty +) - Interpersonal relations, freedom to love/work
   
   This stage is dominated by puberty, hormones kicking in, reigniting the adolescent’s sexual drives. They revert from selfish sexual pleasures of the Phallic stage turning their attentions toward others and discovering what love is on a more mature level

**Erikson’s Eight Stages of Maturation**

Like Freud, Erik Erikson explained human development with stage theory, but proposed a progression through **eight psychosocial stages** over a lifetime. Problems inherent to each stage must be resolved before maturing into the next. The first five stages closely follow Freud's, but in
a social context. The last three extend through adulthood to old age, parts of life not included in Freudian developmental theory. Erikson's life stages, defined by their psychological conflicts and crises, are:

- **Trust vs. Mistrust**: (Birth to about age 18 months)
  - This stage provides the infant a basic sense of safety (adequate resolution) vs. insecurity and anxiety (inadequate resolution)

- **Autonomy vs. Shame/Self Doubt**: (18 months to three years)
  - Marked by the unfolding of a self-view as capable of bodily control and the ability to make things happen (adequate resolution) vs. the feeling of inability to control events (inadequate resolution)

- **Initiative vs. Guilt**: (Ages 3 to 6)
  - The child develops confidence as an initiator and creator (adequate resolution) vs. lack of self-worth (inadequate resolution).

- **Industry vs. Inferiority**: (6 years to puberty 12)
  - The time to develop adequacy in basic social and intellectual skills (adequate resolution) vs. feelings of failure and lack of self-confidence (inadequate resolution)

- **Identity vs. Role Confusion**: (Adolescent years, 12 to 20)
  - A comfortable sense of self as a person is reached (adequate resolution) vs. a fragmented, shifting or unclear sense of self (inadequate resolution)

- **Intimacy vs. Isolation**: (Early adulthood, 20 to 40)
  - Development of the capacity for closeness and commitment to another (adequate resolution) vs. feelings of aloneness and separation or denial of need for closeness (inadequate resolution)

- **Generativity vs. Stagnation**: (Middle adult years, 40 to 65)
  - Marked by focused concern beyond oneself to family, society and future generations (adequate resolution) vs. self-indulgent concerns and a lack of orientation toward future (inadequate resolution)

- **Ego Integrity vs. Despair**: (Later adult years, 65 on)
  - A sense of wholeness and basic satisfaction with life is seen (adequate resolution) vs. feelings of futility and disappointment (inadequate resolution)

**COMPARISON OF SYSTEMS: FREUD VS. ERIKSON**

- Freud’s term: **Oral stage**. Erikson’s stage: Basic trust vs. mistrust. The infant must resolve whether or not to trust the primary caretaker

- Freud’s term: **Anal stage**. Erikson’s stage: Autonomy vs. shame. As a toddler grows, autonomy develops from positive interactions with parents or caretakers

- Freud’s term: **Phallic stage**. Erikson’s stage: Initiative vs. guilt. Occurring during the early years of schooling, this stage results in the establishment of favorable relationships and the ability to set goals and to carry out plans without infringing upon the rights of others

- Freud’s term: **Latent stage**. Erikson’s stage: Industry vs. inferiority. To avoid feelings of inferiority, the school age child must master social and academic skills
Freud’s term: **Genital stage.** Erikson’s stage: **Identity vs. role confusion.** During adolescence, a sense of personal identity and a direction for the future emerge.

Erikson’s stage: **Intimacy vs. isolation.** Occurring in early adulthood, this is the time of establishing the intimate bonds of love.

Erikson’s stage: **Generativity vs. stagnation.** A generative person exhibits commitment to the well being of future generations, a commitment developing during the years of middle adulthood.

Erikson’s stage: **Integrity vs. despair.** In the maturity of older adulthood, a person comes to terms with personal limitations.

**PERSONALITY THEORY + TRAIT THEORIES**

Standing apart from psychoanalysis, the field of personality psychology was developed in the 1930s by Harvard theorists [Michael Murray](https://www.socialworkexam.com) and [Gordon Allport](https://www.socialworkexam.com), with additional work by [Raymond Cattell](https://www.socialworkexam.com) and others.

Cattell created a list of 171 personality traits which, factored and correlated, show sixteen ways in which personalities can diverge. Surface traits or observable behaviors give evidence of deeper source traits, measurable with the **Sixteen Personality Factor Questionnaire**. Since limited empirical confirmation is available, Cattell's claim to pinpointing basic personality with this method is not universally accepted.

Founded more on uncontrolled observation than on scientific method, personality theories tend toward the philosophical.

**Major Approaches To Personality Theory**

- Trait
- Psychoanalytic
- Humanistic
- Cognitive

According to Murray, two kinds of needs, basic (primary needs) and learned (secondary needs), shape personality. External events either aid or block fulfillment of needs. Needs and environmental press combine to create **thema.** Two assessments based on Murray’s work are the Thematic Appreciation Test (TAT) and the Edwards Personal Preference Schedule (EPPS).

The word association technique and the concept of introversion/extroversion are contributions demonstrating [Carl Jung](https://www.socialworkexam.com)'s lasting influence on personality assessment. Using free associative responses to a list of a hundred words, Jung presented four structural aspects, typing personality according to the following:

- Introversion/extroversion
- Sensing/intuition
- Thinking/feeling
- Judgment/perception
Used in education, counseling and research, **Myers-Briggs Type Indicator** is grounded in Jung's early work.

Proposing a lifetime progression through stages of personality development, Sullivan viewed social interactions as showing a dynamic self, influenced by expectations of the outside world. When opposing personifications (senses of the self and of others) evolve and coexist, a person must search for balance between the "bad" and "good" selves.

**Trait Theories**

Viewing personality traits as ranging from specific behaviors to general ways of dealing with the world, **Gordon Allport** saw personality less as a reaction to outside events than as a changing, internal process. Comparing people in the same culture, Allport determined certain traits that define the culture. He then identified **personal traits** as the five to ten traits that may be used to describe a particular person, while **cardinal traits** are those that contribute to the dominant feature in someone’s personality.

Allport also concluded a person's philosophy of life may be understood by knowing his/her set of values. Allport, **Philip Vernon**, and **Gardner Lindzey** created the **Study of Values** assessment, designed to measure moral/ethical world view according to attitudinal categories: theoretical, economic, aesthetic and religious.

**STAGES OF MORAL DEVELOPMENT - LAWRENCE KOHLBERG**

Studying children and their ways of dealing with moral choices, **Lawrence Kohlberg** theorized **Six Conventional Stages** occur in **Moral Reasoning**. He divided the stages into three levels:

- **Pre-conventional level**
  - **Stage 1**: Punishment and obedience orientation
  - Physical consequences determine what is good or bad
  - **Stage 2**: Instrumental relativist orientation
  - That which satisfies personal needs is good

- **Conventional level**
  - **Stage 3**: Interpersonal concordance (good boy/nice girl)
  - What pleases or helps others is good
  - **Stage 4**: Law and order orientation
  - Maintain the social order
  - Devotion to duty is good

- **Post-conventional level**
  - **Stage 5**: Social law contract
  - Values agreed upon by society determine what is right
  - **Stage 6**: Universal ethical principle orientation
  - What is right is a matter of conscience in accord with universal principles
  - Moral Level is assessed using the **Heinz Story**
The Heinz Story

In Europe, a woman was dying of a rare form of cancer. Doctors believed there was only one drug that could save her. Her particular local druggist was charging $2,000 for a small dose of this drug, although it only cost him $200 to make. The woman’s husband, Heinz, could only manage to collect $1,000 for the drug. He pleaded with the druggist to sell it to him cheaper, but the druggist refused. Desperate, Heinz decided to break into the druggist’s store and steal the drug to keep his wife alive.

Should Heinz Have Done This?

Kohlberg presented this and other case scenarios to his subjects in order to observe their reasoning and outline his theories on the development of morals in children.

SOCIAL LEARNING THEORY - ALBERT BANDURA

Albert Bandura's social learning theory holds that behavior occurs as a result of the interplay between cognitive and environmental factors. Persons learn by observing others, intentionally or accidentally, in a process known as modeling. In groups, members learn from one another.

Bandura expanded the overall definition of behaviorism. He suggested, while it was true a person’s environment was responsible for his behavior, people also had a strong influence over the nature of their environment. He coined his idea reciprocal determination.

Observational Learning

In what is perhaps one of Bandura’s most well known studies in observational learning, a group of children were shown a video of a young woman physically and verbally abusing a ‘bobo’ doll, a 5-foot tall blow-up punching bag. The woman yelled, kicked and beat the doll with a hammer while the children watched. After viewing the video, the children were left in a playroom with a bobo doll and several small hammers while observers watched through a two-way mirror in the next room. As he predicted, the children imitated the same behaviors they had witnessed in the video - beating, hammering and yelling aggressively at the doll. After a series of experimental variations, Bandura outlined several factors that lead children to model behaviors of others. Collectively these came to be known as Bandura’s Social-Learning Theory.

Bandura also developed a theory of self-regulation, which states we have the ability to control our behavior through a series of three main steps:

- **Self-observation**: Paying close attention to a specific behavior, how frequently it occurs, under what circumstances, etc.
- **Self-judgment**: Comparing ourselves with a standard either self-imposed or set by society, then creating a goal for ourselves based on that standard
  - E.g., Vowing to exercise three days per week
- **Self-response**: Rewarding yourself each time you meet or surpass your standard, and punishing yourself any time you don’t

Over time, our cumulative successes and/or failures lead us to develop what is known as a self-concept. A person who has had a life of successes probably has a favorable self-concept, whereas a person who has failed to meet his standards and constantly punishes himself probably...
has a poor self-concept. Bandura also warned against too much self-punishment, outlining three problems that may arise from such an approach:

- **Compensation:** A person may develop a superiority complex
- **Inactivity:** A person may become depressed, apathetic and bored
- **Escape:** A person may seek to escape his problems through television, drinking, drugs or suicide

**Bandura’s Modeling Therapy**

Modeling therapy is based on the idea that a person suffering from a psychological disorder can correct his problems by observing someone else dealing with similar issues. While developing his theory, Bandura conducted experiments on herpephobics, people with a phobic fear of snakes. In his experiments, the herpephobics stood by and observed while an actor pretending to have a fear of snakes approached a cage with a snake inside. The actor went through a series of steps, first withdrawing from the cage in fear, then using calming self-talk to gradually conquer his phobia and eventually removing the snake himself from the cage. Bandura found the therapy to be overwhelmingly effective. Many clients were able to extinguish their fears after just one round of observation, despite knowing the person they were watching was an actor.

**LANGUAGE DEVELOPMENT**

Noam Chomsky saw language as an innate capacity. From this nativist viewpoint, people possess innate mechanisms for language acquisition. Many nativists believe in a critical period for language acquisition and cite the success of language adaptation among adolescent immigrants over adult immigrants as support.

**Definitions Relating To Language:**

- **Phonology:** The study of the sounds of a language
- **Phoneme:** Smallest unit in a language (in English "st," but not "sb")
- **Morphology:** The study of morphemes or the smallest combinations of sounds that have meaning within a language (prepositions, prefixes and suffixes)
- **Syntax:** Rules of grammar
- **Semantics:** Rules for selecting words that express an intended meaning
- **Pragmatics:** The use of language in different social contexts (turn-taking, nonverbal communication and slang)

**Language Structure**

- **Surface structures:** Organization of words, phrases and sentences
  - “Visiting relatives can be tiresome.”
- **Deep structures:** Meaning gained from surface structures
  - “Relatives who visit can be tiresome.”
  - “Going to visit relatives can be tiresome.”

Effective verbal communication involves translating deep structures into surface structures that will be understood by the listener. Listening is the opposite; in order to understand the communication, a listener must determine the deep structure from the surface structure.
Language Acquisition

A child’s first words are likely to be social expressions such as:

- “Hi,” “bye-bye” or “thanks”
- Names for objects that are permanent, familiar and usually movable such as “Dada” or “blanket”
- Action words such as “punch” or “fall”

Since they often receive more adult attention, only children tend to develop language most quickly. Words representing sensations (such as cold) appear later in linguistic development.

Deaf and normal children vary developmentally. During the first half of the first year, both make sounds. In the second six months, hearing children increase the variety of sounds made, whereas deaf children do not.

Stages Of Language Development

- **Babbling:** 6-8 weeks
  - Babbles include sounds used in all languages
- **Cooing:** 10-12 weeks
- **Echolalia:** 9 months
  - Child forms quasi-sentences without real meaning
- **Holophrastic speech:** 1-2 years
  - Single words are used to express whole sentences with the first words generally being nominals
- **Telegraphic speech:** 18 to 24 months
  - Pre-sentences such as “me go” and “more juice” are formed
  - Vocabulary increases
- **Grammatically correct sentences:** 2½ to 5 years
  - The youngster can understand the concept of a lie age four
- **Metalinguistic awareness:** 6 to 7 years
  - Language is viewed as a communication tool
  - The child views himself/herself as a user of language
  - Although recent research indicates the age may be earlier, it has been believed a child begins to voluntarily lie at age seven

**LINGUISTIC RELATIVITY - BENJAMIN WHORF**

Benjamin Whorf’s theory of linguistic relativity was based on his work with Native Americans, specifically the Hopi language. His theory, conjointly with Edward Sapir called, the Sapir-Whorf hypothesis, claimed language shapes the way people think. Because they have differing languages, cultures vary in their understandings the world. Presently, the link between language and thought is considered to be bi-directional.

- Behaviorists view language acquisition and use as controlled by environmental factors
- Not surprisingly, boys rely more on language strategies that:
• Establish dominance
• Gain attention
• Involve giving orders
  ➢ Additionally, males talk for longer periods of time and are more likely to interrupt a speaker than females
  ➢ Girls use language to give support and demonstrate attentiveness
  ➢ In cognitive tasks and measures of language development, bilingual children do at least as well as monolingual children

**MEMORY**

With less working memory than adults, young children typically have a memory span of 2-3 digits while adults can repeat 6 or more. By age 9 or 10, children use rehearsal, elaboration and organization to increase retention.

**Definitions Relating To Memory:**

  ➢ **Metacognition:** The ability to think about thinking
  ➢ **Metamemory:** The ability to reflect on memory as a process
  ➢ **Infantile amnesia:** The lack of memories earlier than the first three years of life, generally experienced by children and adults
  ➢ **Giftedness:** Possession of advanced metacognitive skills and abilities to select, evaluate and apply cognitive strategies
    • Gifted children have mild elevations in self-concepts

**GROWTH AND MATURATION**

Maturation is the development of a clear identity and power of choice; it includes the ability to communicate with others. Coping skills increase with self-esteem.

The components of self-esteem are security, belonging, competence, direction and selfhood. To build self-esteem and increase communication, family roles need to be identified and this knowledge used to build relationships. One intervention is a **family life chronology** (three generations).

Two types of worldviews: "**Threat and Reward**" (With rigid rules, this type of view divides people into rule-makers and rule-followers.) vs. "**Seed**" (Each person has the innate potential for growth.)

Family reconstruction is an exercise in which roles in significant family historical events are examined to determine what implicit premises guide perceptions and interactions. It includes an analysis of how family members handle differences.

**Self-manifestation** (congruence) analysis seeks to determine what models have impacted a person from early life onward. Experience and ability to make choices are expanded.

Being a sculpting (group posture) technique, a **parts party** builds awareness and exercises both mind and body. Assets are labeled. Drama, metaphor, art and stories are used.
Different perspectives help explain different theories of human growth and development. These approaches include behavioral, organismic, maturational, structural and interactional:

**Behavioral**

Similar to viewing life as a television melodrama, this worldview considers a person’s actions to be mostly reaction to environmental factors. Since external circumstances control behavior and the concept of being the master of one’s fate is an illusion, social and other environmental influences are paramount. Cognition, mind and biology are minimized.

**Organismic**

Like the dramatic protagonist presenting character as fate, this view sees people as cognizant actors shaping their own destinies. Environment provides the setting for biological factors that drive development.

**Maturational**

Growth and differentiation are bounded, but not caused, by environmental circumstances.

**Structural**

A person creates his/her own development by mindfully interacting with the environment. Maturity and both social and physical influences complement these choices.

**Interactional**

Development is marked by change in an ever-changing world. A contextual view, the interactional process sees people (as neither gods nor pawns) reacting to and acting upon changing biological, social, cultural, historical and other environmental contexts. Rather than providing congruity, achievement increases challenge.

**IDENTITY ISSUES IN ADOLESCENTS**

Erikson considered development of a stable identity to be the primary developmental task of adolescents and viewed adolescence as a period of "psychosocial moratorium" during which an individual experiments with different roles before choosing one. **James Marcia** distinguished **Four Identity States** or patterns that characterize adolescence:

- **Identity diffusion**: The adolescent has not yet experienced an identity crisis, explored alternatives or committed to an identity
- **Identity foreclosure**: When an adolescent has not experienced a crisis but has adopted an identity (occupation, ideology) imposed by others, identity foreclosure has occurred
- **Identity moratorium**: A period marked by confusion, discontent and rebellion, identity moratorium occurs when an adolescent experiences an identity crisis and is actively exploring alternative identities
- **Identity achieved**: The identity crisis has been resolved by evaluation of alternatives and commitment to an identity
G. Stanley Hall (1904) identified adolescence as a period of "storm and stress" involving emotional maladjustment and instability. Research has not ruled this out. About 10-20% percent of adolescents experience distress, a rate similar to the adult population. More likely to experience depression, drug use and delinquency or to attempt suicide than preteens, adolescents do experience great life changes. Parents who provide their teens with support and reassurance while allowing them to establish their own views promote the strongest sense of personal identity. Egocentrism reemerges during the teen years and involves confusion about personal thoughts and the thoughts of others. Such egocentrism is generally manifested in two phenomena:

- Accounting for their acute sense of self-consciousness, adolescents frequently feel they are onstage
  - For example: A teenage girl who imagines everyone is staring at the pimple on her nose
- A strong belief in the uniqueness of one’s own experiences, the personal fable leads to a sense of immortality

**Parenting Styles - Diana Baumrind**

There is no one right way to bring up children, however, Diana Baumrind categorized parental relationships with children into four basic styles:

**Authoritarian Parents**

Demanding conduct that meets absolute standards, stressing obedience and using harsh punishments to ensure compliance, authoritarian parents exhibit a high degree of control and little warmth. Children of authoritarian parents are irritable, aggressive and dependent. They often have a limited sense of responsibility, low levels of esteem and poor academic achievement. Parents who consistently use punitive, repressive methods are likely to produce children who are socially withdrawn, hostile and rebellious.

**Authoritative Parents**

Displaying rational control, warmth and responsiveness and promoting independence, authoritative parents set clear rules and high standards, meanwhile explaining their rationales for decisions and encouraging discussion with their children. Children of authoritative parents are assertive, self-confident, socially responsible and achievement oriented. They often earn high grades in school.

**Indulgent-Permissive Parents**

Indulgent-permissive parents are warm and caring but provide little control, make few demands and are non-punitive. Their children are often impulsive, self-centered, easily frustrated and low in achievement and independence.

**Indulgent-Uninvolved Parents**

Displaying low levels of warmth and control, indulgent-uninvolved parents minimize the time and effort expended upon their children. Children of indulgent-uninvolved parents have low levels of self-esteem and are often impulsive, moody, aggressive, delinquent and rebellious.
Parental Discipline

Characteristic of authoritarian parents, **power-assertion** includes physical punishment, threats and deprivation. Using punishment to control aggression can actually increase it, especially when the child does not identify strongly with the person administering the punishment and when punishment is not accompanied by an explanation of why the behavior is undesirable.

Harsh inconsistent discipline, lack of positive parenting and poor supervision have been linked with aggression and other antisocial behaviors. Whereas, communication of clear standards of behavior, coupled with the use of reasoned praise, has been associated with reduction in aggression and antisocial behaviors.

**Peer Relationships**

As friendships with those who are similar in race, gender, interests and attitudes, peer relationships provide an important component of developing social skills.

- Ages 4-7: Peers are playmates, children who like each other and play together
- Ages 8-10: Trust and assistance are important
- Age 11: Intimacy and loyalty build

**Gender Differences**

- **Females**
  - Drawn to the emotional and intimate aspects of relationships
  - More in friendship exclusive than males
  - Greater self-disclosure
- **Males**
  - More emphasis on shared interests and activities
  - Have a larger number of friends
  - By adulthood, quality outranks quantity

According to the buffering hypothesis, a person’s perception of having social support becomes more important than the actual amount of support.

As pointed out by **Stephen Gilligan**, adolescent girls are especially vulnerable during their adolescent years and experience a relational crisis that involves psychological separation from themselves, others and the world as a result of external pressures to conform to cultural stereotypes.

**Children Who Are Popular With Peers**

- Have a positive self-concept
- Are attractive, intelligent and creative
- Are friendly and exhibit good social skills

**Children Who Are Actively Rejected By Their Peers**

- Are overaggressive or withdrawn
- Are immature and lack social competence
- Tend to get low grades and have a poor self concept
Are at higher risk for delinquent, anti-social behaviors as adolescents
May show anxiety, depression and other psychological issues

Peer Pressure
- Conformity to peers is more likely for pro-social behavior than for antisocial behavior
- The effect of peer pressure is greatest in the areas of overt observable behavior such as choice of music and dress or smoking, drinking and drug use
- Middle school and high school students CAN resist peer pressure to act antisocially
- Parents have a greater effect than peers on decisions related to career, college, politics and other important issues
- Assertion has been successful in prevention of drug abuse among children with the “Just Say No!” campaign

Sibling Relationships
The nature of sibling relationships varies over the period of childhood.
- It is influenced by the temperament of the siblings
  - During childhood, considerable sibling rivalry is the pattern
  - Middle childhood is marked by closeness and conflict
  - In adolescence, conflict declines
- Siblings get along better if they believe parents do not have a favorite
- The sibling relationship often mirrors the parental relationship
- The more the parents intervene, the more frequent the conflicts will be
- In later life, sibling relationships are highly variable

Historical Trauma
The collective emotional and psychological injury both over the life span of an individual and across family generations, historical trauma is a result of a societal/ethnic/racial trauma.
- Such as:
  - Holocaust
  - Native American Genocide
  - Japanese Concentration camps
  - Slavery
- The detrimental effects are wide ranged
  - Psychological
    1. Could lead to Depression
    2. Ultimately suicide
  - Behavioral effects might lead to
    1. Alcoholism
  - Medical problems may arise such as
    1. Heart disease
  - Societal problems may crop up
1. Such as child abuse and domestic violence
2. These can be helped using treatment goals
   • Psychoeducational and normalization of feelings regarding the trauma
   • Sharing effects of trauma in order to provide relief
   • Collective mourning/healing in order to create positive group identity and reunion with community

> Another detrimental effect might lead to Survivors' Child Complex
  • Fixation on the trauma
  • Failed attempts to resolve the past

> The problem may be Disenfranchised Grief
  • Loss cannot be openly mourned (due to culture or present societal circumstances)

> Some may develop Transposition
  • Living in the past and the present

> Psychological symptoms of trauma include:
  • Nightmares
  • Perceived obligation to ancestors
  • Individual feels inhibited with shame
  • Society suffers the loss of an ancestral tradition
  • 1st Generation often has Post Traumatic Stress Disorder

> Coping strategies:
  • Memory candles
  • Living testaments
  • Bring back ancestral tradition

COUPLE REACTIONS TO ANTICIPATORY TRAUMA

For example, when a couple's relationship is strained with one spouse dying of terminal cancer, they go through several phases:

> Emotional Phase
  • Fear of what they are losing and if they will be able to handle the loss
  • Anger possibly at their spouse
  • They might feel confused
  • Or hopeless to fix it
  • It might lead to loss of control
  • Numbness, feeling like nothing will help
  • They might become moody
  • Or very irritable snapping at anything the spouse might say regardless of the subject
    1. For example, “It's Monday, no it's the first day of the work week.”
  • That may lead to guilty feelings later when they realize they never gave the spouse a chance

> The Behavioral Phase
  • May lead to social withdrawal with a spouse giving up all their activities and withdrawing into their bedroom
This most certainly leads to disruption of daily activities. They may become so sensitive, they become easily startled or jumpy, or cry at the drop of a hat.

**The Cognitive Phase**
- Their thoughts become preoccupied, anticipating the inevitable trauma
- This leads to difficulty concentrating on anything other than the end coming
- In some, their self-esteem takes a nosedive
- They become totally indecisive in all their thought processes
- And tend to have poor memory recall

**Somatically,** their entire body may be effected by their worry
- Their muscles become tense
- Which can lead to headaches
- Gastric problems
- Loss/irregular sleep and appetite can cause the body to be fatigued

Treatment techniques vary, but several helps are:
- Social support from friends and family
- Taking care of your physical self
  - Engaging in daily exercise
  - Eating healthy
  - Getting regular sleep
- For some, turning to spirituality offers hope and relief
  - Including meditation or guided relaxation
- Make sure they remember the power of positive thinking, engaging in positive self-talk
- When all else fails, find the humor daily and trust things will get better

**Physical/Emotional Abuse**

**Risk Factors and Relational Patterns of Endangerment**

**Risk Factors For Victimization**
- Being female
- Young age
- Being a minority
- Drug and alcohol use
- High-risk sexual behavior
- Exposure to victimization as a child
- Low education level
- Unemployment
- Low SES socioeconomic status
- Little or no support system
- Low self-esteem
- Adolescence or developmental transition period
Having a verbally abusive, jealous or possessive partner
Couples with income, educational or job status disparities
Dominance and control of the relationship by the male
Weak community sanctions against victimization
  • E.g., Police unwilling to intervene
Traditional gender norms
  • E.g., Women should stay at home and not enter the workforce and should be submissive to the man

**Risk Factors For Perpetration**
- Low self-esteem
- Low income
- Low academic achievement
- History of delinquency in youth
- Drug and alcohol use and abuse
- Depression or other psychological diagnosis
- Anger management issues
- Axis II disorders
- Past history of abuse
- Social isolation
- Unemployment
- Emotional dependence or codependence
- Belief in strict gender roles
- Abuse of power and control
- Past history of victimization
- Marital conflict-fights, tension and other struggles
- Marital instability
  • E.g., Divorces and separations
- Unhealthy family environment or blurred boundaries

**Abusive Behaviors**
Abuse is defined as “improper or excessive use or treatment” and can come in many forms, not just physical. Abusive words can be devastating, just as sexual or emotional abuse, especially to an innocent child.

**Child Abuse**
The abuse of a child results in physical, emotional and social consequences.
- These consequences include:
  • Cognitive developmental delays
  • Poor school achievement
  • Few friends
• Problems in relationships with teachers and other adults
• Aggressiveness and other behavioral problems

Additionally, abusive parents were often abused themselves. Having a very low tolerance for normal infant behaviors, they also tend to misinterpret their children’s behaviors in negative ways. Often they exhibit high levels of anger and conflict.

Recognizing Signs Of Abuse

In The Child
- Sudden changes in behavior or school performance
- Non-medical attention for problems brought to parent’s attention
- Learning problems or difficulty concentrating that cannot be attributed to specific disabilities
- Tends to be watchful, expecting something to happen
- Lacks adult supervision
- Overly compliant, passive or withdrawn
- Comes to school or other activities early, stays late and does not want to go home

The Parent
- Shows little concern
- Denies existence of, or blames the child for, problems at school or home
- Asks their child’s teachers to use physical discipline
- Describes child as bad or burdensome
- Demands high levels of academic and physical performance
- Relies on child for care, attention or emotional needs

Parent And Child
- Do not look at or touch each other
- View of relationship is only negative
- State they do not like each other

Spousal Abuse
Generally, battering does not occur constantly. According to Dr. Lenore Walker, about two-thirds of the acts of spousal abuse follow an identifiable cycle of violence:

- Build-up of tension
- Incident of acute battering
- Loving contrition

When the woman perceives balance between the costs of abuse and the benefits of the husband’s positive behaviors (loving contrition), the relationship stays relatively stable. When the costs outweigh the benefits, the wife may try to pull away, which could evoke either increased abuse or an attempt to seduce the wife back into the relationship.
Additionally, the wife stays because she believes her husband will change. She may also fear her departure will trigger additional violence; a belief seemingly supported by research that indicates 70% of spousal abuse occurs after the spouse has attempted to leave.

**Cycle Of Abuse Model**

- **Phase 1: Tension building stage**
  - Anger
  - Blaming
  - Arguing
- **Phase 2: Acute battering incident**
  - Hitting
  - Slapping
  - Use of weapons
  - Sexual abuse
  - And/or verbal threats and abuse
- **Phase 3: Honeymoon phase or calm stage**
  - Male may deny violence, make excuses or apologize and promise reform
  - This stage may decrease or vanish as the pattern continues

**Cycle Of Abuse**

**Tension Building Stage**

During this phase of the cycle, tension builds. Stressors such as jobs, finances, children and other areas of conflict increase the tension; there may be verbal, emotional or physical abuse during this phase. Over time, abuse and battering escalate in frequency and severity. The woman attempts to control the abuse through various coping techniques such as avoidance, placating or giving in. These stopgap measures do not work for long, if at all. Once tension reaches an unbearable level, the acute battering incident occurs.

**Acute Battering Incident**

An uncontrolled discharge of built-up tension, the battering incident occurs when the process has stopped responding to any control. Rarely is the trigger for moving into this phase the woman's behavior; rather, it is usually the internal state of the abuser or an external stressor (such as problems at work, a financial crisis or a minor event such as a flat tire). The battering that occurs is usually much more intense than anything in phase one, and the woman may be severely injured. Since the acute battering incident may be triggered by anything, prediction of its timing is impossible. Occasionally, a woman may unconsciously provoke the incident. She knows from experience that it is coming and wants to get it over with, plus she knows a calm or honeymoon phase will follow the abuse. There is no escape once the battering has begun; only the batterer can end the incident.

**Honeymoon Phase**

Realizing he has gone too far, the abuser typically exhibits loving, kind behavior while apologizing and promising the battering will never happen again. Both the abuser and the victim want to believe the cycle will not be repeated. He believes she has learned her "lesson," and she is
pulled back into the relationship by his sincere apology and placating behavior, perhaps including a gift of flowers, weekend retreat or a new dress. Tension has been dissipated by the abuse, and both members are relieved. During this honeymoon phase, the couple becomes very close emotionally; the effect of the abuser's generosity, helpfulness and genuine interest during this phase cannot be minimized.

Ironically, it is during phase three that victimization becomes complete. The emotional, symbiotic bonding that occurs strengthens the commitment each has to the relationship. The victim is finally experiencing the relationship in a positive way, thus it becomes increasingly difficult for her to leave it. After the victim has been through the cycle a number of times, her self-esteem begins to wither. She understands she is trading physical and psychological safety for brief periods of peace and happiness. The duration of each phase varies between and within couples. Slowly, the honeymoon phase fades and the couple moves once again into the tension-building phase. The cycle repeats.

**SEXUAL ABUSE TREATMENT FOR VICTIMS, PERPETRATORS AND THEIR FAMILIES**

Sexual assault is a traumatic event from which many victims never fully recover. Victims often develop problems with Posttraumatic Stress Disorder (PTSD), Depression, poor self-esteem, interpersonal difficulties and sexual disorders. PTSD is overwhelmingly the most common disorder related to sexual abuse.

Children may have some symptoms that are different from adults such as agitated behavior, repetitive play involving the trauma, frightening non-specific dreams and reenactment of the traumatic event.

**Short-Term Treatment Goals**
- Establish therapeutic rapport and open communication with the client
- Assess the level of symptomology
- Obtain medical assistance (forensic examination)
- Obey child abuse laws (which require mandatory reporting)
- Assess for suicidal tendencies
- Have the client tell their story
- Identify and express their feelings about the abuse
- Decrease their feelings of guilt and shame
- Increase their feelings of empowerment

**Long-Term Treatment Goals**
- Ensure safety from any and all further victimization
- Help the client understand and control the feelings and behavior that accompany the assault
- Build back their self-esteem

**Therapeutic Interventions**
- Have a client write out what actually happened including their feelings
- Play Therapy
• Angry tower: Have the client build a tower out of blocks or Lego bricks, then let them verbalize while throwing things at the tower, watching it topple, to allow their feelings to emerge

➢ Mutual Story telling
  • Client and therapist take turns telling stories (they may use puppets, dolls or stuffed animals)

➢ Art Therapy
  • Associate color with feelings
  • Draw different scenes for different feelings

➢ Letter
  • Have the client write a letter to the perpetrator that describes their feelings about the abuse
    1. Process and discuss the letter

➢ Develop a personalized Safety Plan
  • Take self-defense classes
  • Find safety escape routes
  • Who to call in cases of emergency
  • Domestic violence safety plans can be searched for online

➢ Challenging Beliefs
  • Discuss the myths and realities
  • Reduce their feelings of shame and guilt

➢ Encourage group work

Family Interventions
➢ Encourage parents to reassure the child that they are not angry at the family member/victim
➢ The best thing parents can do is believe the child
➢ Encourage the whole family to find support, as well as being a support for each other; take care of themselves too during this difficult time
➢ Establish safety for the whole family
➢ Have parents request an advocate
➢ Encourage the family to make sure the client knows they are not to blame
➢ Discuss myths as a family

FUNCTIONAL FAMILY THERAPY

A family-based prevention and intervention program, functional family therapy is successful in a variety of contexts. It’s used primarily to treat high-risk youth and their families. This model allows for successful intervention in complex and multidimensional problems through culturally sensitive, flexibly structured clinical practice.

The Treatment Goals
➢ Identify the primary focus of intervention (the family)
➢ Reflect an understanding that positive and negative behaviors both influence and are influenced by multiple relational systems
Multisystemic prevention programs
• Focus on the multiple domains and systems within which adolescents and their families live
• Multilevel intervention includes:
  1. Treatment system
  2. Individual functioning
  3. Therapist as major components
• Works first to develop family members’ inner strengths and sense of being able to improve their situations
• Provides the family with a platform for change and future functioning that extends beyond the direct support of the therapist and other social systems
• It includes a systematic and multiphase intervention map
  • Phase Task Analysis:
    1. Forms the basis for responsive clinical decisions
    2. Gives functional family therapy a flexible structure by identifying treatment strategies with a high probability of success
• Flexibility extends to all family members, thereby results in effective moment-by-moment decisions in the intervention setting
  • Practice is both systematic and individualized

Assessment
• Assessment is ongoing throughout each phase of the intervention model and is a multifaceted process
• Focuses on understanding the ways in which behavioral problems function within family relationship systems
• Focus varies with each phase of treatment based on the following principles:
  • Ways family relational systems affect the presenting behavior problems - in both functional and dysfunctional ways
  • Identify risk and protective factors
  • Identify family, individual and systemic issues that affect treatment
• Assessment should be multilevel, multidimensional and multimethod
  • Individual factors
    1. Client’s cognitive and developmental level
    2. Psychological conditions
  • Systemic
    1. Assess family in psychosocial context
• What goes on during daily family life
• Behavioral and contextual factors include external
• Social factors that influence the adolescent
  1. Assess family functioning
• Purpose of assessment is to plan the most effective treatment
Intervention Phases

Phase 1: Engagement And Motivation

- Maximizing factors that enhance intervention credibility:
  - The perception that positive change might occur
- Minimizing factors likely to decrease that perception:
  - Poor program image
  - Difficult location
  - Insensitive referrals
  - Personal and/or cultural insensitivity
  - Inadequate resources
- Therapists apply reattribution
  - Reframing
  - Developing positive themes
- Establish a family-focused perception of the presenting problem
  - It will increase the families’ hope & expectation of change
  - Decrease resistance
  - Improve alliance and trust between family and therapist
  - Reduce oppressive negativity within families and between families and the community
  - Help build respect for individual differences & values

Phase 2: Behavior Change

- The therapist implements short and long-term behavior change plans tailored to each family member.
- The Assessment focus:
  - Cognitive, or coping strategies
  - Interactive, the reciprocation of positive behaviors
  - Competent parenting
  - Understanding of behavior sequences, such as blaming and negativity
  - Therapists provide behavioral interventions while guiding and modeling specific behavior changes

Phase 3: Generalization

- Apply positive family change to a range of problem areas
- Therapists help families maintain change & prevent relapses
  - Linking families with available community resources
  - Improving a family’s ability to work in the system in which it is embedded
  - Encourage the family to utilize community support systems and change deteriorated family-system relationships

FAMILY THERAPY FOR ANXIETY AND DEPRESSION

Family Risk And Protective Factors For Anxiety And Depression

- Parent and adolescent conflict, parental rejection and parental depression have been linked to depression in childhood and adolescents
There is evidence that maternal characteristics such as low warmth, negativity, catastrophizing and low autonomy granting are linked to psychopathology and alcoholism. Anxiety has also been linked to marital negativism and dissatisfaction.

**Family Based Treatment For Child And Adolescent Emotional Problems**
- When testing several therapy options, results favored individual CBT over the other interventions in the rate of recovery and depressive symptoms.

**Family Based Treatment For Adult Depression And Anxiety**
- Behavioral couples therapies for Depression focus on teaching couples to communicate and problem solve more effectively, while increasing positive interactions and reducing negative exchanges.
- Family interventions for child and adolescent emotional disorders have lagged behind the progress seen in family approaches for behavioral disorders.
- There is slightly more evidence for the effectiveness of family interventions for child anxiety than Depression.

**DIVORCE**

The diagnosis typically assigned for clients and families dealing with divorce is Depression. The symptoms are usually the same for children, adolescents and adults.

**Typical Symptoms Of Depression**
- Persistent sadness
- Inability to enjoy favorite activities
- Increased irritability
- Physical problems such as headaches and stomach aches
- Poor school performance
- Poor work performance
- Persistent boredom
- Low energy
- Poor concentration
- Changes in eating and/or sleeping patterns

**Short-Term Objectives**
- Develop therapeutic rapport
- Identify feelings and anxieties about divorce
- Increase social contacts and create a support system
- Develop coping skills to deal with depressive thoughts and feelings
- Discuss the feelings about the loss of the family relationship as it was
- Help the client adapt to new situations

**Long-Term Treatment Goals For Treating Depression Due To Divorce**
- To improve each individual’s mood and stability
- Prevent further episodes of Depression
Help the client become well established in a new family living arrangement

Interventions

- **Verbal therapy**: To discuss feelings
- **Play/Art therapy**:
  - Pairing emotions and colors
  - Draw different representations of emotions symbolically
  - Use clay or other materials to recreate story
  - Puppets to tell a story
  - Board games designed to discuss feelings
- **Writing**:
  - List positive and negative emotions or changes
  - Journal their feelings
  - Unsent letters
    1. Write letters explaining your feelings
    2. Knowing they won’t be sent, allows you more freedom to vent
- **Parents**:
  - Teach parents about typical emotional reactions they will see in their children and how to handle them
  - Encourage parents to make teachers aware of the situation
  - Have parents engage in an activity with the children each week, teach dyadic techniques

**Dealing With Clients During Child Custody**

**The First Thing You May Consider Is A Therapy Contract**

- Individualized to fit the client’s needs or based on the requirements of the foundation based on a court order
- Frequency must be determined prior to counseling process
  - Many clients will only participate for court minimum requirements
- Specific confidentiality contract and explanation of confidentiality limitations is essential

**Be Careful With Alliance Building**

- Any alliance can be interpreted as choosing sides, one family member over another
- Extra effort is necessary to establish a multipartial alliance in which the therapist is experienced as caring, but also fair
- The therapist must be honest, provide direct feedback about the behavior occurring, but reframe changes you are hoping for in the most positive light
- Problematic behaviors related to the conflict are directly confronted, but the positive intent of each client is always underscored

**Making An Assessment**

- Begin with a form of evaluation that involves:
  - Separate meetings with each parent and children
1. With or without new spouses, depending on the issues involved
   • Also, a review of court records and other relevant reports available
   • Consultations with other therapists involved might be helpful to the therapist
     1. They might offer insight you missed
     ➢ Identify family strengths and weaknesses

Treatment Plan
➢ Should include not only the traditional goals but also:
   • Format of future sessions
     1. What time
     2. Focused on what issues
   • Who will participate
     1. In what combinations
➢ Goal Setting
   • The main goal is to reduce the damaging aspects of custody disputes such as:
     1. High conflict - leads to anger and confuses the issue
     2. Triangulation - two ganging up against the one
     3. Broken family structure
     4. Lack of safety
     5. Impact on daily functioning

ADOPTION
The idea of adoption has changed over the last few decades, from a last resort to a natural option in creating a family.

➢ With the ease of travel, many adoptions are from outside the US, blending not only a new family but also cultures and races as well
   • Known as transracial and transcultural adoption
➢ Adoption occurs for many reasons:
   • The wish to expand families
   • To provide a home for children in need
   • Kinship adoption may include grandparents adopting the children of their children
   • More single people of both genders are adopting today than ever before
   • As are gay and lesbian couples
➢ There are many decisions for people who adopt:
   • If the choice is motivated by infertility, many issues can accompany the choice:
     1. Feelings of loss and inadequacy being unable to reproduce
     2. Feelings of giving up on a dream of having their own by natural means
     3. Anxiety and fear about making this decision to adopt a child someone else created
     4. Stress, related to procedures of adoption, how society might impact their decision, or how their families and support systems will react
   • The paper work alone can be overwhelming
• Stress may even affect a marriage if couples have different coping skills or if one is more ready to adopt than the other

Foster Children
Foster Care may be another route considered and has it’s own problems:

- Being able to provide the appropriate medical, emotional or academic support for foster children with special needs
- You must be prepared to suffer the potential loss of the relationship when the child is returned to their home or adopted by another family
- Stress of dealing with the child’s biological parents and family

Parenting Adopted Children Offers Some Challenges

- You should address the child’s questions about their adoption, about birth parents and be able to prepare child for questions by others about their adoption
- Any parent, but especially adoptive parents, must to be aware of changes in behaviors that may indicate an emotional struggle:
  - There may be social withdrawal, not wanting to play with others
  - Inattentiveness that affects productivity at home or school
  - Anger outbursts and temper tantrums
  - Attachment anxiety or fear of being alone
  - There may be changes in eating or sleeping patterns

The Role Of The Family Therapist Provides Several Aspects

- It can help the family understand the impact of adoption on the family and the child
- The therapist can work with the child who may have a hard time talking to the adoptive parents about the adoption, fearing it might show a sign of disloyalty or being unappreciative
- They can help normalize the feelings of wanting to learn about their biological parents and the reasons why they were put up for adoption
- The therapist should also work with the biological children in the family, giving them a place to explore their feelings about the adoption
- With the adjustment to new relationships, the family therapist can ensure positive communication while creating appropriate boundaries to benefit the children and strengthen the family

Adoption And Its Impact On The Birth Parents

Most parents struggle with the decision to place the child up for adoption. Those who decide to do so, begin to plan for a great loss in their own lives with the hope that placing the child for adoption will result in a better life for their baby and for themselves.

- Parents will go thru grieving the loss of the child
- The sense of loss is usually intense and lengthy
- Not only the actual loss of the child, but also the loss of immediate life plans since all plans revolved around that child
Trauma can be impacted by:

- The process
- Lack of support from family and friends
- The behavior of the adoption agency
- Level of communication with the adopting family

Clients often express feelings of numbness, shock and denial, as well as grief. Parents need to normalize these as typical reactions to loss otherwise they find an extra struggle adding a sense of privacy around it, which may limit help from support systems such as other family members who may not be informed. Due to the secrecy, this loss often lacks typical cultural rituals or ceremonies necessary to gain closure.

Grieving is not just for the child, but losses that accompany it:

- Loss of the parenting role
- Feelings of loss may reoccur during holidays, anniversaries or birthday
- Stress of pregnancy and adoption so close after, may take a toll on the couple’s relationship
- If the parent is young
  - This may cause a significant issue in future parental relationships
  - Will they ever be ready to have a child?
  - Also, they may have to drop out of school

The guilt and shame can weigh the parent down immeasurably:

- Societal values often show a lack of understanding over the circumstances leading up to the adoption
- Culturally, there is still an association of shame with unplanned pregnancy
- The parent may express feelings of unworthiness
- Clients who discuss their feelings with supportive friends, family or counselors, may more easily come to terms with their decision over time and be able to integrate the experience into their lives in a healthy way

There also may be identity issues:

- Clients often ask themselves if they even are “parents”
- Some mothers may experience a sense of incompleteness after giving birth
- Parental status is not acknowledged by society, family or friends for those who give up children for adoption
- The issue of being involved in the child’s life and how to integrate with the adoptive family is an important one

The long-term issues must be dealt with:

- Feelings about the adoption may be life long, but varying in intensity
- Some of the factors that have been found to be associated with long-standing grief include:
  - A birth mother's feeling that she was pressured into placing her child for adoption against her will
• Feelings of guilt and shame regarding the placement
• Lack of opportunity to express her feelings about the placement

- For some birth parents, the ability to establish a successful marriage or long-term relationship may depend upon the openness with which they can discuss their past experiences of birth and adoption placement
- Some birth parents never tell their spouses or subsequent children of the child they gave up

THE IMPACT OF DEVELOPMENTAL DISORDERS ON FAMILY SYSTEMS

Symptoms Of Developmental Disorders

- Aggression and perhaps violence
  • Work with family on behavioral issues, reinforcing appropriate behaviors
  • Work with family on parental coping skills with difficult situations

- Alienation of parents, caregivers and authorities
  • Educate the family on the symptoms of disorders and what to take as a symptom rather than a personal attack
  • Process how to handle isolation moments
    1. What the client shares as input on how they would like to be addressed or left alone until ready to return to family participation

- Antisocial attitudes and actions
  • Insight and reality therapy with clients on what impact their behaviors have on the family and their natural consequences
  • Make sure the family has consistent discipline for inappropriate behaviors

- Behavioral and learning problems at school
  • Encourage the family to be in close communication with school figures to prioritize school goals and continue strengths

- Cannot express trust, intimacy and affection
  • Educate clients on the realities of the disorder and behavioral symptoms
  • Work with the family to process feelings in regard to having a loved family member who has not yet developed these essentials of relational interaction

- Lacks empathy, compassion and remorse
  • Parenting skills enhanced to encourage the education and modeling of these skills in the home to promote it within the client

- Needy and clingy, or pretends independence
  • Behavioral methods encouraged by all family members to make sure enabling is minimized and support for growth is promoted

- Withdrawal and perhaps Depression or Psychosis
  • Work with the family to ensure the therapy treatment and medications are attended to

FAMILY THERAPY FOR CHILDHOOD AND ADOLESCENT DISORDERS

- Family Risk and Protective Factors
  • Childhood and adolescent behavior problems have been strongly and consistently linked to a number of family factors, such as conflict and aggression
• Longitudinal studies show that ineffective parenting practices in childhood maintain antisocial behavior into adolescence

➢ **Family Based Interventions For Child Behavioral Problems**
  • Various family therapy approaches specifically target the coercive family patterns, maintaining behavior problems while at the same time bolstering protective factors in the family and other systems that have an impact on the child

➢ **Engagement and Retention Therapy**
  • One of family therapy’s major contributions is an increased focus on strategies for engaging difficult youth and their families in treatment

➢ **Parent Management Training**
  • Focuses on the parent in treatment
  • Helping parents identify, observe, and react to the child’s problem behavior in new ways
  • Applying social learning principles to increase parenting skills to shape the child’s behavior
  • Providing opportunities to practice new parenting skills and apply them in the home

➢ **Functional Family Therapy**
  • This model is based on the assumption that children’s behavior problems serve a function within the family system and are initiated and maintained by maladaptive interpersonal processes
  • Treatment targets change in these destructive interactional patterns and uses behavioral interventions to reinforce positive ways of responding and to establish more effective problem solving

➢ **Multisystemic Therapy**
  • Several different models have demonstrated efficacy and are generating evidence of effectiveness community-based replication studies
  • These therapies promote positive outcomes such as more pro-social peer relationships and family functioning, as well as reducing conduct problems

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**FAMILY THERAPY FOR EATING DISORDERS**

**How Eating Disorders Effect Families**

**Salvador Minuchin’s structural family therapy** and the Milan model both address eating disorders and their effect on the family unit. Eating disorders are usually diagnosed in teenage girls but can occur in any individual. There are a wide variety of causes:

➢ Peer pressure, wanting to fit in
➢ Academic over achievers
➢ Conflicts within the family

Any may lead an individual to become excessively concerned with how much they eat, even to the extent they become obsessed with being thin. While these conditions may lead to Anorexia Nervosa or Bulimia, the exact cause of eating disorders is still unknown. Left untreated, Anorexia Nervosa can be fatal.
Eating disorders can consume the client in obsessive, negative thinking and behaviors and consume the client’s relationships with family members.

Clients demonstrate the following symptoms:
- They become depressed, isolated and tired
- They avoid relationships in order to avoid the pressure to eat
- They are physically depleted

For family members:
- Seeing a family member starve or damage her/his body is stressful
- Parents, spouses, or others become intrusive in their efforts to get the person to eat or to stop purging
  1. The result may be that the see them as enemies trying to control them rather than help
- The symptoms have become the individual’s way to avoid facing problems more directly or are an attempt to feel in control when the rest of life feels out of control.

**Family Risk Factors For Disordered Eating**
- Interactional patterns in families of eating disordered patients tend to constrain autonomy and the expression of intimacy
- Disruptions in attachment relations are characterized by destruction of communication
  - Behavioral family therapy contends eating disorders may develop if a person has no other way to speak or represent feelings
  - Family dynamics, problematic communication patterns, losses, or stresses like abuse have contributed to negative feelings the person could not deal with directly

**Family Based Behavioral Interventions For Eating Disorders**
- Emphasizes parental control over eating and incorporates cognitive restructuring
  - Problem-solving training has also been tested in comparison to individual therapy for anorexic clients
- The model of behavioral family therapy was more effective than an individual approach because it focused on the building of ego strength and facilitated autonomy in terms of increasing body weight from pre to post treatment
- Treatments were equally effective in outcomes such as:
  - Eating attitudes
  - Body shape dissatisfaction
  - Depressive symptoms

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**DEATH AND DYING - ELISABETH KÜBLER-ROSS**

A realistic understanding of death and dying develops during childhood and is related to both cognitive level and experience.

- At ages 3-4, children do not understand that death is irreversible; they believe the dead retain some capacities they had while they were alive
- By ages 5-9, children know death is universal but personalize it
- By age 10, children generally understand that the end of life is a biological process
• Television seems to be speeding this development
• Some five-year olds have an accurate understanding of death.

Seeming to be greatest among those of middle age, anxiety about death is a personality function and relates to age. Anxiety about death is lowest among well-adjusted people, whose lives are marked by high self-esteem and a sense of mastery and purpose.

*Kübler-Ross’s 5 Stages of Grief (Mnemonic: DAB-DA):*

- **Stage One: Denial:** “That did not happen.” “Stop joking.”
- **Stage Two: Anger:** “There is no God.” “This should not have happened.” “Why me?”
- **Stage Three: Bargaining:** “God, I promise I will never ______ again if you bring him/her back.”
- **Stage Four: Depression:** “Why did this happen? It is not fair.” “How can I go on?” Silent suffering and grief are characteristic of stage four.
- **Stage Five: Acceptance:** “Things happen for a reason. I need to find the reason.” “It’s OK.” This stage is accompanied by a sense of peace. Resolution: “I am OK. ______ would want me to go on.”

It has been suggested that experiencing any loss can lead to this series of emotions.

**FAMILY THERAPY FOR BEREAVEMENT**

Bereavement is found in the DSM Diagnosis Manuel under “Additional Conditions That May be a Focus of Clinical Attention” - used for death of a loved one.

- Depression in this case, is considered “normal” but an individual may be seeking treatment to relieve symptoms such as insomnia or Anorexia Nervosa
- Expression of “normal” bereavement time is relative to different cultures
- Major Depressive Disorder is not diagnosed unless symptoms last longer than two months after the loss

**Reactions Commonly Seen In Children:**

- **Disbelief:** Children may act as if it did not happen
- **Complain:** Headaches, stomachaches, or have a fear of their own death
- **Anger:** Concern over their own needs and about being alone, or with God
- **Guilt:** Feelings of causing death, or not having been “better”
- **Anxiety/Fear:** May become clingy and need validation of love
- **Regression:** Revert to bed wetting or thumb sucking
- **Sadness:** May develop lethargy and prefer isolation

**Short-Term Treatment Goals**

- Express fear and anger, grieve in a healthy way
- Loss and Grief Counseling Group
- Recall fond memories
- Create a phone list of supportive people to call
- Develop new coping techniques
Find a “safe place” to spend limited time thinking about the deceased
Begin an exercise regiment
Relaxation techniques help
  • Try progressive muscle relaxation or guided imagery

**Long-Term Treatment Goals**
- Reach a point of coping without being overcome with grief
- Get back to your normal activities
- Reduce feelings of guilt and anger towards yourself, others, and God
- Re-mature over regressed behaviors
- Try to gain a better understanding of death and life

**Therapeutic Interventions**
- **Writing Activities**
  • Write a letter to the deceased for closure
  • Journal your thoughts (these may be shared in counseling, in group, or with family members)
- **Art therapy**
  • Finger paints are useful in expressing feelings
  • Draw pictures of activities enjoyed with the deceased (these are useful dealing with children)
  • Make a collage on a theme
  • Make use of a splatter room: an area where (particularly children) are free to throw violent splotches of paint to get anger out
- **Play Therapy**
  • Use modeling clay or dough to vent anger or create ritual objects
  • Puppetry might help to express feelings
  • A sand tray to can be used to play out themes, “bury” the deceased for closure, or rake sand for relaxation or meditation.
- **Bibliotherapy**
  • Use of appropriate self-help books
  • Books related to symptoms the client is displaying
- **Loss Graph or Timeline**
  • Used to discuss types of loss
  • Used to recall fond memories and celebrate life
- **Storytelling**
  • Fantasy monologues
  • Mutual storytelling
- **Therapeutic Metaphors**
  • Helpful in understanding the concept of death
- **Empty Chair**
  • Gestalt technique
  • Imagine the deceased in chair and speak to them for closure
GRIEF AND LOSS - COUPLES

Couples grieve in different ways, often misunderstanding each other's reactions or needs.

- Some clients are hesitant in showing feelings of sadness when their partner has had a "good day" or vice versa
- Some partners may not want to talk about the loss, but still feel comfortable when the other needs to do so
- Crying is another area where partners may differ:
  - It is an acceptable and healthy expression of grief, but many men find it difficult to do so, due to society implication about men who cry
  - Men often feel the need and are encouraged by others to be strong
- Grieving is emotionally, physically & mentally exhausting and does not leave much energy for anything else
- Good communication is essential so misunderstandings and intense emotions do not lead to conflicts
- Going through grief is such a stressful process:
  - It can be a crucible for differentiation, or
  - If not handled properly, a detrimental challenge in the relationship
- As a counselor, it is important to help spouses recognize their coping differences and how not to be blaming or resentful
- Psychoeducational sessions on the differences in grieving in different genders and cultures as well as personality types may be helpful
- Husbands & wives may react differently to intimacy as well
  - One partner may need and seek this closeness and the assurance that not everything has changed
  - Another partner may take the suggestion of intimacy as an affront, not understanding how anyone could think of intimacy at such a time
  - Help couples to see these reactions are normal
  - Normalize and assure couple that with time and patience, they may be able to reestablish intimacy when it is right for both of them

INFERTILITY

Infertility is the inability to conceive during one year of sexual intercourse without the use of contraception, or the inability to carry a pregnancy to live birth.

There are two kinds of infertility diagnoses:

- Primary infertility - Couples who have never had a child
- Secondary infertility - Couples who are unable to conceive or to achieve a live birth after having a previous children

Male infertility

- Lifestyle habits can markedly affect the quality of the semen
For example:
- Alcohol can damage sperm-producing tissue
- Tobacco decreases sperm survival and function
- Diet and vitamins have been researched to affect sperm production
- Sexual practices can be altered to increase fertility, such as:
  1. Abstinence, perhaps periods of three to four days, produce larger semen quantities and greater viability
  2. Certain common lubricants such as KY jelly, lotions and oils can kill sperm and decrease fertility

**Female Infertility**
- Can often lead to profound distress for women
- It may affect sexual functioning in the couple’s relationship
- It is associated with a wide range of factors:
  - Physical problems may be - hormonal, anatomical, genetic or due to the immune system
  - Psychologically this can lead to - denial, grief, helplessness, anger, anxiety and guilt
  - Environment - work related stress, family issues and gender role expectations

**Goals Of Therapy**
- Explore their beliefs about creating a family
- Identify and explore feelings and reactions to infertility
- Create a support system
- Provide educational materials related to medical procedures
- Assist partners in communication about sexual relationship

**INFIDELITY**
- Begin with confronting the couple on whether the purpose of therapy is to rebuild the marriage or help with the termination
- The Interpersonal Trauma Model
  - Is the process leading to recovery and forgiveness
  - Establishes safety and addresses the painful emotions and traumatic symptoms
- Extramarital affairs are attempts at resolving the conflict through triangulation
- When establishing safety:
  - Explain the affair must be over to begin true marriage counseling
    1. This means more than not just having sexual intercourse
    2. All personal contact in person, on phone or in writing must be ceased
    3. Any unplanned encounters should be shared with spouse
- When discussing the affair:
  - Make it clear to the clients that the purpose of sharing is healing and to keep this in mind before sharing details
  - In order to relieve the pressure, the who, what, where and when questions should be dealt with in the beginning to some degree
• More personal questions regarding motivations and emotions should be dealt with later in the process when a net of safety and trust has been established
  ➢ Goal of treatment is empathic mutual exploration
  • The marriage is stronger and is couple-centered rather than child-centered
  • Risk signs for infidelity are recognizable and should be acknowledged and handled as they come up
  • The marriage is one of trust, commitment, mutual empathy and shared responsibility for change

**SEXUALLY TRANSMITTED INFECTIONS (STI)**

Sexually transmitted infections are most often associated with engaging in promiscuous behavior or being unfaithful to one’s partner, which makes it challenging for clients to seek help and medical attention for their often treatable infections.

Treatment involves more than medical consultation due to the impact of the diagnosis on the couple and or family. Therapists can work with the couple to deal with the emotional and relational concerns influenced by the positive diagnosis.

The DSM diagnosis would fall under “Mood Disorder due to general medical condition."

**Short-Term Treatment Goals**

- Stabilize the medical condition
  - Ensure the client does this with a medical doctor
- Treat their acute symptoms
- Help the client accept that this is a chronic disease and will need continued medical care

**Long-Term Treatment Goals**

- Encourage the client to establish a treatment regimen
  - If your body feels relief from the symptoms, you can better handle your personal life
- Help increase their acceptance of the disease and its consequences
  - If this problem was indeed associated with promiscuous behavior, they will need to deal with the fallout
- The client must openly acknowledge the high risk behaviors associated with the disease
- Identify the emotional effects of the disease
  - Not only for the client, but their partner and family as well
- Help the client establish a healthier lifestyle
- Identify sources of stress that could have a negative impact on the client’s health
- Identify and address fears related to the medical condition

**Couple Treatment Goals**

- The client needs an accurate understanding of the transmission and treatment of STIs in order to reduce anxiety related to transmission and reinfection
- Discuss the feelings related to the diagnosis and its impact on the couple’s relationship
Reestablish relationship boundaries, particularly in regard to fidelity, in order to rebuild emotional safety within the couple
Identify the long-term impact of the STI and how the couple will handle upcoming issues
Help the couple develop better communication skills to increase trust and intimacy in their relationship
Build coping skills for both partners

Interventions
The therapist may prescribe bibliotherapy on the medical issues related to STI
• To help the couple more thoroughly understand the medical condition and its effects on their lives
Offer the couple instruction on the correct use of condoms
• In order to protect themselves from any reoccurrence
If intercourse needs to be on hold for safety reasons, teach the couple other ways of having sexual intimacy
• Such as massages
Brainstorm with the couple on how they can recreate emotional closeness

HIV AND AIDS
AIDS (Acquired Immune Deficiency Syndrome) is the advanced stage of the HIV (Human Immunodeficiency Infection) defined by the Centers for Disease Control in 2002 as a T cell (type of white blood cells that fight off infection) less than 200 out of a normal count of 1000. The patient's immune system, progressively destroyed by the Human Immunodeficiency Virus, can no longer fight off infection, so the patient ends up dying from an opportunistic infection.

Some trends in AIDS are:
• Over 700,000 cases of AIDS reported in the US since 1981
• More than 21.8 million deaths worldwide from AIDS
• HIV is increasing among most populations, including minorities, women and heterosexuals
• It is decreasing among white gay men and IV drug users
AIDS is one of the top ten leading causes of death among Americans between the ages of 25 and 44. It is the final stage of HIV disease and the most serious. Starting with Acute HIV infection, the immune system weakens. If left untreated, it progresses from asymptomatic HIV, to symptomatic HIV and ultimately to AIDS. HIV infected people may have no symptoms for up to ten years, yet they can still pass on the disease infecting others.

It can be transmitted a variety of ways:
Unprotected sex (homosexuals and heterosexuals) through genital fluids
Intentional or accidental sharing of needles
Blood transfusions (risk is 1 in every 450,000 to 600,000 transfusions)
Transmission from mother to baby via breast milk or the birth process of children born to HIV-infected mothers
And in other rare ways (e.g., unsterile medical or dental equipment, etc.)
Symptoms
Flu-like symptoms may be experienced 1-2 months after exposure to HIV. They typically go away and there is a progression through "asymptomatic infection" which can last from 2 years for children to 10 years for adults when the virus is killing T cells but not to its full extent as in full blown AIDS. During the period of asymptomatic infection, some signs and symptoms include:

- Swollen lymph nodes
- Lack of energy
- Continuous skin rashes
- Short-term memory loss
- Frequent fevers

In full-blown AIDS, opportunistic infections and cancers are likely. The ELISA blood test is used to diagnose HIV antibodies, which may take as long as 6 months after exposure to develop. Two positive blood tests are necessary for the ELISA to be considered positive for HIV, to be followed by a positive Western Blot blood test.
SECTION 4: THE DSM AND MENTAL HEALTH

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM)

The DSM uses a multiaxial system to classify patterns of abnormal behavior. Evaluation considers five axes, with the first three providing an official diagnosis and the remaining two showing environmental and conditional data that can be useful in treating an individual:

- **Axis I:** Clinical Syndromes and V Codes (factors worthy of attention in treatment, but not part of the disorder)
  - Clinical disorders, including major mental disorders, as well as developmental and learning disorders
- **Axis II:** Developmental and Personality Disorders
  - Underlying pervasive or personality conditions, as well as Mental Retardation
  - Usually permanent disabilities that don’t allow for normal day-to-day functioning
- **Axis III:** Acute medical conditions, physical disorders and conditions including substance abuse
- **Axis IV:** Severity of Psychological Stressors
  - Psychosocial and environmental factors contributing to the disorder
- **Axis V:** Global Assessment of Functioning or GAF score
  - An evaluation scale ranging from 100 meaning good functioning to 0 encompassing several dysfunctional

**DSM Facts**

- It is the handbook for mental health professionals
- Includes all categories of mental disorders and their corresponding diagnosable criteria
- Intended to be used by those with clinical training in accordance with the American Psychiatric Association
- It provides a uniform criteria for diagnosing including:
  - Sociological
  - Psychological
  - Biological
- To ensure the manual is contemporary with social times, each revision has discarded some previously diagnosable disorders such as:
  - Pre-menstrual Dysphoric Disorder
  - Masochistic Personality disorder
- It now no longer includes homosexuality as a mental disorder, replacing it with sexual orientation disturbance, though it is still controversial

A few selected categories of mental disorders provided by the DSM are: Cognitive Disorders, Substance Abuse Disorders, Mood Disorders, Anxiety Disorders, Eating Disorders, Personality Disorders and Psychotic Disorders. Patients may also have two concurrent psychiatric diagnoses, giving them a dual diagnosis mental disorder. Often a disorder is concurrent with Anxiety or Depression.
Cognitive Disorders
- Defined as significant cognitive deficiency and noticeably different cognitive functioning
- It may assume a short-term form (Delirium) or long-term form (Dementia)
- Diagnosed by a variety of methods, including interview, physical exam and EEG

Substance Abuse Disorders
- Defined as a dysfunctional pattern of substance abuse that causes distress
- Includes several other criteria, including unsuccessful attempts to control use and withdrawal upon discontinuation of substance
- The DSM includes eleven categories of substances abuse, from alcohol which is a sedative to amphetamines or uppers which includes caffeine
- Treatment includes abstinence, education, psychotherapy and 12-step programs, such as NA and AA

Mood Disorders
- Include Major Depressive Disorder, characterized by a depressed mood or loss of interest or pleasure for at least two weeks
- And Bipolar Disorder, in which depression alternates with manic episodes
- Treatment for Mood Disorders includes antidepressant medication, Lithium for Bipolar, psychotherapy and group therapy
- Suicide, concurrent substance abuse and non-compliance with medications for Bipolar patients are to be considered

Anxiety Disorders
- Noted by a pervasive feeling of anxiety and often accompanied by somatic symptoms, the following all fall into the category of Anxiety Disorders in the DSM manual:
  1. PTSD (Post Traumatic Stress Disorder)
  2. OCD (Obsessive Compulsive Disease)
  3. Panic Disorder

Eating Disorders
- Anorexia Nervosa, where there is an intense and unreasonable fear of weight gain
- Bulimia Nervosa, in which the patient binge eats and then follows this with self induced purging (through vomiting, diuretics and/or laxatives)

Personality Disorders
- Maladaptive manners of behavioral, cognitive, perceptual or psychological functioning
- Ten categories, including:
  1. Paranoid
  2. Schizoid
  3. Schizotypal
  4. Antisocial
  5. Histrionic
  6. Borderline
  7. Narcissistic
  8. Avoidant
  9. Dependent
10. Obsessive-Compulsive
   - Diagnosed through interviewing
   - May be treated in a variety of ways, including antipsychotic medication, group therapy, psychotherapy and hospitalization (in crisis)
   - These disorders are difficult to treat due to their ingrained nature and common non-compliance with medication

   ➢ Psychotic Disorders
   - A break with reality and fall into Schizophrenia of various types and brief reactive psychosis
   - They are diagnosed through a physical exam and interview, then treated by hospitalization and/or antipsychotic medications

**DISORDERS COMMONLY DIAGNOSED IN INFANCY, CHILDHOOD OR ADOLESCENCE**

These are *Axis I Disorders*, (EXCEPT Mental Retardation which is an Axis II Disorder), those that probably *began in youth* rather than those that are identified with adult onset. The following are some of the disorders in the DSM category of Disorders Commonly Diagnosed in Infancy, Childhood or Adolescence including several of the different types that fall into each major disorder category:

   ➢ Mental Retardation
   - Mild
   - Moderate
   - Severe
   - Profound

   ➢ Learning Disorders
   - Reading Disorders
   - Mathematics Disorders

   ➢ Motor Skills Disorders

   ➢ Communication Disorders
   - Stuttering

   ➢ Pervasive Developmental Disorders
   - Autistic Disorder
   - Rett’s Disorder
   - Asperger’s Disorder

   ➢ Attention-Deficit and Disruptive Behavior Disorders
   - ADHD
   - Conduct Disorder
   - Oppositional Defiant Disorder

   ➢ Feeding And Eating Disorders of Infancy Or Early Childhood
   - Pica

   ➢ Tic Disorders
   - Tourette’s Disorder

   ➢ Elimination Disorders
• Encopresis
• Enuresis

When a child is described as unable to achieve or slow in school, learning disorders relating to reading and/or mathematics must be considered.

As the client is being evaluated, function and symptoms must be evaluated. Because children must function at home, at school and with peers, all three areas must be assessed. Grades and behavior are keys to understanding function in the academic setting. Relationships with parents and siblings, and the completion of assigned chores provide clues to function at home. If the child is hurting others or involved in criminal behavior or gang activities, function with peers is impacted by the symptoms. Additionally, age appropriateness of behavior must be assessed. What is completely normal for a four-year old may not be age appropriate behavior for a sixteen-year old.

Although many of the disorders will be under treatment by another specialist, some symptoms and their effects may necessitate the intervention of a therapist. In evaluating relevance, the therapist considers the effect of the disorder upon the child and the possible appropriateness of family therapy. Knowing the limitations of therapy, the clinician must evaluate resources already in place, as well as what might be added to enhance the child’s ability to function. Effect of the disorder upon family interactions must also be assessed, particularly in a determination of the potential effectiveness of family therapy.

MENTAL RETARDATION

Approximately 2,000,000 individuals in the United States are Mentally Retarded. The diagnosis as described by the DSM requires an IQ of 70 or below as measured by standardized IQ testing, impairment in general functioning (adaptive functioning) in two areas and onset before the age of 18. If onset is after age 18, this is considered Dementia.

About 80-85% of these individuals are mildly retarded, (IQ of 50-70 is considered educable) about 10% are moderately retarded (IQ of 35-50 is considered trainable), 3-4% are severely retarded (IQ scores of 20-35) and 1% of individuals are profoundly retarded (IQ below 20). Individuals with severe and profound retardation will undoubtedly need supportive or institutional care for life. Mentally Deficient and Intellectually Deficient are terms sometimes used in reports and documents as a substitute for Mental Retardation. These terms are interchangeable, but are often chosen due to personal preference of bias.

There is an identifiable cause for Mental Retardation in about 50% of the cases. Factors are often biological and are more likely to create moderate to profound Mental Retardation. Environmental factors, including perinatal problems, infant illness, neglect and malnutrition all are factors that can lead to retardation in intellectual development. Moderate to profound Mental Retardation is distributed evenly across all social classes. Mild Mental Retardation appears more commonly in lower classes. One interesting point - infant developmental measures are not a good predictor of future retardation; however, they are a good predictor of exceptional intellectual development in the future. The WISC-IV is not a good measure of more severe retardation because it has an inadequate floor. Tests such as the Stanford-Binet or Woodcock Johnson-Cognitive Battery are better measures on the lower end of the scale.
The Following Are Examples Of Cases:

Vignette #1:

Bobby is 6 years old. His parents report he started school this year and can’t keep up with the other kids. He’s unable to identify letters and can’t yet write his own name. Interviewing him, you find he’s very difficult to understand and often uses words that make no sense. His parents are of average education level and speak well. Apparently, Bobby also has trouble tying his shoes and bathing on his own. His IQ is 68 as measured on the WISC-IV in both Verbal and Performance areas (Full Scale of 67).

In this example:

This child may very likely be diagnosed with Mild Mental Retardation. He meets criteria with the IQ score below 70. Further, he has problems with communication and self-care skills. Of course, it is important to get a good history of childhood illnesses and injuries. This can help to clarify the diagnosis.

Vignette #2:

Tommy is 12 years old. His mother says he can’t read and even has trouble writing his own name. He’s difficult to understand when you speak with him. His Full Scale IQ in the WISC-IV is 69, with a Verbal of 62 and a Performance IQ score of 75. His mother reports he has some trouble with self care skills. His mother is of a low SES with a 5th grade education.

In this example:

This is a difficult case to make a differential diagnosis. However, several factors lend themselves to not diagnosing Mental Retardation. First, the IQ scores show a significant split (12 points on the WISC-IV is considered significant). His performance IQ score is in the borderline range. Furthermore, his mother is of a low education level (carefully look into early stimulation, e.g. reading, talking, etc.). This child probably has some language problems or learning disabilities that affect his intellectual development and school performance.

Pervasive Developmental Disorders

Autism

This Pervasive Developmental Disorder is characterized by an inability or hardship in communicating and developing social skills and relationships. Furthermore, children with Autism show a repetitive pattern of behaviors, movements and thoughts. Autistic Disorder generally shows signs of onset before age 3. Around 70% to 80% of autistic patients show signs of Mental Retardation and have IQs below 70. Some children with Autistic Disorder develop exceptional skills in specific areas such as mathematics or musical ability. Autism cannot be cured; treatment is directed towards helping the children make adjustments to lead a more stable and productive life. Behavioral therapy is used to teach daily living skills, though only about 2% can live independently and have successful occupations. Haloperidol has been used to treat some of the more aggressive symptoms of Autism.
RETT'S DISORDER
This Pervasive Developmental disorder is found only in girls, with an age of onset anywhere from 5 months to 4 years. Though early development is normal, by the time of onset social and motor skills regress and are severely hampered. Children with Rett's Disorder especially show lack of hand skills and often show hand-wringing motions. Behavioral therapy has been shown to be ineffective. Treatment is only for support and to alleviate discomfort from symptoms. During stages of seizures, Carbamazepine has been shown to reduce seizures.

ASPERGER'S DISORDER
A Pervasive Developmental Disorder that has an age of onset around 3 to 5, Asperger’s Disorder is characterized by maintenance of standard cognitive and linguistic development, with difficulty in forming social relationships, repetitive motions and abnormally clumsy motor skills. The best form of treatment would be through a social-cognitive method with a speech and language pathologist to deal with social and everyday problems. Asperger's is less severe than Autism and most patients can live a fairly normal life, though their personal and social difficulties often cause significant distress.

FEEDING AND EATING DISORDERS OF INFANCY OR EARLY CHILDHOOD
PICA
An early childhood eating disorder, Pica involves eating inappropriate objects such as dirt, stones, hair, paper, etc. Children with Pica must be past the developmental stage where it is considered normal for infants to try to put anything and everything into their mouths. Behavioral therapy is generally suggested to help children differentiate between nutritive and nonnutritive objects.

TIC DISORDERS
A tic is a sudden, uncontrollable and repetitious muscle movement usually in the upper body such as the face, neck or shoulder. Tics involve sudden jerks and sharp movements in contrast to tremors that are continuous movements. Tic Disorders often occur with (comorbid) Obsessive Compulsive Disorder. They may also include vocal tics, such as repeatedly cursing or barking. The four main tic disorders are:

- Tourette's Disorder
- Chronic Motor or Vocal Tic Disorder (CT)
- Transient Tic Disorder
- Tic Disorder Not Otherwise Specified (NOS)

TOURETTE'S DISORDER
The most prevalent Tic Disorder, Tourette’s involves many uncontrollable movement tics and at least one vocal tic. The muscle tics involve face twitching and eye blinking; vocal tics involve cursing, grunting and even barking. The age of onset is usually around 7 to 8 years old and before 18. Haloperidol and pimozide are the two most common medicines used for controlling the tics, though Tourette's Disorder itself cannot be cured.
ATTENTION-DEFICIT HYPERACTIVITY DISORDER (ADHD)

As described by the DSM, ADHD includes either symptoms of inattention or hyperactivity-impulsivity with at least six symptoms in either area.

Symptoms of inattention include:

- Problems listening
- Following through on instructions
- Organizing work or activities
- Forgetfulness
- Reluctance or distaste of tasks that require sustained attention
- Losing things that are required for tasks or activities

Symptoms of hyperactivity include:

- General inability to sit still
- Fidgeting
- Problems playing quietly
- Driven behavior
- Excessive talking

Symptoms of impulsivity include:

- Problems with blurring out answers
- Waiting in turn
- Interrupting or intruding on others

Young children may be naturally more prone to hyperactive and impulsive behavior. The criteria should have an onset prior to age 7 and should continue beyond that age; it should create impairment in two or more areas at a clinically significant level.

ADHD is often difficult to distinguish from Anxiety or Oppositional behavior for a couple of reasons. First, children with ADHD often have co-morbid symptoms of Anxiety and Oppositional Behavior. Second, Anxiety and Oppositional Behavior often "look like" ADHD and can become confusing when presented by a parent or teacher who has already made up their mind the child has ADHD.

Two Brief Vignettes That One May See In Clinical Practice

Vignette #1:

Little Johnny's mother describes him as "very hyper". She says Johnny "is always moving, never sits on the couch but climbs all over it and won't stop talking". Furthermore, his teacher agrees, he can't stay in his seat for more than a few minutes, always butts in line when going to the lunchroom and he yells at the other children to hurry when playing a game. He often tries to play out of turn. Johnny is currently 12 and has been having increasing problems for the past several years.
In this example:
It is likely Johnny has ADHD, in particular, Primarily Hyperactive-Impulsive Type. Three symptoms of hyperactivity and three of impulsiveness are described.

Vignette #2:
Billy is 10. His mother also describes him as "very hyper". He doesn’t like to go to bed at night and often puts up a fight. He doesn’t play well with other children. He’s impatient and often yells and fights with them. Billy doesn’t listen when told to do his chores and he can't seem to follow instructions given by the teacher. He’s failing in school. He’s been having these problems for some time.

In this example:
Billy may have ADHD, Inattentive Type. However, the diagnostic criteria are not met. He may be Oppositional, based on his refusal to go to bed and fighting but he may be refusing to follow instructions rather than having trouble attending to them. If he is fearful of going to bed, he may suffer from Anxiety (Night Terrors) or he may simply be afraid of the dark. Often, anxious children may have trouble sitting still. School failure may be due to a specific learning disorder or reading problem and the course of the disorder is not clear from the description. This description might meet the diagnostic criteria for ADHD, Not Otherwise Specified, but the symptoms of inattention and hyperactivity-impulsivity must be differentiated from Anxiety, Oppositional Behavior and learning disorders. It is possible these other symptoms are co-morbid with ADHD. An important question clinically may be: are Oppositional and Anxiety symptoms primary or secondary to ADHD?

Medication

- **Most Common**
  - Methylphenidate (Ritalin)
    - Helps to better focus their attention
    - Always be aware of a patient taking this medication (how much, how often, when) it could affect counseling sessions
  - Atomoxetine (Strattera)
    - Increases levels of norepinephrine and helps control behavior
    - Do not give to patients with heart problems as Atomoxetine may cause sudden death

**OPPOSITIONAL DEFIANT DISORDER**
For treatment of Oppositional Defiant Disorder and Conduct Disorder, the primary setting will not be an office but a residential treatment program, day program or combined school/community facility. With this population, any techniques that focus on consequences, reinforcements or rewards are helpful. Additionally, methods that delay impulses by using any cognitive strategy, such as “stop/listen/think,” may provide assistance. Anger management can be useful.

Oppositional Defiant Disorder (ODD) generally occurs in children from ages 6 to 18 with an onset around age 8. The disorder is characterized by a noncompliant, belligerent and argumentative interaction with authority figures, usually adults. Children with ODD typically
have an angry and irritable nature; these negative symptoms persist for a minimum of 6 months. However, the violation of social norms, as in Conduct Disorder, is not seen. The best course of treatment for Oppositional Defiant Disorder is behavioral therapy; medication is generally not required if ODD is not comorbid with another disorder.

**CONDUCT DISORDER**

Conduct Disorder is characterized by angry and belligerent behavior that, unlike symptoms in Oppositional Defiant Disorder, does break accepted social norms. Symptoms include lying, stealing, truancy, vandalism and harming others. Patients with **childhood-onset** Conduct Disorder show symptoms before age 10, while patients with **adolescent-onset** Conduct Disorder show symptoms after age 10. Treatment is through a behavioral therapy program, with an emphasis on family therapy and providing structure in the patient's daily life. Early drug therapy studies have shown Methylphenidate, Divalproex, and Lithium to have some effectiveness for treating Conduct Disorder.

**Medication**

<table>
<thead>
<tr>
<th>Most Common</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methylphenidate</td>
<td>Ritalin</td>
</tr>
<tr>
<td>• Alleviates aggression, sudden changes in mood and disobedience</td>
<td></td>
</tr>
<tr>
<td>• Most effective in children 5-8</td>
<td></td>
</tr>
<tr>
<td>Divalproex</td>
<td>Depakote</td>
</tr>
<tr>
<td>• Helps reduce belligerence and anger</td>
<td></td>
</tr>
<tr>
<td>Lithium</td>
<td>Lithobid</td>
</tr>
<tr>
<td>• Helps reduce aggression</td>
<td></td>
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</tbody>
</table>

**ELIMINATION DISORDERS**

There are two disorders in this category: Encopresis and Enuresis.

**Encopresis:** Characterized by excreting feces in inappropriate places other than toilets such as in clothes or on floor - either uncontrolled or conscious choice. Diagnosis cannot be made until after age 4 when children have the developmental ability to control their excretions and until a physiological condition is ruled out. The disorder is 3 times more likely among boys. Behavioral therapy is the best treatment, with parents positively reinforcing successful use of the toilet through verbal praise or small rewards.

**Enuresis:** This psychological disorder is characterized by urinating in inappropriate places such as bed or in clothes. The urination may be intentional or unintentional, but like Encopresis, cannot be due to a physiological disorder. Diagnosis must be left until the child is at a developmental point where he/she should be able to control urination properly, usually after age 5. Behavioral therapy is most effective and includes star charts that monitor proper urination. Dry bed **techniques** have also been effective, such as alarm-and-pad monitor, where the contact of urine with a pad sets off an alarm to wake the child. Drugs such as heterocyclic antidepressants and desamine-D-arginine vasopressin (DDAVP) are also used.
Medication

- **Most Common:** *Heterocyclic Antidepressants*
  - *Imipramine*
    - Antidepressant that helps reduce frequency of wetting
    - Should only be used for a maximum of 3 months
  - *Brand Name*
    - *Tofranil*

**SEPARATION ANXIETY DISORDER**

This disorder features improper and extreme anxiety regarding separation from home or attachment figures. To meet the DSM criteria, the disturbance lasts for at least 4 weeks and 3 of eight characteristic symptoms are present. Persistent worry about harm of the attachment figure, worry about that figure leaving and not coming back, and repetitive nightmares about separation are all examples of the symptoms. Children with this disorder usually come from close-knit families, and are afraid of objects or situations they may see as a danger to the family or themselves.

- Depression is frequently co-morbid with this disorder
- An added diagnosis of Dysthymic Disorder or Major Depressive Disorder may be appropriate
- Other common traits include school refusal, concerns about death or dying, fury at the prospect of division and somatic complaints
- Separation Anxiety Disorder can lead to social problems, academic under achievement and interference with the development of autonomy
- Often parents themselves have anxiety disorders and may tend to worry excessively about the child
- It is normal for children between 18 and 30 months to experience problems in separation
- Extreme compliance and perfectionism are common characteristics
- Children with this disorder:
  - Are usually socially awkward and immature
  - Often display internalizing behaviors
  - The child may exhibit trouble sleeping and school absenteeism
  - These children are at risk for other anxiety disorders later in childhood or as adults
  - Separation Anxiety Disorder is not usually seen before the age four (after the period of normal separation anxiety)
  - It is usually recognized in early to middle childhood

A thorough assessment needs to be done to understand the problems. If the child refuses to go to school, you should do what you can to get the child back to school as soon as possible. It is important to separate school phobia from Separation Anxiety. You should then establish a working rapport with the family. An interview with the parents will be necessary to get a full clinical history in relation to the nature of the problem. The parents will be able to provide you with the types of interventions they have tried on their own and what successes they have or have not had. Obtain releases and talk to the child's teachers and then rule out any co-existing mental disorders. A referral to a physician would be helpful to rule out any general medical conditions and possible underlying somatic symptoms associated with the disorder (you will need a release).
You will want to have discussions with the parents regarding treatment goals and strategies since they probably have come to you because the school or their physician asked them to. You will need to be insistent, firm and empathetic, as well as furnishing consistent positive bolstering for desired behaviors. Antidepressant medication is often helpful in treating this disorder. Alternatively, SSRIs and benzodiazepines may be used effectively. However, benzo's are quite addictive and should be used with caution. Finally, you may need to refer the family to a support group.

Parents with anxiety or mood disorders may need their own psychiatric and/or psychological treatment. Both parents and children may present with overly good or nice behavior. Clinicians should watch for overly compliant behavior. This should not be mistaken for understanding or change that is more substantial. Therapeutic "coercion" to return to school can be effective if applied with sensitivity if the child does not have Panic Disorder of a mood disorder.

**Medication**

- **Most Common:** SSRIs (*Antidepressant*)
  - Fluoxetine: *Prozac*
  - Sertraline: *Zoloft*
  - Paroxetine: *Paxil*
  - Helps to relieve anxious symptoms and calms nerves

**REACTIVE ATTACHMENT DISORDER**

Beginning before the age of five, **Reactive Attachment Disorder** is a relational or reactive disorder connected with the parent or caretaker of a child. The mention of abuse or neglect, whether sexual, physical or mental, provides a potential key to consideration of this diagnosis. Foster children are at risk. Whether the type of attachment is **too much** or **too little**, the disorder may be present. Exemplified by inappropriate boundaries, the aspect of the disorder that is typified by too much attachment also involves ongoing conversation about inappropriate situations or behaviors. Unresponsiveness, whether to people or to objects, is a key to recognition of too little attachment. With a sort of frozen response to life, the child with this form of attachment disorder lacks any sort of response to a nurturing person.

**DELIRIUM, DEMENTIA AND AMNESIC AND OTHER COGNITIVE DISORDERS**

The cluster of cognitive disorders includes Delirium, Dementia and Amnesiac disorders. These disorders generally have symptoms related to difficulty in normal thought processes and functioning such as memory loss. These cognitive disorders usually have a biological cause that is generally clearer than other types of disorders. Diagnosis is often made by examining and finding the etiological or biological cause of the disorder. Dementia is especially categorized by its root cause; different types of Dementia include Dementia of the Alzheimer Type, Vascular Dementia and Dementia due to HIV Disease. Cognitive disorders are treated by isolating and treating the underlying root cause of the disorder.
DELIRIUM

Delirium is differentiated from Dementia by a very short onset and consciousness that fluctuates throughout the day. Delirium is characterized by a lack of coherence in the patient's consciousness and an inability to clearly and logically understand and respond to one's surroundings. The periods of delirium generally last for a short length of time, a few hours or days, and include symptoms such as hallucinations, mood fluctuations, nocturnal disturbances, perception and orientation issues, and general confusion. Delirium is the most common psychological disorder among hospitalized patients. It is caused by a dysfunction of the central nervous system. Direct diseases of the brain such as meningitis or encephalitis and injuries such as stroke and traumatic brain injury may lead to Delirium. Systematic medical diseases such as cardiovascular, liver, kidney and lung diseases may also lead to Delirium by cutting off circulation to the brain or by preventing proper metabolism in the brain. Substance abuse and withdrawal of sedative agents may also lead to Delirium.

A thorough and complete mental diagnostic exam and a history of the patient's mental health should be evaluated to make a diagnosis of Delirium. Elderly patients are at higher risk for Delirium. Since Delirium is commonly caused by physical sources, tests such as a computed tomography (CT) scan will reveal visible damage in the brain structure that may indicate Delirium. Electroencephalography (EEG) is also useful in diagnosing Delirium, as patients typically have slower EEG readings.

When descriptives such as clouded sensoria, impaired attention, lack of focus and inability to listen to instructions (or follow through with tasks) form part of the scenario, Delirium must be considered. However, Delirium and Dementia can co-exist. The clinician must wait for Delirium to clear before diagnosing Dementia.

The best course of treatment is to locate the physical source then treat and remove this source, which will generally cause the delirium to go into remission. To treat the symptoms of Delirium, haloperidol (Haldol) is often used. Drugs such as Risperdal, Quetiapine, Ziprasidone and Olanzapine are also used.

Medication

- **Most Common: Neuroleptics**
  - **Brand Name**
  - Haloperidol (Haldol)
  - Risperidone (Risperdal)
  - Olanzapine (Zyprexa)
  - Help to alleviate symptoms of Delirium such as severe agitation and hallucinations

- **Most Common: Benzodiazepines**
  - **Brand Name**
  - Diazepam (Valium)
  - For Delirium due to drug withdrawals

DEMENTIA

Dementia is a cognitive disorder that includes both deterioration of intellectual ability and alterations in the person’s emotional and personality functions. Alzheimer's disease, Vascular
Dementia, general medical conditions (brain tumors, brain trauma, metabolic disorders, kidney, liver, heart or lung disorders) or multiple etiologies all cause Dementia.

A neurologist and a psychiatrist should closely follow persons with this disorder. Medication is often needed to reduce agitation and assist in controlling acting out behavior and wandering. Confusion is common in Dementia, just as psychotic behaviors. While Dementia patients can become floridly psychotic, illusions, paranoia and agitation are most common. Often a very small dosage of Neuroleptic is useful to control agitation and psychosis.

It is advisable to have a consultation with a neuropsychologist who will continue to follow the patient; it is the job of the neuropsychologist to monitor the mental status of the patient. Often, baseline tests are conducted to monitor change in mental status over time. It is also imperative to monitor and control the patient’s environment so as not to add to their confusion. The patient's room should have a large calendar in a primary location. A sign identifying the patient's current location is helpful (e.g., "This is Donna's room in the Harbor Manner Nursing Home"). Items the patient is familiar with should be available. Keeping a stable and consistent environment will help to minimize confusion and agitation.

Dementia is generally a chronic and progressive disorder. Alzheimer's is usually evenly progressive over time, while Vascular Dementia is often stepwise. In Alzheimer's, the patient’s family may not notice changes for a long time. However, when asked to think back, they can usually identify significant changes in memory or personality that they chose to ignore, or chalk up to old age. Alzheimer's has an insidious course, beginning with memory loss, confusion and personality changes, eventually leading to death. After the first signs of Alzheimer's are identified, a patient will generally live no more than 5 to 10 years. Alzheimer's type Dementia is considered untreatable. No form of psychosocial or medical therapy has been shown successful in slowing the progression of the disease. Other untreatable Dementias include Huntington’s chorea and Parkinson’s disease among others. Huntington’s and Parkinson’s are especially tragic in that patients suffer significant distress and depression as the disease progresses. Alzheimer's patients often only suffer in the early stages, as they generally loose higher cortical functions and self-awareness as the disease progresses.

Vascular Dementia, on the other hand, is considered treatable. Vascular Dementia has rapid onset often due to a significant cerebral event (e.g., multiple thromboembolic episodes or cerebral infarctions). The course of Vascular Dementia is usually stepwise, more focal in the area of impairment and may be less insidious in course.

The goals associated with Dementia are:

- Assess the level of impairment
- Ensure the person is getting the appropriate medical care
- Establish relationships with the caretakers and the patient

When doing the assessment, it should cover adaptive, behavioral, cognitive and emotional functioning. It will also be necessary to obtain releases for prior assessment results and medical records. Make sure the client has received a full medical evaluation to rule out obvious medical conditions. Also, ensure the client is receiving appropriate physical care.
In the elderly, Depression often mimics Dementia. Patients can develop Anxiety and Hypochondriacal disorders as well. Major Depression in the elderly is often called Pseudodementia. Further, Delirium can appear similar to Dementia; hence, it is important to differentiate Dementia from other psychological conditions.

Unlike Dementia, Depression usually has a more rapid onset and the patient complains of memory loss. When tested, memory loss is usually mild when the patient is encouraged; depressed patients often give up easily but do better when encouraged. With encouragement, normal memory and orientation can usually be seen. These patients often focus on their failings and have significant affective changes. The depressed patient often answers memory questions with "I don't know", while Dementia patients usually attempt to answer. In addition, depressed patients often show psychomotor retardation while Dementia patients do not (depending on type).

Supportive treatment should include making sure there is good physical care. Nutrition, glasses, hearing aids, etc. should be provided. The patient should be maintained in a familiar environment, should be involved in structured activities and if possible, current events. While there is no current drug treatment for Dementia, treatment of symptoms can be extremely effective to make patient more comfortable and improve their overall mental status.

Supportive psychotherapy will be helpful to the family in adjusting to the situation. While there are no psychological treatments that are very effective with Dementia patients, personal contact by an interested person may be helpful. Reminiscent therapy may help the patient feel more connected to the world (early memories remain intact much longer than recent or short-term functioning).

You will also need to explore what assistance is needed, whether there is family support and what types of community resources are available.

Medication

- **Most Common:**
  - Hydroxyzine: Vistaril
    - For those who develop increased irritability, a mild tranquilizer used for short-term treatment to help alleviate tension and nervousness
  - Memantine: Namenda
  - Donepezil: Aricept
    - Helps to improve cognitive and mental abilities such as memory, language and logic in Alzheimer patients
    - Helps to provide more clarity in thought processes
    (Note: Alzheimer drugs can only reduce symptoms but cannot cure the disease itself)
  - Ticlopidine: Ticlid
    - Serves as an antiplatelet drug to help with Vascular Dementia

**AMNESTIC DISORDER**

Amnesia, a total loss of memory or abnormal forgetfulness, can be caused by a severe emotional trauma or a disease causing brain damage. Amnesia can be temporary or permanent; it can come on gradually or suddenly depending on the underlying cause. In the normal healthy aging process
there may be gradual levels of forgetfulness and loss of memory as opposed to amnesia where these conditions appear as drastic changes.

Care can be provided within the home by a family member or a close friend for an individual diagnosed with amnesia where the basic needs can be met and where their safety is not a factor. Helping the individual become familiar with their surroundings, providing familiar objects or photos can be very beneficial in maintaining some sort of normalcy in their life. When the individual's needs cannot be met and their safety may be a factor, nursing homes or extended care facilities should be strongly considered.

**SUBSTANCE RELATED DISORDERS**

Although substance-related disorders may be most commonly thought of as the result of drug or alcohol abuse, dysfunction stemming from toxin exposure or the side effects of a medication is included as well. The use of alcohol, amphetamines, caffeine, cannabis, cocaine, hallucinogens, inhalants, nicotine, opiates, phencyclidines, sedatives or anxiolytics can be the foundation of a specific substance-related disorder. In addition, a classification of “unknown” or “other” exists when precise determination cannot be made.

**Substance Abuse And Substance Dependence**

With likely symptoms including failure to meet role obligations, lack of friends, legal problems, inability to keep a job, difficulty in parenting and continued use of a substance in spite of negative consequences, Substance Abuse implies a continued pattern of using alcohol or drugs. Although it is usually coupled with adverse consequences, the client continues this pattern of substance use. Maladaptive behaviors result. Substance Abuse lacks the component of dependence, an important consideration in diagnosis.

To apply the classification of **Substance Dependence**, the same symptoms are present as for Substance Abuse, but with greater **duration** and **intensity**. The client may describe tolerance, withdrawal or both. Since tolerance indicates the body’s adjustment to a substance, the client may make statements such as, “I need more to get just as high,” or “I am less drunk than other people using the same amount.” If the client attempts to stop substance use, symptoms of **withdrawal** are experienced. These manifestations include physical symptoms such as sleep disorders, motoric responses and mood changes. Clients may complain of tiredness, inability to concentrate, agitation, depression, irritability or moodiness. Inability to sleep or difficulty awakening may also be present.

The DSM lists eleven classes of substances abused:

- Alcohol
- Amphetamines
- Caffeine
- Cannabis
- Cocaine
- Hallucinogens
- Inhalants
Nicotine
Opioids
Phencyclidine (PCP)
Combined category including hypnotics, sedatives and anxiolytics

Some Symptoms To Watch For
- Bloodshot eyes: Most likely indicates Marijuana Abuse (especially if the patient’s heart is racing), but could suggest Alcohol Abuse
- Paranoia, rapid talking, nose bleeds: Most likely diagnosis is Cocaine Abuse
- Flushed cheeks, slurred speech, difficulty with coordination and balance: Most likely points to Alcohol Abuse

Remission is treated differently than dependence. In cases of remission, the client declares, “I have been symptom free for 30 days” or something similar. An appropriate response of the counselor is to determine what happens following the 30 days. Determining the duration of the remission is important. If symptoms have not been present for a period of two days to one year, early remission is indicated. After one year has passed, sustained remission has been achieved. In addition to the length of remission, the intensity of remission must be determined. In full remission, no symptoms are present after a period of 30 days. In partial remission, some symptoms return.

A therapist should never try to engage a client in a counseling session if that client arrives apparently intoxicated or under the influence of a psychotic substance. The best advise if you find yourself in this situation is to suspend the session and reschedule.

Medication
- **Most Common:** Alcohol Withdrawal
  - **Brand Name:** Valium
  - **Brand Name:** Serax
  - **Brand Name:** Librium
  - Benzodiazepines used in treatment of Acute Alcohol Withdrawal symptoms work on the central nervous system to create a calming effect

- **Most Common:** Opioid Abuse
  - **Brand Name:** Dolophine
  - Methadone Maintenance Therapy is used against heroin, morphine and other narcotic addictions
  - The down sides to this drug are the many side-effects, including death when mixed with certain other drugs, and the fact that it too can trigger dependence and trigger its own withdrawal symptoms

FAMILY THERAPY FOR SUBSTANCE ABUSE

Family Risk And Protective Factors For Substance Abuse
- Relationship factors such as parent-adolescent attachment consistently predict adolescent drug use across cultures
Parenting practices such as low monitoring, ineffective discipline and poor communication are also implicated in substance problems among youth.

**Family Based Interventions For Adolescent Substance Abuse**
- Family based interventions have been found to have superior treatment effects on levels of adolescent drug use compared to individual therapy.

**Family Based Interventions For Adult Substance Abuse**
- It has been concluded from meta analysis of family therapy for drug abuse, that family interventions work equally well for adults and adolescents.
- Family therapy studies with adults and adolescents tend to be of good design quality, show better results than non-family approaches and with adult narcotic addicts, are cost effective components of methadone maintenance.

**Family Based Interventions With Adult Alcoholics**
- Behavioral family therapy techniques have also been adapted in designing interventions aimed at increasing engagement of substance abusers into treatment by mobilizing family support.

**Family Based Interventions With Adult Drug Abusers**
- Family based engagement interventions for adult drug abusers are also gaining empirical support.
- Preliminary evidence for the success of engagement interventions with family members and significant others, suggest that interventions hold promise for enlisting these natural supports to motivate drug abusers into treatment.

**12-Step Programs**
- Patients attend meetings
  - Preferably after or in conjunction with some other form of drug treatment.
- There might be the belief that they will never "recover" from their drug addiction
  - Group meetings help support the positives
- This type of program may leave many feeling powerless over the possibility of ever ending their battle with drug addiction
  - One of the twelve steps is to accept powerlessness
- This type of program may work for some, but has a low success rate.

**In/Outpatient Care**
- Techniques vary by clinician but typically include:
  - Cognitive-behavioral therapy
  - Problem-solving groups
- There is a low success rate with heavily addicted individuals.
- Moderate addicts may find this level of treatment is enough to end their drug abuse problems.

**Inpatient Short-Term Rehabilitation**
- Substance abuse treatment typically lasts for 30 days.
Overseen by medical professionals and trained counselors, often a Certified Drug Addiction Specialist

Goals are primarily:
- Physical stabilization
- Abstinence from all use
- Lifestyle changes

Primarily founded in a modified 12-step approach

**Inpatient Long-Term Rehabilitation**
- Inpatient long-term residential program is a 24 hour a day, 7 days a week treatment
- Duration can be from several months to a year or more
- Residential treatment is conducted in non-clinical settings known as therapeutic communities
- May also include additional treatment strategies, such as social education

**Methadone Maintenance Treatment**
- For clients with a dependence on heroin or other morphine like drugs
- Methadone decreases the feeling of pain and reduces emotional responses to withdrawal symptoms
- A dose typically suppresses an addict's symptoms for 24 hours
- There are downsides:
  - Patients are physically dependent
  - They may find themselves using it for many years after they start treatment
  - In truth, methadone is more addictive than heroin
  - Maintenance involves more time, pain and expense than heroin withdrawal
- Chronic substance abusers tend to be isolated from their families after a long period of damaging relationships
- Substance abuse affects more than the immediate family, extended family members often report:
  - Feeling abandoned
  - Embarrassed by, ashamed of and withdrawn from the substance abusing family member
  - Often choosing to break relational ties
- Family structures in which abuse affects the family relationship differ:
  - Client may live alone or with a partner
  - Both partners may need treatment
- Groups are offered both for addicts and for non-addict partners of addicts
- The treatment of either partner will affect both
- Often, codependence is an issue
- Enabling may have to be explored

**If A Client Lives With A Spouse (Or Partner) And Minor Children**
- You must take into consideration that parental substance abuse has a detrimental effect on the children
There may be triangulation or enmeshment issues if children are either placed in the middle or if the non-using parent is overly protective and bonded with the children due to the substance abuser’s lack of responsibility.

Issues of neglect or trauma may be present if both parents are abusing drugs.

**A Client May Be Part Of A Blended Family**
- Substance abuse can intensify the already shaky ground of a newly blended family and become an impediment to integration and stability.

**With An Older Client Who Has Grown Children**
- As with child abuse and neglect, elder maltreatment can be subject to statutory reporting requirements for local authorities.

**When Client Is An Adolescent And Lives With Family Of Origin**
- Non-using children may find themselves neglected or ignored emotionally due to the focus of parents on the using child.
- Often, at least one of the parents uses as well.

**Where Someone Not Identified As The Client Is Abusing Substances**
- Issues of blame, responsibility and causation will arise.
- Scapegoating may be an issue.
- The therapist must work toward uncovering the underlying motivations for substance abuse and other behavioral issues that bring the family into counseling.
- Any activity, substance, object or behavior that has become the major focus of a person's life to the exclusion of other activities, or that has begun to harm the individual or others physically, mentally or socially is considered an addictive behavior.
- There is a similar impact on the family between physical addiction to various chemicals in drugs and alcohol and psychological dependence to behaviors including:
  - Gambling
  - Sex
  - Work
  - Eating disorders
- These behaviors may produce the endorphins in the brain, producing a “high” sensation.
- When addicted, people continue these behaviors in order to get that endorphin rush, despite the detrimental effects on their work and family.
- Addicts may still crave their addiction behavior even after remaining abstinent for long periods of time.
  - Therapeutic modalities believe this craving will be a lifelong challenge and a continual stress on the addict’s support system.
- Withdrawal symptoms when behavior is ceased can cause feelings of:
  - Irritability
  - Agitation
  - Depression
  - All of which affect the entire family system.
- During active addiction, many clients live in denial and hurt their families.
Building trust back and healing wounds caused in the family is important to keep in mind during therapy

**Drug Abuse and AIDS/HIV in Females**

The fourth chief cause of death in childbearing females in the United States is AIDS. Females who are also substance abusers have a higher risk of contracting HIV or AIDS, particularly if they share drug paraphernalia (as HIV is spread through shared needles, syringes, cotton swabs, rinse water and cookers), and because females are also more likely to have unprotected sex. There was a reduction in the number of females newly contracting the AIDS virus in the years 1993-1994, however there are still 85,000 cases of AIDS among adult and young females in America. It is important to note:

- 62% of these cases were caused by the female injecting herself, or by her having sexual relations with another injected drug user
- 37% were caused by heterosexual contact

When treating a woman in a drug treatment program, it is beneficial to include the following basic needs covering comprehensive services: food, clothing, shelter, transportation, counseling for jobs, occupational training, legal assistance, literacy training, opportunities for education, parenting training, family therapy options, couples counseling, medical services, child care, social services, social support, psychological assessment, mental health care (if needed), assertiveness training and family planning services.

Women need specialized treatment programs, as many traditional programs do not offer the specialized services required. These services must include ongoing treatment or contact with the center, because many females experience relapses at one time or another. Another benefit to ongoing contact is the program's role in helping the woman rejoin society.

**Schizophrenia and Other Psychotic Disorders**

Psychosis is a term describing severe mental disturbance, not a specific disorder. Many disorders have symptoms of psychosis including: Schizophrenia, Schizophreniform Disorder, Brief Psychotic Disorder, Schizoaffective Disorder, Shared Psychotic Disorder, Delusional Disorder, Psychotic Disorder Due to a General Medical Condition, Substance Induced Psychotic Disorder and Psychotic Disorder NOS. These disorders are clinical syndromes, not discrete diseases.

Most psychotic disorders do not have clear etiology. Of course, the disorders related to medical conditions and substance withdrawal are more easily traced to a precipitating factor and are therefore more likely to be easily diagnosed.

Evaluation of persons suspected of having a psychotic disorder requires a good history and a physical examination by a physician. Generally, non-organic disorders present with disturbances in thought and emotion, while organic disorders tend to present with mental clouding, confusion and disorientation because of some degree of Delirium. This is not a hard and fast rule and in practice, there are many exceptions. The following are some characteristics that suggest the presence of an organic disorder:

- No personal or family history of mental illness
• Someone who presents with Schizophrenia-like psychotic symptoms will undoubtedly have some family or personal history of psychiatric treatment
  • This is particularly true if the subject is well into adulthood
  First time psychotic breaks usually occur in early adulthood (early 20's for men, late 20’s for woman)
  • The lack of history makes it more likely that there is some organic factor operating
  ➢ There is a history of serious medical illness with periodic relapses
  • This suggests organic etiology, especially if the subject is an elderly person
  ➢ There is very rapid onset
  • If the onset is in a few hours or days, this is a strong indicator of organic etiology
  • With symptoms that are not organically based, family members usually report some period of time that the client is acting "strange"
  ➢ The client presents with significant memory loss, confusion, disorientation and clouding of consciousness (that may fluctuate rapidly - within hours)

Major Depression and Bipolar Disorder may have psychotic symptoms that are secondary to affective symptoms. Affective Disturbance always precedes psychosis in these cases. Individuals with severe personality disorders may have brief periods of psychosis, especially in times of severe stress. Psychotic symptoms usually resolve when the environmental stressors are stabilized, either through direct psychosocial intervention or by removing the individual from the environment and placing them into a stable, safe environment such as a hospital setting. Both Pervasive Developmental Disorder NOS and Autistic Disorder may have psychotic symptoms. Again, these symptoms appear to be secondary to the developmental impairment.

Medication

➢ **Most Common**: Antipsychotics  
<table>
<thead>
<tr>
<th>Antipsychotics</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlorpromazine</td>
<td>Thorazine</td>
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<tr>
<td>Haloperidol</td>
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<tr>
<td>Olanzapine</td>
<td>Zyprexa</td>
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<tr>
<td>Clozapine</td>
<td>Clozaril</td>
</tr>
</tbody>
</table>
  
(Note: Clozaril must be monitored biweekly - danger for major drop in white blood cells)
• Antipsychotics help to better control psychotic effects - 2nd Generation drugs are now preferred due to less side effects

**SCHIZOPHRENIA**

A Description Of Schizophrenia

➢ Symptoms of Schizophrenia
  • Delusions = false, culturally inappropriate beliefs
  • Hallucinations, especially hearing voices
  • Associated abnormal behavior

➢ At its worst, it may become
  • Chronic
  • Include relapses and remissions
  • Client will experience a general decline in self-care
• The ability to lead an independent life is thwarted

Individuals with Schizophrenia display odd, unusual and idiosyncratic behavior that result from defects in ego functioning. One aspect of this is the loosening of ego boundaries. What I mean by loose or fluid ego boundaries is difficulty distinguishing internal fantasies and thoughts from external reality. Moreover, the individual's internal world is not integrated. There appears to be internal chaos, confusion, and sometimes overwhelming anxiety. This is the result of impairment in primary, autonomous ego functioning that involves basic contact with reality and the integration of thoughts, feelings and perceptions. In the acute phase of Schizophrenia, there are five areas of disturbance (symptoms) that should be assessed:

- Thought form
- Thought content
- Perception
- Emotion
- Behavior

Most of these symptoms will be readily apparent in an interview.

**Disturbance of Thought Form:** This may be a formal thought disorder where thinking is illogical and often incomprehensible.

**Characteristics of a formal thought disorder include:**

- Loose Associations: Disconnection of ideas, jumping from topic to topic (often mid-sentence)
- Over-inclusiveness: Use of irrelevant information that interrupts logical thought
- Neologisms: Creation of new words that may have meaning to the client
- Blocking: Simple speech that stops mid-sentence
  - Speech may start again after a few minutes, but is often in another place
  - This may be due to the interference of hallucinations
- Clanging: Word choice based on sounds
  - The client will often rhyme a primary word in one sentence with a word from a previous sentence
- Echolalia: Repeating words without concern for meaning
- Concreteness: Inability to think in abstract terms
- Alogia: (also called "Poverty of speech") The client speaks very little without intentional resistance
  - Individuals with a formal thought disorder, which is pathognomonic of Schizophrenia, appear to be caught up in an idiosyncratic world and have a relatively unique way of communicating
- Other psychotic disorders may also include characteristics of a formal thought disorder

**Schizophrenia: Delusions and Hallucinations**

While Schizophrenia is considered a chronic illness, the course of the illness appears to include several stages. These stages are often classified according to the particular point of view or
theoretical orientation of the clinician. The DSM is considered non-theoretical as to diagnosis and etiology. Rather, the DSM is empirically based and is organized into diagnostic categories according to symptoms. Whatever the theoretical considerations, for the purpose of communication and third party reimbursement, the DSM is the most widely utilized tool for diagnosing mental disorders.

In classifying Schizophrenia, the DSM identifies both active (acute psychosis) and residual (less acute, chronic and long-standing symptoms) phases. The DSM also uses "Residual" as a subtype classification. Most people diagnosed with Schizophrenia will move between subtypes as their illness progresses. Other subtypes refer to acute, sub-acute and chronic phase patterns of symptoms. With this said, let's look further at the acute symptoms of Schizophrenia as they may manifest clinically.

**Disturbance of Thought Content (Delusions) and Disturbance of Perceptions (Hallucinations)**

In the organization of the DSM, these symptoms give further clues as to both the diagnosis of Schizophrenia and the subtype classification.

Delusions are fixed false beliefs that are usually incredible and beyond belief. They may be "bizarre" or "non-bizarre." Non-bizarre delusions are a characteristic of Delusional Disorder. Usually, the more acute the illness at the time of assessment, the more disorganized and bizarre the delusions will be.

**Types Of Delusions That Might Be Seen**

- Bizarre and confused delusions with no systematic content
- Persecutory delusions that also lack systematic form
- Delusions of Grandeur - "I am the second coming of Christ." or "I am the president."
- Delusions of Influence - "I have powers of mind control and can make you stand on your head if I want."
- Ideas of Reference - Casual events in the lives of others are viewed as being directed toward the individual
- Thought Insertion - "The FBI is transmitting thoughts into my mind."
- Thought Broadcasting - "The Government has been listening to my thoughts for years."
  - So the individual covers her head and entire apartment with aluminum foil to block the transmission

Most Delusions have a paranoid flavor. In the DSM, preoccupation with delusions is considered a characteristic of the Paranoid Subtype of Schizophrenia. The other criteria for the Paranoid Subtype include prominent auditory hallucinations and a lack of the following: disorganized speech, catatonic or disorganized behavior, or flat or inappropriate affect. Perceptual disturbances (hallucinations) can be auditory, visual, olfactory and tactile.

Auditory hallucinations may present as running commentary, negative or threatening statements or directives for action such as command hallucinations (often to hurt or kill oneself or others). Illusions are also possible, as are derealization (the world seems unreal) and depersonalization (the experience of observing oneself from the outside). Note that the latter is different from dissociation.
Schizophrenia - Emotions And Behavior

The term "Schizophrenia" has been misused for years. This misuse is partially the result of dramatic license taken in movies and in the media, but is also due to ignorance on the part of the average person. The word "Schizophrenia" literally means "split mind." Eugene Bleuler coined this term in 1911 as a replacement for "Dementia Praecox," which means premature Dementia, to describe the cleavage between cognitive and emotional functions in the mind. He was really describing the "fragmentation" of the ego functions that cause one to lose touch with reality.

In common usage, Schizophrenia became synonymous with "split personality" and was used to mean "of two minds" or "two personalities." This has led to the use of the term "Schizophrenia" to describe everything from Dissociative Personality Disorder to simply feeling extreme ambivalence. More recently, common usage of the term Schizophrenia has brought with it concerns of very dangerous or murderous behavior. In reality, most people diagnosed with Schizophrenia are much more dangerous to themselves, due to their lack of self-care and poor judgment, than they are to others.

Schizophrenic individuals, especially during acute psychosis, may display a variety of emotions in a short time period. This affective lability may be quite intense and may appear inappropriate for the situation or subject of discussion. Labile emotions are more characteristic of acute psychosis, whereas a blunted or flat affect is more characteristic of residual or chronic phases of the illness. However, this is not a hard and fast rule.

Previously, we mentioned disturbance of behavior. This includes such anomalies as bizarre or strange behavior, grimacing and posturing, ritualistic behavior (sometimes similar to OCD symptoms), excessive "stony" stillness and aggressiveness or inappropriate sexual behavior.

The use of the DSM specifier "With Good Prognostic Features" would be utilized if the onset of acute symptoms is shorter (fewer than 4 weeks after noticeable behavior change) and there is good premorbid functioning. Other considerations for the "With Good Prognostic Features" specifier are: a lack of blunted affect and the presence of confusion at the height of the episode. On the other hand, the "Without Good Prognostic Features" specifier is used if fewer than two of these indicators are present. Research has also shown that a later than average age of onset of the illness is indicative of better prognosis while earlier onset is a poor prognostic indicator. Do not confuse this with the use of the DSM specifiers, which do not include "age of onset."

A closer look at the differential diagnosis of Schizophrenia will provide important clues as to how to conduct a good Mental Status Exam. The MSE is important for assessing the current functioning (in the office) of the individual being assessed. Combining the MSE with a good history is the core of a diagnostic assessment.

Family Risk And Protection Factors For Schizophrenia

- Studies have focused on the link between expressed emotion to Schizophrenia and unexpressed symptoms
- Expressed emotion in families of schizophrenics has been shown to be bidirectional in nature and its impact on the client and on family exchanges is likely mediated by the patient’s level of symptoms and social skills
Family Based Interventions For Schizophrenia

- There is evidence to support the use of family interventions as one component of the treatment of schizophrenics
- Certain family patterns, most notably high criticism and rejection, complicate the recovery process for schizophrenics

Results

- Family treatment reduces relapse and re-hospitalization
  - On average, six treatments are needed to treat and prevent one such event
- Family treatment helps client compliance with medication
- However, family treatment does not alter the emotional climate or perceived burden in the family, rather how the family handles it

Clinical Implications

- Family treatment helps prevent relapse, but it is expensive in the amounts required for effect
- It is unknown whether the benefits of the treatment are from the family therapy techniques or a result of the improved compliance with medication

Schizophreniform Disorder

Schizophreniform Disorder is virtually identical, in the initial clinical presentation, to Schizophrenia except, according to the DSM, there is:

- A shorter duration
- The diagnosis does not require impaired occupational or social functioning (however, it is hard to imagine how psychosis would not impair functioning)
- Symptoms are usually more turbulent during the acute episode, but functioning following is usually better

Delusional Disorder

A person with Delusional Disorder will have the presence of non-bizarre delusions for at least 1 month. Bizarre delusions often distinguish Delusional Disorder from Schizophrenia. Bizarre delusions are clearly implausible and are not "derived" from ordinary life experiences. Daily functioning is usually not impaired (aside from the impact of the delusions) and the person's behavior is not odd or bizarre in an obvious way. There is no display of pervasive disturbances of mood or thought found in other psychotic conditions. There are either no hallucinations or hallucinations are not prominent. Personality is usually preserved and there is no disorganized behavior or grossly confused thought processes as in Schizophrenia.

- Delusions are often of persecution, but may also include infidelity, grandiosity, somatic change or erotomania
- Delusions are usually specific to a certain person, a given place, time or activity
- The delusions are usually well organized with elaborate reasons for what they are doing
- The delusions are generally grandiose
These patients generally do not seek out treatment on their own, but are usually identified by a family member. Diagnosis is difficult because these individuals are so mistrustful. The therapist has to be careful not to become "the enemy." When dealing with a Delusional Disorder, the theoretical approach is usually supportive. It is most important to gain the trust of the individual through a neutral and accepting attitude. These patients are extremely sensitive to criticism making rapport building very difficult.

The goals associated with Delusional Disorder are to conduct an assessment and address any safety issues as well as establishing a working alliance. When making the assessment, you must be cautious. The patient may be testing you to determine whether you should be perceived as dangerous. You will assess the client for dangerousness to self or others and take any necessary action to ensure safety. Intervention is a very gradual process. Engage the patient in their world; get inside to really understand things from the patient's perspective. With empathic and sensitive involvement, you may be able to slowly allow the patient to see things from your perspective.

Antipsychotic medication may be helpful to take the "power" out of the delusion. Antidepressants may also have some positive affect. Medication compliance is very important and should be monitored as well.

Two unusual conditions have been observed in patients with Delusional Disorder:

- **Capgras Syndrome**: In which a patient believes a person close to him has been replaced by a double
- **Fregoli Syndrome**: The patient identifies various people encountered as "psychologically identical" to a familiar person
  - In this syndrome, the patient acknowledges there is no physical similarity to the other person, but continues to insist they are identical

**BRIEF PSYCHOTIC DISORDER**

Brief Psychotic Disorder is characterized by psychotic behavior such as delusions, hallucinations, disorganized speech and grossly disorganized or catatonic behavior. The symptoms must be present for at least 1 day but less than 1 month and there is a return to full premorbid functioning. Puzzlement and emotional disorder are characteristic associated features. Stress may trigger or exacerbate the symptoms.

Specifiers include:

- With Marked Stressor
- Without Marked Stressor
- Postpartum onset

If the psychosis continues past 1 month, the diagnosis would then be upgraded to one of the other psychotic disorders. These include:

- Delusional Disorder
One of the disadvantages of a symptom based categorization (as shown in the DSM) can be seen with the lumping together of Postpartum Psychosis with the Brief Psychotic Disorder. It is much more likely that Postpartum Psychosis (which occurs in .01 to .02% of new mothers) is related to a mood disorder. However, postpartum disturbances may actually be discrete from other disorders.

Theoretical approaches most often applied to this disorder are psychoeducation and cognitive-behavioral. Supportive psychotherapy is probably the most effective form of treatment. Support and empathy as well as a safe environment will often assist a person in returning to normal functioning. You should emphasize ways in which the patient can make lifestyle changes that will be helpful in impeding a recurrence. Treatment of postpartum onset of Brief Psychotic Disorder should include the baby and mother together. This of course must take into account the severity of the psychosis and the level of dangerousness in the situation. Some theorists believe postpartum illnesses are related to relational disturbances between mother and baby combined with attachment issues from the mother’s history.

You will need to conduct an assessment, address any safety issues, stabilize the symptoms and institute a working rapport with the patient and his/her family. The next step will be to verify the diagnosis through the MSE and a short assessment. A referral to a psychiatrist will be needed to rule out medical and substance-related causes of the symptoms (get a release). If the patient presents as a danger to himself/herself, arrange for involuntary hospitalization.

If the patient does not need to be hospitalized, then refer them out for a medication evaluation (obtain a release). Before you decide on the outpatient treatment, you should discuss the treatment goals and strategies with the patient and their family.

Initially, it may be useful to see the patient several times a week, especially if treatment takes place in an outpatient setting. In a hospital setting, there should be consistent support and structure. Often, this is enough to help the individual return to premorbid levels of functioning. In the acute stages of psychosis, it is best not to challenge psychotic beliefs but to explore them for meaning. While psychotic symptoms appear to be nonsensical and meaningless, they undoubtedly have meaning for the patient. Empathic attunement and understanding of the patient’s suffering will often cause significant and rapid remission of symptoms. Then a clinician may choose to address issues related to tolerating and coping with stress and distress.

**MOOD DISORDERS**

The diagnostic cluster of Mood Disorders, Major Depression, Dysthymia, Atypical Depression, Bipolar Disorder I & II and Cyclothymia respond well to cognitive-behavioral, interpersonal and related interventions. Within the larger objective of overall adjustment, mood stabilization, alleviation of depression and mania, enhancement of coping skills, improvement in relationships and the prevention of relapse are vital treatment objectives.
Possibly accompanied by family therapy or a support group once symptoms have diminished, individual therapy is the approach for Mood Disorders. Focus should be placed upon altering behaviors and cognitions. For severe mood disorders, medication may need to be combined with psychotherapy for greatest response.

For effective treatment of the various forms of Depression, cognitive-behavioral techniques are most effective. Targeting overgeneralization, perfectionistic thinking, and the tendency to catastrophize, techniques from cognitive therapy provide the needed assistance. Training in communication skills to enhance interpersonal relationships coupled with help in decision-making and assertiveness training, empowers the client to solve problems he/she faces. By increasing pleasurable activities additional progress may be made.

**DEPRESSION**

Individuals suffering from Depression apparently have a greater number of stressful life events than healthy individuals. Psychosocial stressors appear to have more significant impact early in the course of the Depression and during the first episode. Psychosocial stressors appear to have less impact on later episodes and later during the course of the initial onset. Further, loss early in one’s life has been linked to Depression. This includes loss of a parent other than death. However, the link is considered weak and less impactful than recent events.

There are a number of approaches that have been found effective in the treatment of Depression. Some theoretical approaches that seem to be helpful are cognitive-behavioral (CT) and interpersonal psychotherapy (IPT). When patients exhibit mild or moderate symptoms, psychotherapy is the number one treatment. More severe Depressions appear to be most effectively treated with medication and psychotherapy. The primary reason for using a cognitive-behavioral approach is to help patients change their thinking and behavior. In the cognitive-behavioral school, it is believed that distorted cognitions and beliefs cause Depression. The therapist helps identify negative thoughts and assumptions replacing them with more positive beliefs.

The interpersonal therapy helps to refine social functioning. Social support is considered important in the development of Depression. The goal of interpersonal therapy is to improve disturbed relationships thereby improving adaptation to stress. The focus is on current relationships; however, earlier relationships are not ignored. Several problem areas are generally addressed in IPT:

- Unresolved grief
- Difficulties with role transitions
- Interpersonal disputes
- Inadequate social skills

The first stage of treatment involves diagnosing, educating and assessing interpersonal relationships. Treatment involves identifying problems and using specific here-and-now interventions. Depression is considered a "medical condition" and is thereby legitimized. It should be noted that IPT is neither psychodynamic nor cognitive-behavioral therapy but shares qualities of both.
Several forms of brief psychodynamic therapy are considered useful in the treatment of Depression. These include "brief focal therapy", "short-term anxiety-provoking therapy" and "broad focus psychodynamic therapy". While these approaches are considered valuable, none have been significantly researched.

Both IPT and CT have been researched and found effective in the treatment of Depression. However, they have been researched largely by the creators of the therapies. Since they are concrete and can be "replicated" with some consistency, they lend themselves to research. Further, the creators are empirically oriented and designed approaches that lend themselves to research. Researchers have created manuals that are used by clinicians. They follow specific protocols and procedures. Psychodynamic approaches are less replicable and have generally not been studied with any consistency. Hence, they do not have the empirical backing of IPT and CT. More research is being conducted by psychodynamic clinicians and researchers. In the future, other forms of therapy may be proven as effective as CT and IPT.

Medication

- **Most Common**: SSRIs *(Antidepressant)*
  - Fluoxetine
  - Sertraline
  - Paroxetine
  - **Brand Name**
    - Prozac
    - Zoloft
    - Paxil

  - These **selective serotonin reuptake inhibitors (SSRIs)** are antidepressants that inhibit the uptake of serotonin.
  - Other antidepressants are the **tricyclic** class such as Tofranil, Elavil, and Anafranil and the **Monoamine Oxidase (MAO) Inhibitors** such as Parnate, Nardil, and Marplan.
  - These, like the heterocyclics, help improve the patient’s mood, alleviate anxieties, boost energy and helps patient sleep more normally. However, tricyclics have more possible side-effects than SSRIs and MAO Inhibitors carry strict dietary regulations (patients cannot eat foods rich in the amino acid tyramine).

**MAJOR DEPRESSIVE DISORDER**

Major Depressive Disorder is major depressive episodes without a history of manic, mixed or hypomanic episodes. This disorder is two times more likely in adolescent and adult females than in males. In the preadolescent period, this disorder affects boys and girls equally. Major Depressive Disorder causes the person to feel unmotivated, sad, listless and emotionally drained. Behavioral manifestations may vary from profound psychomotor retardation and withdrawal, to agitation and irritability.

These symptoms have a profound impact on activities of daily living. A person suffering from this disorder may find it difficult to work, sleep, eat and function from day-to-day. Approximately 25% of the cases include a "presumed" precipitating factor. It appears there is a precipitant in 50% of the elderly population. A thought disorder is sometime present like Major Depression with psychotic features. Delusions are often mood congruent. Hallucinations are rare and when present, usually paranoid or self-deprecating in nature. In the elderly, Depression is often called Pseudodementia because it often "looks like" Dementia (e.g., psychomotor retardation, confusion, memory impairment).
Classical psychoanalytic theory postulates that depressed patients have suffered a real or imagined loss of an ambivalently loved object. The person reacts with rage that is turned inward. Cognitive theory postulates a cognitive triad of distorted perceptions. This theory holds that a person's negative interpretation of his own life causes self-deprecating thoughts that lead to depression. Biological theories focus on several neurotransmitters, particularly Norepinephrine (NE) and Serotonin (5 HT). It is suggested that lower levels of one or more of these neurotransmitters causes Depression. Some of the evidence for these theories comes from the action of antidepressants. (They increase levels of neurotransmitters and thereby reduce depressive symptoms; hence it must be lower levels of these chemicals that "create" the depression.) While some tests that measure neurotransmitter levels show lowered presence in depressed patients, the results are inconsistent.

Assessment should include both psychosocial and medical. You will need to conduct an assessment and address any safety issues with your patient. Establishing a good therapeutic rapport and relieving immediate symptoms is imperative. Supportive psychotherapy is imperative. Warm and empathic understanding can go a long way to improving functioning quickly.

During the clinical interview or assessment, you might use the BDI-II to measure the severity of the patient's Depression. The assessment should include suicide and homicide risks. If suicidality is present, you should discuss the plan or means of suicide and take necessary action. A referral to a physician is a good idea to rule out any possible general medical condition that may pre-exist (obtain a release).

A referral to a physician will be necessary also to obtain an antidepressant medication evaluation. Finally, explain the diagnosis and treatment suggestions to the patient. Make sure you are supportive and non-judgmental to relieve some of the patient's immediate symptoms. Find out what type of support the patient has and elicit community resources.

Medication

- **Most Common:** SSRIs (*Antidepressant*)
  - Fluoxetine: Prozac
  - Sertraline: Zoloft
  - Paroxetine: Paxil

- Usually prescribe SSRIs similar to ones used for Depression or *tricyclic* antidepressants for extremely severe cases

**DYSTHYMIC DISORDER**

Dysthymic Disorder is a form of Depression that is not as debilitating as Major Depressive Disorder. Dysthymic Disorder is sometimes called, Neurotic Depression (or Minor Depression). The implication is that Dysthymia is the result of psychological or social factors that create a depressive reaction as opposed to Major Depression that is endogenous and neurochemically based. While there is empirical evidence that suggests a familial pattern to Major Depression and therefore a genetic component, the line of differentiation is not so clear. This disorder is more common in women than men and is considered chronic Depression that is continual in nature. Diagnostic criteria for Dysthymia include a course that lasts for 2 years or more. Only about 6% of the population will suffer from Dysthymic Disorder.
Factors that predispose one to Dysthymic Disorder include: A major loss in childhood (often an important caretaking person), a recent loss, chronic stress, the presence of a personality disorder with compulsive or dependent features and alcohol or drug abuse. Often those persons who suffer from a Major Depressive disturbance will have a clearing of the more severe symptoms and chronically suffer from a "residue" of Dysthymic Disorder. This is called "Double Depression". Dysthymia must be differentiated from Adjustment Disorder that usually results after a clearly identifiable stressor and resolves after the stress disappears.

You will need to conduct an assessment and address any safety issues with your patient (e.g., suicide potential, self care issues). Establishing a good therapeutic rapport and relieving immediate symptoms is imperative. First, one must rule out Depression as secondary to other conditions (e.g. medical, alcohol or drug abuse). During the clinical interview or assessment, you might use the BDI-II to measure the severity of the patient's Depression. The assessment should include suicide and homicide risks.

If suicidality is present, you should discuss the plan or means of suicide and take necessary action. A referral to a physician is a good idea to rule out any possible general medical condition that may pre-exist (obtain a release). A referral to a physician will be necessary also to obtain an antidepressant medication evaluation.

Some theoretical approaches that seem to be helpful are supportive, cognitive-behavioral and interpersonal psychodynamic. When patients exhibit mild or moderate symptoms, psychotherapy is the number one treatment. However, it has been shown that both medication and psychotherapy together may be most effective in some cases. Supportive psychotherapy will allow space for the client to express their concerns and to ventilate. Often depressed persons feel that no one cares and no one will listen - so listen! The primary reason for using a cognitive-behavioral approach is to help patients change their thinking and behavior. The interpersonal therapy helps to refine social functioning.

Finally, explain the diagnosis and treatment suggestions to the patient. Make sure you are supportive and nonjudgmental to relieve some of the patient's immediate symptoms. Find out what type of support the patient has and elicit community resources. Watch for countertransference issues. Often a depressed client can evoke anger or protective behaviors due to overt or covert helplessness. Be aware of your own responses to the client and utilize these to assist in deepening your understanding of the client’s struggle.

**Medication**

- **Most Common:** SSRIs (Antidepressant)  
  - **Fluoxetine**  
  - **Sertraline**  
  - **Paroxetine**

- **Brand Name**
  - **Prozac**
  - **Zoloft**
  - **Paxil**

- Tricyclic antidepressants can be used if SSRIs are not effective

**BIPOLAR DISORDERS**

Bipolar Disorder is a major mood disorder including moderate or severe depression that alternates with very high levels of happiness and physical activity most of the time. Mania, at some time
severe enough to compromise functioning, is required for Bipolar I Disorder. 90% of patients have periods of depression. A “manic episode” usually develops over several days and 20% of Manics have hallucinations and/or delusions.

Severe Mania may be indistinguishable from an organic Delirium. A person with this disorder usually has a difficult time concentrating, needs very little sleep and may have inflated self-esteem. Often people with this disorder have also had at least one major depressive episode. A patient with Bipolar Disorder may have severe depression but may present with mild depressive symptoms. Attacks are often separated by months or years, but cycling between depression and mania may occur over days or weeks. Pure Mania (Unipolar Mania) is rare, but may occur.

Bipolar II Disorder is diagnosed when a patient has a Major Depression but also experiences a Hypomanic episode (usually around the time of the depression) but never develops a full manic episode. 5 to 10% of first-degree relatives with Bipolar Disorder develop the illness. Bipolar Disorder is considered a genetic disorder due to 70% concordance for identical twins. There is some evidence to suggest an abnormality on chromosome 11, but this is not clear at this time.

In individuals with this disorder, the first manic episode usually occurs before age 30. Onset is usually rapid and resolves within 2 to 4 months. In addition, one or more periods of depression have usually already occurred. Suicide is a major risk during depressive episodes. Legal difficulties or substance abuse are major risks during manic episodes.

Theoretical approaches used with this disorder are psychoeducation and cognitive-behavioral therapy. The treatment of Bipolar Disorder deals with the acute manic and acute depression as well as the prevention of manic and depressive recurrence. It seems discussing the diagnosis and including the patient in his or her own treatment is effective. The patient should keep a chart of sleeping and mood patterns.

You will need to conduct an assessment including a thorough clinical history and psychosocial as well as addressing any safety issues. Establish a therapeutic relationship with the patient and try to relieve their immediate symptoms with Lithium. If mania is present, then the patient may need to be hospitalized to ensure personal safety. A referral to a physician is a good idea to rule out any possible general medical condition that may pre-exist (obtain a release). A referral to a physician will be necessary also to obtain an antidepressant medication evaluation. Meet the patient in a quite place with minimal stimulation. Firm limits may be needed to prevent acting out or self-destructive behaviors.

Finally, explain the diagnosis and treatment suggestions to the patient. Make sure you are supportive yet firm regarding dangerous behaviors. You may be able to reduce some of the patient's immediate symptoms by acting non-judgmental and genuine. Find out what type of support the patient has and elicit community resources. Family therapy may be helpful to educate and allay the fears of family members. They are an important resource and should be utilized if possible.

Medications

- **Most Common:** Lithium
- **Brand Name:** Lithobid

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• Helps to stabilize mood and to control the typical switching from depressive to manic stages.

➢ **Most Common:** *Anti-convulsants*  
  **Brand Name**  
  Divalproex  
  Depakote

• For mild Bipolar Disorder  
• Stabilizes mood, prevents mania and to a certain extent Depression

➢ Neuroleptic medication in small doses may help hypomanic episodes

• Larger doses may be needed to treat any mania

*Please make note:* These and other psychotherapeutic medications offer special concerns with children, elderly and women who may be pregnant (the latter being advised to stay away from them while pregnant or nursing).

### Anxiety Disorders

When the diagnosis is any type of Anxiety Disorder, a physical examination is generally indicated. Including Generalized Anxiety Disorder, Panic Disorder, Phobias (simple, Agoraphobia and social), Obsessive-Compulsive Disorder and PTSD, Anxiety Disorders respond well to *cognitive-behavioral interventions and behavior therapy*, particularly in vivo desensitization. Objectives of treatment include reduction of anxiety and improved management of stress. With the lessening of anxiety, related behaviors and somatic symptoms also diminish. Development of socialization skills and giving a sense of mastery are additional goals.

In a cognitive approach, cognitive restructuring, focused cognitive therapy and panic education are applicable for Anxiety Disorders. Techniques included in behavior therapy are anxiety management training, relaxation, guided imagery, stress inoculation, problem solving, progressive muscle relaxation, meditation, biofeedback and exposure.

When any sort of Anxiety Disorder is diagnosed, individual therapy provides assistance. The most effective therapy is primarily behavioral in approach with a secondary cognitive emphasis. Depending on the nature of the disorder, group therapy may prove equally effective. Ancillary family therapy may be needed as well. Unless the condition is disabling, medication is not generally needed; however, it may provide supplementary treatment, particularly with Panic Disorders and OCD.

When a client presents with any type of phobia, exposure-based treatments (including desensitization), relaxation and social skills training are effective treatment choices. Antidepressants or benzodiazepines may be indicated.

For the person suffering with *obsessive-compulsive disorder* (OCD), exposure therapy, anxiety management training, and cognitive processing therapy provide treatment options. Antidepressants may be indicated. (see note under generalized anxiety above).

### Panic Disorder

Individuals diagnosed with Panic Disorder suffer from panic attacks involving intense fear such as dying or losing control, doubled with a variety of physical symptoms. Panic attacks may be abrupt and peak within 10 minutes; they may last only a few minutes or they may last for hours.
Symptoms are often perceived as medical in nature and can also include:

- Pounding heart
- Chest pains
- Trembling
- Choking
- Abdominal pain of distress (nausea)
- Sweating
- Dizziness
- Confusion
- Dread
- A desire to flee

Attacks may have no noticeable precipitant (unexpected panic attacks) or may be triggered by situations such as crowds, stress or anticipation of an attack (situationally bound panic attacks). Situationally predisposed attacks occur when one has an attack during exposure to a trigger; but attacks are not necessarily bound to this trigger.

Panic attacks may be chronic or may appear and disappear. With Panic Disorder, at least one attack is followed by one month of persistent feelings that the person will have another attack. It should be noted that "panic attack" is not a disorder, rather, it is a symptom. Panic Disorder, according to the DSM, is either present with or without Agoraphobia. Further, Agoraphobia may be present without a history of panic attacks.

There appears to be a genetic component to Panic Disorder, with 15% of first-degree relatives and 30% of monozygotic twins suffering from the disorder. Common co-morbid conditions include Major Depression, Social and Specific Phobias and Alcoholism. The disorder occurs twice as often in females than in males. Panic occurs most often with Agoraphobia.

The theoretical approaches used in this disorder are behavioral, cognitive-behavioral, psychoeducation and psychodynamic.

Reduction of the patient's fears and helping them to understand his/her physical complaints generally helps reduce the patient's fears. Moving the personal explanation from medical concerns is paramount to successful treatment. Taking a look at what triggers the attack can be especially helpful. However, since panic attacks often come without apparent triggers, this is often difficult. The somatic component is so powerful that it may be difficult to convince the patient they are not close to death when they have an attack.

The medical goal in dealing with Panic Disorder is to reduce the symptoms the patient is experiencing. Another goal is to teach the patient better coping abilities in response to the anxiety. Types of intervention used are relaxation therapy, recognizing the bodily sensations they are experiencing and provide effective breathing before the attack is in full force. For an insightful patient, you will want to identify triggers and look at the underlying meanings of the attacks.

Cognitive-behavioral therapy and psychopharmacotherapy are shown to be most effective and have been widely accepted due to significant empirical research. Systematic desensitization and
exposure either in vivo or imaginal are shown to be quite effective in modifying panic response. Panic control treatment, CBT (computer-based training), relaxation therapy and bibliotherapy are also useful approaches. Panic education provides a worthwhile cognitive technique.

Medication, including SSRIs, tricyclics and benzodiazepines are also quite effective. Medication should be used in conjunction with cognitive-behavioral treatment. Often, medication is used for six months with cognitive-behavioral treatments then the patient is slowly weaned off the medication. However, relapse is high and may require "half dose" maintenance.

**Medication**

- **Most Common:** *Antidepressants*  
  - Fluoxetine *SSRIs*  
  - Sertraline  
  - Paroxetine  
  - Inhibit the uptake of serotonin, relieving symptoms of anxiety
  - Diazepam *Benzodiazepines*  
  - Alprazolam  
  - Benzodiazepines have a rapid response time so they are ideal in treating patients with extreme symptoms  
  - Very addictive and difficult to cease taking these drugs

**AGORAPHOBIA**

This disorder in the cluster of Anxiety Disorders is defined as having unreasonable anxiety toward being in locations, usually public places, where escaping may be complicated or embarrassing if a panic attack does occur. There is also a fear that help will not be able to reach the patient. When public places are avoided due to this fear, the patient is said to have Agoraphobia. Patients may deal with this fear by avoiding these situations completely or going with another person. Behavioral and cognitive-behavioral therapies are used to treat Agoraphobia, as are drugs such as monoamine oxidase inhibitors (MAOIs).

**OBSESSIVE-COMPULSIVE DISORDER (OCD)**

A person with this disorder will have obsessions and compulsions that occupy much of their time or cause significant distress or impairment. The obsessions or compulsions will attempt to be ignored, suppressed or eliminated. With this disorder, the person does realize their obsessions or compulsions are excessive and are created by their own minds. Obsessive-Compulsive Disorder is chronic and tends to occur mostly with women.

Obsessions are repetitive ideas, images or impulses that intrude into the individual’s thinking. They are unwanted, distressful and are sometimes frightening and violent. An example of a frightening obsession is the impulse to jump in front of a car or the concern that he/she may attack a spouse or child. An individual may ruminate endlessly about locking the door or turning off the stove. Compulsions are often obsessions made manifest. Common compulsions include counting, hand washing and cleaning. Compulsions may become ritualized to the extent that they take up huge amounts of time. These rituals are often based on **magical thinking** (e.g., clapping my hands 50 time will prevent my mother from dying).
OCD afflicts 2% of the population and sometime remits spontaneously. Approximately 8% of first-degree relatives of OCD patients are also afflicted. Symptoms often begin in the twenties and have an episodic course. One of the differential diagnostic factors in OCD is the discomfort the rituals cause. Sometimes, schizophrenics exhibit bizarre rituals, however, they are usually comfortable with them. OCD can reach psychotic proportions. It is important the clinician use caution not to diagnose Schizophrenia.

The theoretical approaches used in this disorder are behavioral, cognitive-behavioral and rational emotive. Exposure and response prevention is the most successful for ritualizers. Patients with obsessions respond best to imaginal exposure and thought stopping. Patients with moderate to severe symptoms are prescribed psychotherapy and medication. This combination seems to work the best.

First, you will need to conduct an assessment and establish a working relationship so you can motivate the client for treatment. During the intervention phase, you will need a thorough clinical history including a psychosocial and family history. You will then need to determine if the behavior is ego-syntonic or ego-dystonic. Next, an agreement should be made with the patient on treatment goals and strategies. Finally, discuss the treatment and benefits with the patient so you can increase motivation.

Medication provides rapid change. Behavior therapy should always be used as a compliment to medication for long-term change. One should be cautious that the patient does not leave therapy prematurely once they receive some relief from the medication. Patients with OCD tend to have little insight into deeper aspects of their intrapsychic world. Obsessions and compulsions are a means of keeping oneself unaware of more painful or unacceptable parts of oneself. Relief from these symptoms often significantly reduces the desire for treatment. It is vital for the clinician to develop a strong therapeutic alliance and not push any "uncovering" work. Generally, the clinician should keep the focus on short and long-term symptom relief. Medication should be considered short-term relief and behavioral psychotherapy should be framed as important for long-term change.

**Medication**

- **Most Common:** SSRIs (Antidepressant)  
  - Fluoxetine (Prozac)  
  - Sertraline (Zoloft)  
  - Paroxetine (Paxil)

- Inhibit the uptake of serotonin

**POSTTRAUMATIC STRESS DISORDER (PTSD)**

Posttraumatic Stress Disorder is a condition that sometimes develops in the aftermath of a specific stressful, traumatic event. The disorder exceeds 1 month and involves re-occurring memories of the trauma. Other symptoms include emotional withdrawal, intrusive memories, emotional numbing and increased physiological arousal. Examples of traumas include (but are not limited to) abductions, rapes, incest and combat experiences.
PTSD was first "discovered" and classified due to symptoms presented by Vietnam veterans. Similar patterns of symptoms were in the past called "shell shock". People with this disorder often become emotionally numb and try to avoid anything that will trigger unwanted memories. People with Posttraumatic Stress Disorder often have difficulty sleeping, aggressive behavior and anxiety attacks.

The theoretical approaches used in this disorder are psychoeducation, cognitive-behavioral and psychodynamic. Symptoms of PTSD may be chronic (lasting many years resulting from unresolved childhood trauma) or may be much shorter in duration. Rapid treatment after a traumatic incident has been shown to prevent the more chronic symptoms. Some believe Borderline Personality Disorder is related to early childhood trauma. PTSD in childhood may result in characterological defenses that become engrained in the adult personality. Further, individuals with a history of early trauma or disrupted attachment relationships may be more vulnerable to develop the maladaptive patterns of behavior associated with PTSD later in life.

With PTSD, you will need to conduct an assessment and establish a working relationship with the patient. You should also reduce isolation and provide some measure of immediate symptom relief; this can often be accomplished through education and supportive empathic listening. A thorough clinical history as well as a psychosocial will be needed. Family dynamics and emotional functioning are also very important to assess. A referral may be needed for a physician to see if there is a general medical condition (you will need to get a release). If your patient is in crisis, then crisis intervention will be necessary. Finally, you will need to make an agreement with the patient in reference to treatment goals and refer them to support groups as well as community resources.

EMDR, eye movement desensitization and reprocessing, is a new therapy that has promise in treating PTSD. However, it is too early to tell how effective it really is. Stress reduction techniques have been found to be very effective in treating clients with this disorder. Since the client has learned to avoid recollecting traumatic events, caution should be used in proceeding with treatment. Symptoms may be exacerbated as the client explores his/her past traumas.

Generally, exposure has been found to be the most effective treatment for PTSD. Exposure is repeated discussions of the traumatic situation. Validation of the individual's trauma and the damage done is crucial. Often, reappraisal of the traumatic situation will be useful. For patients who were traumatized as children, looking at the situation through adult eyes and using the "inner adult" to protect the child is helpful. For a patient who was sexually abused as a child, reenacting the incident with more adaptive responses can empower them and shift the patient to a new perspective. (One example would be to have the patient imagine that he/she had a baseball bat with them at the time of the abuse. The clinician can explore possible responses in this scenario.)

Incest victims often blame themselves for the abuse; therefore, the clinician should be cautious not to add to the belief that the patient should have done something different to prevent the abuse. Stress reduction techniques have been found to be very effective in patients with this disorder. Since the patient has learned to avoid recollecting the traumatic events, caution should be used in proceeding with treatment. Symptoms may exacerbate as the patient explores the events.
Medication

- **Most Common:**
  - **Fluoxetine**  
    - **SSRIs (Antidepressant)**  
    - **Prozac**
  - **Sertraline**  
    - **Zoloft**
- **Risperidone**  
  - **Antipsychotic/Mood-stabilizer**  
  - **Risperdal**

  All medications are used to alleviate the symptoms of PTSD such as reoccurring memories, shock and emotional numbness.

**GENERALIZED ANXIETY DISORDER (GAD)**

Generalized Anxiety Disorder occurs when a person feels anxious all of the time and when there is no obvious reason for worry. This person may overly worry about money, family or health when there is no evident reason to feel this way. This disorder most often hits people when they are children or adolescents and is more common in women than in men.

The symptoms of Anxiety fall into two categories:

- **Apprehensive expectation**
- **Physical symptoms**

People with Generalized Anxiety Disorder often feel a sense of general dread that something bad is going to happen. This is differentiated from Depression in which a person feels something bad "has" happened. Muscle tension, fatigue, inability to relax, difficulty concentrating, irritability and fatigue are typical symptoms. Personality traits of individuals with GAD are essentially unknown.

Theoretical approaches associated with this disorder are cognitive-behavioral and behavioral. Methods of treatment include pinning down the cognitive responses that add to the anxiety and then questioning whether those cognitions are rooted in reality. Self-monitoring, relaxation and exposure methods are often used in behavioral therapy. A combination of the above seems to be the most effective short-term treatment for the disorder.

A multimodal approach often yields the best results since the anxiety the patient is experiencing is a result of several interacting systems. Pharmacotherapy may be an option if symptoms are severe or when psychological interventions are not possible.

You will need to conduct an assessment, establish a working relationship and arrange some measure of instant symptom relief. When doing the assessment be sure to get a thorough clinical history as well as an emotional psychosocial. You will need to refer to a psychiatrist for possible medication (if needed). You should also refer to a physician to see if there is any medical cause for the symptoms.

Finally, you should discuss the diagnosis with the patient and make agreements for treatment. Empathy and support are very important when dealing with this disorder. Instant relief is often achieved by an empathic stance, since people with GAD may be misunderstood by the people around them. Also, since others are less affected by the concerns of the patient, their feelings of worry may be discounted. It can be freeing for an individual to listen and "get inside" the patient’s worry and not rationalize away the fears and concerns (this is what family and friends do).
Once treatment has begun, several approaches have been found useful. Behavioral approaches can be used if treatment is short-term and is controlled by third party payors. In this case, systematic desensitization, an anxiety management program, CBT (computer-based training) and relaxation with CBT have proven quite effective. Imagined and real life situations are utilized in the relaxation procedure. Cognitive restructuring may be useful to alleviate the negative cognitions of worry and negative anticipation.

Antidepressants or Azapirones may also be indicated. NOTE: Of course, you as a therapist and not an M.D., do not recommend pharmacological interventions to a client. Be cautious of possible answers on the exam having you recommend drugs.

Medication

- **Most Common**: Antidepressants (Anxiolytics) - Brand Name
  - Diazepam - Benzodiazepines - Valium
  - Alprazolam - Xanax
    - Helps patient to relax, think clearer, sleep better and lead a more normal life
  - Nortriptyline - Tricyclic Antidepressants - Pamelor
  - Amitriptyline - Elavil
    - Tricyclic antidepressants have been found to be as effective as anxiolytics in the treatment of GAD
    - Tricyclics seem more efficacious in treatment of the negative effects and cognitions, while anxiolytics seem to act on somatic symptoms
  - Buspirone - BuSpar
    - Alleviates anxiety and is less addictive than other drugs

**SOMATOFORM DISORDERS**

Somatoform Disorders are diseases that have physical symptoms and characteristics but lack the corresponding biological and physical causes. The six main types of Somatoform Disorders are:

- Somatization Disorder
- Undifferentiated Somatoform Disorder
- Conversion Disorder
- Pain Disorder
- Hypochondriasis
- Body Dysmorphic Disorder

The cause of these disorders is usually some unconscious motive. The primary motive is generally a desire to avoid dealing with a certain emotion by manifesting it as a physical symptom. The secondary motive is a want for attention from caretakers or a desire to avoid certain responsibilities. Specific treatment varies per the specific type of disorder. In general, Somatoform Disorders are difficult to cure completely and the symptoms often return. Medications are rarely used; exceptions are Pain Disorder where antidepressants are used and cases where Somatoform Disorder is comorbid with other diseases.
Medication

- **Most Common: SSRIs (Antidepressants)**
  - Brand Name
  - Fluoxetine
    - Prozac
  - Sertraline
    - Zoloft
- **Most Common: Tricyclic Antidepressants**
  - Brand Name
  - Amitriptyline
    - Elavil

  - Used primarily to help alleviate pain disorders

**FACTITIOUS DISORDERS**

Factitious Disorder refers to a person who fakes an illness in an attempt to make people think they are sick. They do this for their own "psychological" reasons to be in the sick role. People with this disorder may go to extremes to maintain they are sick. Sometimes people with this disorder will falsify their medical histories and even take medications so they will become physically ill to substantiate their claim of being sick. They will often move from hospital to hospital to receive care.

Patients with Factitious Disorder are usually loners with a history of severe trauma and deprivation. They generally have extreme difficulty establishing close interpersonal relationships and often have personality disorders. This disorder is distinguished from Malingering in several ways. First, factitious patients seek the sick role for secondary psychological gain. Perhaps they believe being sick is the only way to make contact with others and to get them to care for them. Malingers are feigning sickness for other secondary gain (e.g., monetary, to get out of some responsibility). It is likely factitious patients really believe they are sick, even if they go to great lengths to get into the role (they may justify this by saying that while they are sick, people don't believe them).

Patients suffering from Factitious Disorder are unlikely to seek out psychological help and generally focus on medical treatment. (However, patients may feign psychological symptoms as well.) General medical practitioners or ER attendants are often the first to encounter these patients. They are often difficult to distinguish from Somatization Disorders, considered a hysterical condition, meaning the illness is unconscious and related to psychological conflict. Some believe Factitious Disorder is unconsciously motivated. However, for Factitious Disorder, the motivator is "external" incentives, whereas Somatization Disorder is motivated by internal conflict. Patients may make themselves sick through a variety of means (e.g. taking stimulants to create tachycardia, swallowing metal, taking anticoagulants or producing a fever by manipulating the thermometer.)

Theoretical approaches associated with Factitious Disorder are cognitive-behavioral, reality and psychodynamic. Hypnosis and "face saving" techniques like double bind have proven to be effective in treatment. These techniques help the client to accept therapy in a more positive light than by confrontational treatments.

You will need to conduct an assessment and make the diagnosis first. After you have made the diagnosis, you will establish a rapport with the patient so you can create motivation for the psychotherapy. This may be done by noting to the patient being so sick is obviously stressful; perhaps talking about the stress might be helpful. Next, you will need to determine whether the
client is a danger to himself/herself or others. Increasing motivation for treatment with the patient may be difficult since people with this disorder often resist referrals to mental health professionals. With the patient motivated to get attention, it may be possible to give them what they need, thereby engaging them in treatment. However, it is likely the factitious patient will fear being "found out" and may continue to resist treatment.

Finally, you should make the patient feel accepted and show empathy. You will want to focus on the patient's underlying dysphoric feelings by making them the focus of the treatment. Their self-destructive behavior might be tactfully pointed out to them after a solid rapport is developed.

Medication
- No medications are used to treat factitious disorder

**DISSOCIATIVE DISORDERS**

**DISSOCIATIVE FUGUE**

Dissociative Fugue is a confusion about or loss of one's personal identity and purposeful travel away from one’s home. This includes inability to recall portions of one's past. Dissociative Fugue generally occurs with rapid onset after a traumatic experience or bereavement. Occasionally, you will find with this disorder that the person takes on a new identity. This generally occurs for short periods away from home. However, there are situations in which the fugue has lasted for weeks or months. Individuals with Dissociative Fugue may develop complex personalities and function in complex roles. However, they generally lead simple lives and remain relatively reclusive. There is often a single episode and remission may spontaneously occur without treatment. This disorder is more common in alcohol abusers.

Theoretical approaches applied to this disorder are psychodynamic, cognitive, behavioral, hypnosis and family therapy. Hypnosis is often used to recover aspects of the person's memory, but there is no single approach that is most effective. Hypnotic age regression is a useful framework for making information accessible from an earlier time period. Demonstrating that information may be made available to consciousness can facilitate the working through of emotionally laden components.

It is important to differentiate Dissociative Fugue from organic conditions and Malingering. Occasionally, severe depressive or anxiety states may include states of Amnesia. Somnambulism may include amnestic states, but this is generally accompanied by clouding of consciousness. PTSD, Somatoform Disorders and other dissociative states often include Amnesia.

With Dissociative Fugue Disorder, you will need to conduct an assessment and establish a working relationship with the patient. The assessment should include a thorough clinical history, psychosocial and physical exam to rule out organic conditions. A neurological exam, including CAT scan and sleep deprived EEG may be a necessary step for further evaluation. The assessment should look for any possible mental health disorder, as well as substance abuse. Establish safety and stabilize the patient making sure the patient is not a danger to him/her self or others. While you are establishing your rapport, you should emphasize safety and make the client feel they have control over their own treatment.
In sorting out organic conditions, it is important to establish if old skills are preserved during the attack. This is uncommon in the presence of organic brain damage or other organic conditions. Establish if there is any obvious secondary gain. However, secondary gain does not necessarily indicate Malingering. It is likely that all dissociative states include some form of secondary gain. It is also important to determine if there are any other reasons the patient may have for intentionally and consciously changing their identity.

Patients may be quite motivated to maintain their Amnesia if it serves the purpose of avoiding highly charged emotions or life situations. Allowing the patient to free-associate to fragments of memories that have returned can often be effective. Working with the patient to change environmental conditions or teaching coping skills may make dissociative mechanisms less important. The goals of treatment may be simply to return the patient to their previous level of functioning (recover lost memories). However, it may be difficult to plan the course of treatment until the patient's memories are fully recovered.

**Medication**
- Medications are generally not used to treat Dissociative fugue, though antidepressants or antipsychotics may be used to treat certain symptoms

**SEXUAL AND GENDER IDENTITY DISORDERS**

Within the DSM, Sexual Dysfunction, Paraphilia and Gender Identity Disorders comprise a cluster of related dysfunctions.

In identifying and treating Sexual Disorders, recognition of the sexual response cycle is essential. Normally this cycle moves from desire to arousal to orgasm. In Sexual Dysfunction, the cycle is broken at some point.

With distressing, repetitive sexual fantasies or behaviors, Paraphilia is characterized by sexual arousal centered upon nonhuman objects or nonconsenting persons. Fetishism and Pedophilia are included in this category.

In a Gender Identity Disorder, disparity exists between an individual’s biological sex and gender identification. The person may physically be male, but identifies himself as a woman or vice versa. Having nothing to do with preference of partner for sexual intercourse, Gender Identity Disorder involves a mismatch in personal identity.

**SEXUAL DISORDERS**

When the initial diagnosis seems to indicate a Sexual Disorder, the clinician must rule out underlying mental health conditions such as Anxiety or Depression. Additionally, biochemical or medication-induced explanations of symptoms should be explored.

**SEXUAL AROUSAL DISORDERS**

**Male Erectile Disorder**

Male Erectile Disorder is a common Sexual Arousal Disorder. Erectile dysfunction is the inability to achieve or maintain an erect penis that is sufficient for sexual intercourse. This disorder is the most untreated condition in the world even though treatment is effective 95% of the time. It is
likely patients with this disorder are resistant to taking the problems to their doctor or mental health professional. Many men feel inadequate or ashamed to discuss the problem. The most frequent cause of Male Erectile Dysfunction is vascular or blood vessel disease, such as hardening of the arteries. Smoking is a common cause of vascular degeneration. It is vital that a full medical evaluation be completed before beginning therapy to rule out organic medical conditions. While mental health treatment is effective for some forms of Male Erectile Dysfunction, medically induced problems are not improved by psychosocial treatment.

Theoretical approaches associated with this disorder are behavioral therapy targeting performance anxiety, cognitive therapy focused on covering scripts, individual psychotherapy, systemic approaches, psycho educational and psychodynamic. The goals of therapy are to enhance sexual arousal, lower the anxiety felt regarding sexual performance and address issues that limit sexual satisfaction. Behavioral and cognitive-behavioral therapies seem to be the most effective methods of treatment. Some techniques that are applied with the mentioned therapy are systemic desensitization, relaxation, reframing, modification of maladaptive sexual attitudes and working through unconscious conflicts. Sensate focus is the most commonly and most effectively used therapeutic technique.

You will need to conduct an assessment and establish a therapeutic rapport with the client. Reducing feelings of shame, anxiety and blame in relation to the problem is very important when starting the therapy. When doing the assessment you need to get a thorough clinical history in reference to the onset and past history of the disorder, as well as the frequency and severity of the symptoms. An important assessment will be to look for possible pre or co-existing disorders like Depression and Substance Abuse that may be contributing to the symptoms. Another referral may be needed to rule out medical causes of the disorder, (you will need a release). You will want to discuss and make an agreement with the patient in reference to the treatment. You should determine whether treatment will be individual, couple-based or both. Treatment tends to be more effective and successful if the afflicted individual has a willing and cooperative partner.

Clinicians can teach sensate focus to a couple. Sensate focus involves non-genital and non-demanding caressing by the partners without intercourse. The couple should be encouraged to focus on pleasurable feelings rather than sexual culmination. Gradually, the partners move to pleasurable genital (oral or manual) contact without intercourse. Other non-intercourse sexual techniques range from Sildenafil, endocrine treatments, and intracorporeal injections to penile vascular surgery, prosthetic implants and vacuum pumps (the medical approach offers a variety of options). As the patient becomes more relaxed and arousal is sufficient for a full erection, intercourse is permitted. Intercourse often occurs as a natural course of treatment and as arousal increases.

Couples therapy may be useful to reduce conflicts between the couple that may interfere with sexual arousal. Psychodynamic therapy may be helpful to address intrapsychic conflicts that cause Erectile Dysfunction. Any measures that reduce anxiety about sexual performance including group therapy, hypnotherapy or systematic desensitization can be effective.

It should be noted: Many states have specific requirements for "sex therapists". While one does not need to be a sex therapist to use these techniques, clinicians should be conversant in their state law. A clinician should be trained and supervised in any techniques they use.
ORGANISMIC DISORDERS

For effective treatment of Female Orgasmic Disorder, cognitive-behavioral approaches focus on anxiety reduction and attitude change with the intent of increasing positive feelings about sexual behaviors and the frequency of orgasm. When non-orgasmic symptoms are rooted in traumatic experiences, insight-oriented treatments are indicated. Sensate exchanges can be productive.

Challenging self-defeating cognitions and establishing cooperative partner relationships provide foundational treatments for Premature Ejaculation. Behavioral interventions for ejaculatory control and start/stop therapies offer specific help. Antidepressants may be prescribed.

SEXUAL PAIN DISORDERS

In treating Dyspareunia, behavior therapy may employ systematic desensitization. Additional techniques include sensate focus activities, imagery techniques, cognitive restructuring, relationship interventions and supportive psychotherapy. Lubrication provides physical assistance, while surgery may be necessary in some cases.

Relaxation, desensitization, guided fantasy, self-control activities and supportive psychotherapy are useful in treatment of Vaginismus. Additionally Kegel exercises are useful physical components of care.

To treat hypoactive sexual desire individual psychotherapy is the treatment modality of choice; depending on the situation, either vasoconstrictive medications or dilators may provide assistance.

For female orgasmic disorder masturbatory training may be indicated; for male orgasmic disorder genital stimulation may provide assistance. Treatment options for paraphilias include CBT and aversive conditioning.

PARAPHILIAS

Paraphilias involve strange and unusual sexual desires and fantasies about certain objects or regarding the humiliation and mistreatment of one's sexual partner. However, Paraphilias must be actions and not just fantasies; the patient must have acted on his fantasies. Furthermore, to clinically diagnose the disorder, the Paraphilia must cause major distress or social and occupational impairments and must last over 6 months.

Exhibitionism is a type of Paraphilia where the patient exposes the genitals to unsuspecting victims and receives pleasure from their shock and surprise. Fetishism is gaining sexual pleasure from an inanimate object; for example, a man who masturbates while stroking a women's scarf would have a fetish for scarves. Pedophilia is receiving sexual pleasure from young children, either by engaging in sexual activities with children or watching pornographic material involving children. Pedophilia involves one partner who is at least 5 years older than the other. Voyeurism is receiving sexual pleasure from watching others who are engaging in sexual activity, naked or undressing. Patients of Voyeurism do not try to contact the people they are observing and simply gain pleasure from watching. Treatments include cognitive-behavioral therapy and some drugs that lower sex drive.
GENDER IDENTITY DISORDERS

Gender Identity Disorder involves a strong feeling that one was born in the wrong gender and a strong desire to become a member of the other sex. Patients of Gender Identity Disorder are typically attracted to the same sex and often try to take hormones to gain characteristics of the other sex. Treatments vary but focus on relieving the significant distress and conflict that patients feel about being in the wrong sex.

EATING DISORDERS

ANOREXIA NERVOSA

A disorder characterized by the obsessive preoccupation with body weight and food, Anorexia Nervosa can be fatal. Denial of their symptoms is characteristic of these patients. Even the famous with all their money and glamour are captives of this consuming disease. The obsession to be thin and the classic inability to see the reality of their emaciated body can ultimately lead to death. Individuals suffering from Anorexia Nervosa focus on:

- Loosing weight
- Peculiar handling of food
- Intense fear of gaining weight
- Obsessive thinking about one’s weight
- Disturbance of body image in which one feels fat when weight is normal
- Amenorrhea (loss of menstrual period) in females

Treatment of Anorexia Nervosa is a multifaceted endeavor. The initial focus of treatment is to restore one’s nutritional state to normal. Malnutrition is life threatening and can cause psychological symptoms that make treatment more difficult. If the patient will be treated on an outpatient basis, you should refer to a physician for a comprehensive physical exam, lab work - you will need a release. In some cases, hospitalization may be required.

Once nutritional status is restored, behavioral, cognitive and eclectic psychotherapy including dietary management are more effectively utilized. Psychodynamic, group and family therapy has shown to be successful as well.

Some Helpful Techniques

- Challenging distortions in body image
- Improving self-esteem
- General social skills training
- Assertiveness training
- Group treatment

The first step is to get the individual’s cooperation. This is not easy, since many patients deny the severity of their symptoms. A weight gain contract may be used so the patient is clear that the bottom line is to normalize eating habits and remain healthy. Conduct an assessment of the patient and address any safety issues. You will also need to establish a therapeutic relationship with the patient so you can motivate them for treatment. A thorough clinical history including an emotional psychosocial will be needed.
Make yourself aware of the signs of low self-esteem as well as deficits in self-regulation. Evaluate eating patterns, compensatory behaviors (use of laxatives, obsessive exercise, purging, etc) and ritualized behavior around body measurement and body image.

Finally, have the patient self-monitor their eating habits as well as their feelings about weight and self-image. Emphasize goal setting at the very start of treatment. Set specific goals and put them into a few categories so the goals don't seem too overwhelming.

An evaluation with a dietician can be helpful. For the anorectic patient, an evaluation with a dietician can have a powerful impact by helping the patient to become knowledgeable about nutrition, dieting and healthy eating.

**Medication**
- Medications have no direct use with Anorexia Nervosa

**BULIMIA NERVOSA**

Bulimia Nervosa is an eating disorder where the person binge eats and then uses a variety of compensatory behaviors to limit weight gain. A binge is defined as a larger than normal amount of food than most people would consume in a similar time period. The bulimic person usually binges alone, due to significant shame that is associated with their binging behavior. The bulimic individual often binges on high calorie and sweet foods.

While Bulimia Nervosa often includes purging behaviors (vomiting after a binging episode), this is only one of several possible "compensatory behaviors". The individual suffering from Bulimia Nervosa often begins with attempts to diet and lose weight. The attempts result in extreme hunger and obsessions with food. The person then binges after a significant period of struggle to avoid consumption of food. The binging behavior results in significant shame and distress. The purging behavior often creates a significant relief from the distress. Other compensatory behaviors include use of laxatives, diuretics, enemas or excessive exercise.

The theoretical approaches applied with this disorder are cognitive-behavioral (including dietary management) and interpersonal psychotherapy. Cognitive-behavioral therapy is effective in addressing perfectionistic thinking that is characteristic of bulimic patients. They often strive for perfection and feel like complete failures if unable to achieve perfection. Psychodynamic, group, psychoeducation and family therapies are also included.

As with all eating disorders, a multimodal approach seems most effective. This might include nutritional counseling, psychotherapy and pharmacotherapy.

You want to establish normal eating habits with the patient. A meeting with a nutritionist is often helpful to work out healthy dietary plans. Cognitive-behavioral treatment can be useful in modifying binging and compensatory cycle. It is important to modify the patient’s thinking patterns so they can learn more realistic coping skills. If the individual purges, gaining control over this impulse is important. This may be the first step in breaking the cycle and dealing with the underlying emotional issues.

Conduct an assessment of the patient and address any safety issues. You will also need to establish a therapeutic relationship with the patient so you can motivate them for treatment. A
thorough clinical history, psychosocial and medical workup is imperative. Make yourself aware of the signs of low self-esteem as well as deficits in self-regulation. A personality assessment may be useful. It is quite important to assess the individual’s social environment to understand how others may be maintaining or encouraging the bulimic behavior.

Finally, have the patient self-monitor eating habits as well as their feelings about weight and self-image. Emphasize goal setting at the very start of treatment. Set specific goals such as resisting the impulse to purge for a specific period of time. Each week this period may be extended. Expect the individual will slip - be patient. Work on small goals and focus on health.

Since Bulimia Nervosa is usually less life threatening than Anorexia Nervosa, the clinician can be patient with slipping into old patterns, however, always monitor dangerous or unhealthy behaviors.

**Medication**

- **Most Common: SSRIs (Antidepressants)**
  - **Fluoxetine** (Prozac)
  - **Sertraline** (Zoloft)
  - Helps to improve mood and lower occurrences of binges

**SLEEP DISORDERS**

Divided into Primary Sleep Disorders, Sleep Disorders Related To Another Mental Disorder and Other Sleep Disorders, the category of Sleep Disorders includes sleep, stages of sleep and sleep-wake transitions.

Not caused by another mental disorder, a medical condition or substance abuse, **Primary Sleep Disorders** are distinguished as those that do not arise from any of the three sources named. Two categories are noted: Dyssomnias and Parasomnias.

- **In Dyssomnias** an abnormality in the amount, quality or timing of sleep is present; It includes:
  - Primary Insomnia
  - Primary Hypersomnia
  - Narcolepsy
  - Breathing-Related Sleep Disorder
  - Circadian Rhythm Sleep Disorder
  - Dyssomnia NOS

- **In Parasomnias** the dysfunction is characterized by behavioral or psychological events associated with sleep or sleep-awake transitions; included are:
  - Nightmare Disorder
  - Sleep Terror Disorder
  - Sleepwalking Disorder
  - Parasomnia NOS

When the Sleep Disorder is traced to a mental dysfunction, **Insomnia Related to Another Mental Disorder** or **Hypersomnia Related to Another Mental Disorder** may be diagnosed. If
the dysfunction is judged to be the result of another medical condition, **Sleep Disorder Due to a General Medical Condition** provides the category. When the presence of a chemical substance, such as a drug or toxin is suspected as the cause, a **Substance-Induced Sleep Disorder** is present.

**Treatment**

For Sleep Disorders, strategies include insomnia stimulus control therapy, sleep restriction therapy, relaxation training and CBT. Benzodiazepines, Zolpidem and antidepressants may be effective.

**Medication**

- **Most Common:** Zolpidem
  - Helps patient fall asleep quicker and easier by slowing brain activity
- **Most Common:** *Antidepressants*
  - **Trazodone**
    - Causes some sleepiness
- **Most Common:** *Benzodiazepines*
  - **Diazepam**
  - **Alprazolam**
    - Helps to better parasomnias such as Night Terror and Sleepwalking

**IMPULSE-CONTROL DISORDERS NOT ELSEWHERE CLASSIFIED**

Essentially, an Impulse-Control Disorder consists of repeated failure to control the desire to perform an act judged harmful to the individual or to others. Once a thought or desire is generated, tension is built by the desire to act. Gratification, pleasure, or relief results when the desire is fulfilled. Regret, self-reproach, or guilt may or may not follow. Included in this diagnostic cluster are **Intermittent Explosive Disorder, Kleptomania, Pyromania, Pathological Gambling** and **Trichotillomania**.

The dysfunctions of behavior and impulse control respond to a multifaceted intervention program emphasizing behavioral therapy. Including reduction of dysfunctional behaviors and acquisition of positive ones, behavior change is the primary **objective** of therapy. **Interventions** to help achieve these goals include education, focused attention on aspects of the client’s life that have been harmed by dysfunctional behaviors, measurement of changes achieved, and exercises to improve communication and build relationships.

If the client is highly resistant to therapy, group work can help to overcome that reticence. Individual therapy and family therapy may also be effective. Although medication is not considered the primary mode of treatment, such drugs as Antabuse, Methadone and various antidepressants can accelerate progress in some cases. Because of the significance of the physical component of this group of disorders, a medical examination is important as part of the evaluation process.
PERSONALITY DISORDERS
An enduring pattern of thought and behavior that deviates markedly from cultural expectations, personality disorder has an onset between early childhood and adolescence. Leading to personal distress and impaired function, the behaviors are pervasive and inflexible. Pervasiveness is one diagnostic key; the dysfunction must be present when the client is at home, at school or work and on vacation. The younger the client is, the more difficult it is to accurately diagnose a personality disorder. The dysfunction remains stable over time.

With this disorder, the client reacts to every situation using a single personality; three categories have been established to classify the framework of the client’s reaction: coldness, aggression and withdrawal.

Within the cluster characterized by coldness, suspicion and odd behavior are the subtypes of Paranoid Personality Disorder, Schizoid Personality Disorder and Schizotypical Personality Disorder. Within the Paranoid subtype, suspicion is the predominant feature. Unaffected by either praise or criticism, a Schizoid personality is considered cold by others. Actually highly functioning psychotics, Schizotypical personalities are known for their oddness and delusional behaviors.

Subtypes of the cluster characterized by aggressive and attention-seeking behaviors are Antisocial Personality, Histrionic Personality, Narcissistic Personality and Borderline Personality Disorders. With a very high risk for criminal behaviors, the Antisocial personality is reckless and lacks empathy. Given to emotional excesses, the Histrionic personality exhibits a range of responses from anger to sadness to fear, but emotions are shallow. The Narcissistic personality is grandiose and self-important. Although greatly fearing abandonment, the Borderline personality is unable to form stable interpersonal relationships.

Characterized by withdrawal, personality types in the third cluster are Avoidant Personality, Dependent Personality and Obsessive-Compulsive Personality; all are highly dependent and seek to avoid change. Timid by nature, the Avoidant personality fears embarrassment and is deeply affected by criticism. Exhibiting extreme dependency on others, the Dependent personality may be described as clingy. Perhaps characterized as a rigid perfectionist, the Obsessive-Compulsive personality tends toward obsessive-compulsive behaviors.

MENTAL STATUS EXAM

COMPONENTS OF THE INITIAL DIAGNOSTIC INTERVIEW

1. General Presentation
   - Appearance
     - Apparent age, grooming, state of health, hygiene/cleanliness, physical characteristic (build/weight, physical abnormalities, deformities, etc.), state of health, distress, pain, appropriateness of attire, pride, dignity
     - Note "unilateral neglect of dress” description of appearance should be enough detail for identification
• Take into consideration the individual's age, race, sex, educational background, cultural background, socioeconomic status, etc.

- **Motor Activity**
  - Posture (slouched, erect), gait (staggering, shuffling, rigid), coordination, speed
  - Activity level, gestures, tremors, tics/grimacing, relaxed, restless, pacing, threatening, hyperactive or under active, disorganized, purposeful, stereotyped movements, repetitive

- **Interpersonal**
  - Rapport with the interviewer
  - Engaged, interested, cooperative, opposition/resistant, submissive, defensive, fearful
  - Note how they greet examiner

- **Facial Expression**
  - Relaxed, tense, happy, sad, alert, day-dreamy, angry, smiling, distrustful/suspicious, tearful

- **Behavior**
  - Distant, indifferent, evasive, negative, irritable, labile, depressive, anxious, sullen, angry, assaultive, exhibitionistic, seductive, frightened, alert, agitated, lethargic, somnolent

2. **State of Consciousness**

- Alert, hyper-alert, lethargic (reasons for lethargy often organic)

3. **Speech**

- Form - Conversational, distractible, rambling, circumstantial, tangential
- Quantity - Mute, over-talkative or can't be interrupted
- Rate - Rapid, accelerated, pressured, slow, blocked
- Quality - Dramatic, histrionic, sarcastic, humorous
- Expressive Language - Normal, circumstantial, anomia, paraphasia, clanging, echolalia, incoherent, blocking, neologisms, perseveration, flight of ideas, mutism
- Receptive Language - Normal, comprehends, abnormal
- Dysprodia - Flat monotone speech, no emotional expression

4. **Mood and Affect**

- Mood - a symptom as reported by the individual describing how they feel emotionally, such as: normal, euphoric, elevated, depressed, irritable, anxious, angry
- Affect - observed reaction or expressions; range of affect includes: broad, restricted, blunted, flat, inappropriate, labile, mood congruent, mood incongruent

5. **Orientation and Intellectual Ability**

- Orientation - Time, person, place, self
  - The individual should be asked questions such as the day of the week, month, the date, where he lives, where he is now, if he knows who he is
- Intellectual Ability - Above average, average, below average
• General information - The last four presidents, governor, the capitol, what direction does the sun rise, etc.
• Calculation - Serially subtracting 7 from 100 (at least six times), simple multiplication, word problems such as: "if a pencil costs 5 cents, how many pencils can you buy with 45 cents?"
• Abstract Reasoning – Proverbs, this is the ability to make valid generalizations; responses may be literal, concrete, personalized, bizarre (e.g., "Still waters run deep", "A rolling stone gather no moss")
• Opposites - Slow/fast, big/small, hard/soft

6. Attention & Concentration
   - Concentration - Days of the week backward, serial sevens, serial threes, serial fives
   - Attention:
     - Non-numeric test - Read a series of random letters, have patient tap finger or say yes every time they hear the chosen letter
     - Numeric - String of digits forward and backward - starting with three digits, stop when patient misses two of each, average is 7 digits

7. Memory
   - Immediate (10 to 30 sec)
   - Short-term (up to 1 hour)
   - Recent (2 hours to 4 days)
   - Recent past (past few months)
   - Remote past (6 months to lifetime)

8. Thought Processes/Content
   - Deals with organization and composition of thought
     - Examples include: normal, blocking, loose associations, confabulation, flight of ideas, ideas of reference, illogical thinking, grandiosity, magical thinking, obsessions, delusions, depersonalization, suicidal ideation, homicidal ideation

9. Hallucination
   - None, auditory, visual, olfactory, gustatory

10. Insight
    - Good, fair, poor
    - Understanding, thought, feeling, behavior

11. Impulse Control
    - Good, fair, poor
    - The ability/tendency to resist or act on impulses
MSE - ATTENTION, CONCENTRATION AND MEMORY

The initial interview with a client is critical, not only for information gathering, but for rapport building. A skillfully done interview should help the professional:

- Diagnose
- Estimate severity of problems
- Decide on a course of action
- Gain a dynamic understanding of the client
- Engage the client in psychotherapy

Supportive, attentive and nonjudgmental attitude can help pave the way toward a productive interview. As previously indicated, the MSE is a critical component of the initial diagnostic interview. The MSE serves not only to gauge a person’s current level of functioning, but also aids in diagnosis and can serve as a baseline for future reference.

When focusing on attention, two general areas are under consideration. The first is the individual's ability to "attend" or the ability to pay attention for short periods of time without being distracted. The second is the ability to attend for long periods (concentrate). The ability to concentrate is primary in testing higher levels of functioning.

Attention can be tested in several ways. One is to simply observe the interviewee's ability to stay focused and attend to the interview. A more structured assessment of attention may be gleaned with digit span or a non-numeric test. Digit span is simply listing a series of numbers (write them down as you say them), starting with three numbers. They should be spoken in a monotone voice, with one spoken every second in cadence. On the last number in the series, your voice should drop, indicating the end of the series. Start with three numbers (e.g., 3-7-1). Do two sets of three numbers. If at least one of the two series is repeated back, go to four numbers, until the client fails both trials. Then do the same in reverse. The average is five numbers remembered. The non-numeric test consists of reading a list of random letters and asking the client to tap his finger when certain letters are stated. In this test, it is best to have a prepared list of letters.

Concentration can be assessed using serial number counting (subtracting 7, 5 or 3 from 100 consecutively). This may be hard for some people with lower educational levels, so days of the week or months said backward may be substituted. Simple multiplication problems may be useful, but have the same limitations on premorbid intellectual functioning and general education level, as do the serial counting tests. Asking a person to draw a picture or do some math problems on paper will also give information as to their concentration ability.

There are several different types of memory and ways of referring to them. In psychology, the terms “short-term” and “long-term” memory are used. The medical tradition refers to immediate, recent and remote. Some also break this up to recent past and remote past. Unless you want to do a very comprehensive memory assessment (in that case, use a memory assessment instrument) the immediate, recent and remote memory should be assessed. Immediate memory assessments are the digit span (described above), asking the client to remember three objects (dog, house, ball) to be recalled after a 5-minute delay. A counting test where one asks the client to count to a number (e.g., 27) stop for 1 minute, continue counting where they leave off, stop at a specific number for
1 minute, (do this three times) is also useful. Recent memory is events of the last 24 hours.
Remote is assessed with early memories or dates of employment, etc.

**MSE - CONSCIOUSNESS, SPEECH, MOOD AND AFFECT**

The Mental Status Exam can cover a myriad of areas and each mental health professional will need to decide what is important. Professionals from different disciplines are likely to be interested in areas relative to their specialty and area of expertise. For example, a neuropsychologist will be interested in neurological processes as they relate to behavior. Hence, the MSE conducted by a neuropsychologist might be detailed in assessment of attention, concentration, language, memory, etc. A psychiatrist on the other hand, may focus more on issues related to thought processes, mood and anxiety levels. Of course, this is not clearly defined, as many areas of mental health treatment are cross-disciplined. The point is, one "good" MSE does not necessarily look like another. It can be adapted to one’s theoretical orientation as well as the specific information that is required at the particular time. As a rule, the interviewer must adapt to the situation based on information and observation. He must think on his feet, so to speak.

**A brief case example:**

A 25-year-old Hispanic female is brought into your office by her mother. The mother reports her daughter is depressed. You speak to the girl alone and find that she is indeed depressed. In the course of the interview, you note she uses an occasional word that you have never heard before. Since she is Spanish, and you do not speak Spanish, you assume she is substituting occasional Spanish words for English words. However, these words do not "sound" Spanish, so (in passing) you ask about them. After discovering these are made up words, you decide to pursue more detailed inquiry into language, thought processes and thought content.

**In this example:**

The client may have been exhibiting neologisms (made up words - often related to thought disorder and psychosis) or she could have been creating her own private language (for a variety of non-pathological reasons) or she might simply have some articulation problems related to organic brain damage. The interviewer should be "curious" about everything that comes up in the interview and follow the clues.

Some areas of inquiry are easily identified. If the interviewee is clearly drowsy, somnolent or stuporous, this becomes primary to other areas of inquiry. However, if a person is alert and responsive, it is not necessary to conduct a Glasgow Coma Scale.

“Mood and Affect” are areas commonly evaluated in almost all mental status examinations. Mood is a "sustained" emotional state, such as: depressed, euphoric, elevated, anxious, angry and irritable. Affect is more the observable emotional state at the time of the interview. These include descriptors such as: flat, blunted, restricted and inappropriate.

In inquiry about mood, affective clues are important. Facial expression, quality of voice (timber, pitch, intensity), eye contact and muscular tension (among others) all give clues as to mood. Of course, self-report is one of the best ways to evaluate mood. One interesting and useful bit of information for clarifying the difference between Anxiety and Depression is to use Brenner's
**Definitions.** A pervasive feeling that something bad "has happened" is indicative of Depression. If one has a pervasive feeling that something bad is "going to happen" this indicates Anxiety.

**MSE - ORIENTATION AND INTELLECTUAL ABILITY**

Orientation is central to the Mental Status Exam. A person's awareness of their surroundings, location temporally and one’s own identity is primary to general functioning. Of course, everyone occasionally loses track of the date; but when an individual you are interviewing believes it is 1983, or that it is summer when the coat rack in the corner is full, this is a significant finding that must be explored further. Assessment of orientation always includes person, place and time (Oriented x 3). Questions of person generally include the identity of the patient and who you are (doctor or counselor, etc.). Orientation to place may include the city, state, or town, where he/she lives and where they are now. For some patients, it may be appropriate to ask "what planet is this". If they say Jupiter, then you may have an alien (or a psychotic individual) on your hands. Time orientation includes day of the week, date, month and year (Oriented x 4). The interviewer may also ask about the current situation, why a person is in your office, etc.

As a rule, confusion about person is more significant than is confusion about time, place or situation. If the patient says he is the boogieman and you are Jethro Tull, the patient is exhibiting significant problems (Jethro Tull was not an individual, but the name of a group). Problems in orientation are often the result of organicity. However, some very depressed individuals may lose track of time, by several days or even weeks. Further, there is a difference between confusion and delusion about person, place and time. Both Schizophrenic and Dementia patients may exhibit either delusions or confusion in their orientation.

It is often important to quickly evaluate a person's intelligence. This can be difficult (as well as unimportant) if other more acute issues are primary (prominent suicide ideation with a plan, acute psychosis or the person is very distressed and tearful). However, in a routine MSE, intelligence is an important aspect of treatment planning.

Quick and easy intellectual capacity can be obtained through asking the person to perform some simple calculations in their head (serial 7’s, multiplication word problems). It is also important to know if an individual is able to reason abstractly. Proverbs are one of the simplest and best ways of getting information about concrete versus abstract reasoning ability. The responses may be literal, concrete, personalized or bizarre. Examples of proverbs that may be used: "still waters run deep"; "a rolling stone gathers no moss".

Orientation and intellectual functioning is extremely important in the hospital setting. Delirious patients will often be quite disoriented. The MSE can be used for baseline functioning and tracking of the symptom pattern. In Delirium, there is often a fluctuation of consciousness throughout the day. In this case, the MSE can be quite useful. Further, it can be used to decrease medications that might be negatively or positively affecting a patient's mental status.

**SCHIZOPHRENIA AND THE MENTAL STATUS EXAM**

The Mental Status Exam (MSE) can serve as the basis for diagnosing, and can provide a foundation for the dynamic understanding of a client's current level of psychological and emotional functioning. The MSE gleams information on an individual's immediate and current level of functioning at the time of the interview. It should be conducted with sensitivity and
respect for the individual. Much of the information can be gained through natural observation and sensitive inquiry into the individual's difficulties. Some of the information must be directly requested and, ideally, will naturally flow with the interview.

To illustrate the important areas of the MSE, we will look at a clinical vignette.

**Vignette:**

You see a woman in the intake department of a psych hospital. She wears wrinkled clothing and has one missing stocking. Her hair is unkempt. She has trouble sitting still, almost violently shakes her leg and holds her hands up as if making a box in the air. She seems fearful and accuses you of having a gun when you open a desk drawer to get a pencil. Much important information can be gained from simple observation.

The following are suggestions for areas to consider in conducting the MSE. However, the descriptions in this case are not exhaustive and the areas described are more involved and detailed. Many publications and texts give very good descriptions of the MSE; different professionals need to decide what works best for them.

**A. Appearance:** acutely psychotic individuals generally do not pay much attention to attire, grooming or hygiene. They may be disheveled and odiferous (unless family has taken over this responsibility). This woman is generally unkempt and oddly dressed. Unless there is a good reason for the missing stocking, this could indicate significant confusion.

**B. Excessive Motor Activity:** and odd mannerisms that are repeated may indicate agitation or extreme disorganization (think about the Disorganized Subtype). Alternatively, the individual may be rigid in posture (catatonic rigidity) or may exhibit waxy flexibility (limbs can be moved into any position and will remain for extended periods of time). The latter is suggestive of the Catatonic Subtype. One should also look for unusual motoric activity such as Parkinsonian tremors.

**C. Interpersonal Behavior:** This woman exhibits fear and paranoia. Since it may not be so apparent in all cases, asking if the individual is ever "frightened or worried that someone will hurt her" or "concerned that people are sometimes watching her" is a good way to determine the level of paranoid ideation. Observing her way of engaging you in addition to your countertransference reaction can lead to a better understanding of the client's general interpersonal relationships as well as their mood, level of dangerousness, motivation, etc.

**D. Facial Expression:** The individual's facial expression may give important clues as to their emotional state or lack thereof (mood, affect, level of fear, etc).

**E. General Behavior:** In this case, the woman before you is violently shaking her leg. This appears to be indicative of agitation. However, gait problems, ticks, lethargy and somnolence should also be noted.

**Diagnosis**

- According to the DSM, individuals diagnosed with Schizophrenia must exhibit the following symptoms:
• At least 6 months of significant impairment in occupational, interpersonal and self-supportive functioning
• A period of actively psychotic symptoms without the presence of a major mood disorder, autism or organic condition

The course of the illness is classified as "continuous" or "episodic," "with" or "without inter-episodic residual symptoms," or "single episode in partial or full remission." There are also five subtypes that describe the most frequently observed behavioral manifestations during the illness. While Schizophrenia is a well-defined and stable diagnosis, the subtypes are relatively inadequate and ill-defined. Often, individuals tend to have overlapping symptom patterns; therefore, the diagnosis can shift from one time to another. Furthermore, as time passes, the symptoms of the illness tend to converge toward general social withdrawal, idiosyncratic thinking and flattened affect. The course of the illness also tends to become more stable with fewer acute episodes or symptoms.

Neuroleptic medications are used to treat the symptoms of Schizophrenia. The newer antipsychotic drugs tend to have fewer side effects and better efficacy. However, medication tends to treat only positive symptoms and appears to have little impact on negative symptoms. Positive symptoms include active-delusions, hallucinations and bizarre behavior. Negative symptoms indicate a "lack" of behavior such as withdrawal, flat affect and thought blocking.

**Let's look at a case to help get a sense of diagnosis:**

Billy Jean has been acting strangely for several months now. She reports that her neighbors are trying to poison her. They are trying to give her poisoned food and have attempted to pump poisoned gas into her apartment through the air conditioning vents. She states that her mother is in collusion with a "group" that is after her, as are her neighbors. Billy Jean appears very nervous and has pressured speech. She appears confused and frightened.

**This is not even a close call**

The likely diagnosis is Delusional Disorder for the following reasons:

- First, the delusions are non-bizarre
  - In Schizophrenia the, delusions are usually bizarre (e.g. aliens are projecting thoughts into my mind)
- Second, the duration is too short to meet the criteria for Schizophrenia (though it is sufficient to meet the criteria for Brief Psychotic Disorder or Schizophreniform Disorder)
- Third, while there may be an absence of hallucinations in Schizophrenia, this is relatively rare
  - In fact, auditory hallucinations in the form of voices are most common
  - Visual hallucinations are the next most common
  - Olfactory and kinesthetic hallucinations are rare (olfactory hallucinations are suggestive of organicity)
  - A client might have a residual or prodromal
SECTION 5: ETHICS

ETHICAL CODES
Ethics is the study of what constitutes good and bad human conduct, including related actions and values. They are the heart of social work. Although the exam does not include direct ethics questions, application ethics questions are a significant component. Determining the appropriate response is the issue. If the therapist should act at all, the ethical response must be determined.

Respect for clients and the promotion of their welfare provide guidance for ethical determinations. To these ends, the therapist should make decisions and take actions that foster growth rather than dependency and do so in the shortest possible time. Periodic evaluation of sessions is advised. Working within the bounds of his/her training, the ethical therapist understands multicultural techniques and does not promote personal values through the counseling process. Treatments are chosen for their potential benefit to the client, not because they are the only options the therapist knows or the ones that best fit the therapist’s value system. Meeting the needs of the therapist is never the goal of therapy. In a situation where testing is employed, only those tests which have been normed for the population in which the client is included should be employed. Whenever possible, the client’s family should be involved in the therapy process.

Before treatment begins, the therapist is responsible to discuss techniques, risks, fees and limitations of treatment with the client. Until the client has been given this information, Informed Consent is not possible. Diversity is an issue that may well be addressed in the process of obtaining informed consent. As required by specific nondiscrimination statutes, the therapist offers services regardless of the client’s class, race or socioeconomic status, but should also be aware of personal limitations that might indicate the client is better served by a referral elsewhere.

Ethical Practice By A Therapist Is When A Therapist
- Has good moral sense
- Follows the code of ethics
- Is up-to-date on the existing laws that will impact their client
- Has good clinical expertise

The Function Of The Professional Code Of Ethics
- Define the role of the profession
- Express dominant morality of the field
- Define values and goals of the profession
- Define the standards both the professionals and users of the professionals’ services can expect in professional interactions
- Guide the conduct of the profession
- Can provide specific guidance about conduct in the form of advice or mandates

Moral Foundations
- **Autonomy:** People are allowed the freedom of choice and action
- **Non-maleficence:** Above all else, therapist will do no harm
- **Justice**: Humans should be treated fairly with equal distribution of good or bad
- **Fidelity**: Value of honoring commitments and promoting trust
- **Veracity**: Importance of telling the truth
  - You must be someone they can trust
- **Beneficence**: Refers to promoting good

**MALPRACTICE CLAIMS**

These are legal actions taken against a therapist for actions believed to fall below the appropriate standard of care and might cause injury to the client.

**Common Types Of Malpractice**
- Misdiagnosis
- Practicing outside area of competence
- Failure to obtain informed consent treatment
- Negligent or improper treatment
- Physical contact or sexual relationships with patient
- Failure to prevent patient from harming themselves or others
- Improper release of hospitalized patients
- Failure to consult another practitioner or refer a patient
- Failure to supervise students/interns
- Abandonment of patients

**STATUTES, CASE LAW AND REGULATIONS**

**Vicarious Liability**
- Employers and Supervisors are held accountable or liable for their subordinate’s actions
- If that employee/counselor’s actions are part and partial to their job requirements, even though they may not occur at the job site, the employer is still liable for said actions

**Professional Disclosure Statement**
- Tells the client about the education and qualifications of the therapist
- The nature of the therapeutic process
- Procedures and goals of therapy
- Potential harms or risks to the client
- Reasonable benefits of therapy
- Qualifications and policies of therapist
- Theoretical orientation of therapist
- Ability to terminate treatment at any time
- Reassurance of referral sources for treatment (3 is standard)
- Fee disclosure

**INFORMED CONSENT**
- A document the client reads about the specifics of therapy treatment
Client consents to treatment by signing the form

A patient may consent or refuse consent for any treatment. To allow for proper patient consent, the patient must be provided full disclosure (an understanding of relevant information: desired outcome of treatment, likelihood of success, potential risks, alternatives, consequences of lack of treatment). A counselor must adhere to criteria for obtaining patient consent involving voluntarily of consent, patient's capacity to give consent, patient's inclusive understanding of counselor's role and documentation of patient consent. All elements of criteria must be renewed annually. When a counselor terminates a relationship with a patient without sufficient notice resulting in harm to the patient, this is referred to as patient abandonment. If a counselor must close a patient's case and the patient is assessed to be in need of additional services, the counselor must arrange for alternative services before terminating the relationship (written and verbal notice of termination should also be provided).

An advance directive is a legally binding document describing the patient's directives for care should he become incompetent or incapacitated. The Patient Self-Determination Act of 1990 mandates inpatient and home-care facilities counsel patients regarding advance directives. An advance directive may be a living will (describes grounds for medical treatment termination) or a durable or medical power of attorney (assigns a proxy agent who will make medical decisions in the case of patient incompetence, describes grounds for medical treatment termination.) It is a case manager's responsibility that each patient be provided opportunity to add an advance directive to his medical records, learn more about advance directives, or refuse to formulate an advance directive.

**RESEARCH ETHICS**

**Informed Consent Requires**
- The participants to have understanding of the procedure
- Individuals to be competent to give informed consent
- Explanation of potential positive and negative outcomes
- Participants to know that they may be given a placebo
- Explanation of possible risks and discomforts
- Individuals to understand their participation is voluntary
- Consent to be signed and dated by the subject (witness unnecessary)
- Legal guardian to sign if subject is a minor
- The researcher to understand that participants may be stressed by factors that seem matter-of-fact to him/her

**To Protect Confidentiality**
- Do not associate names with data
- Have organizational approval if records are being reviewed without patient consent

**Deception**
- Is to be used only as a last resort
- Must be justifiable
Must be revealed to the participant as soon as possible  
Requires sensitivity  

**Animal Research**  
- The purpose of the experiment must be clearly understood  
- Consider the level of consciousness of the animal  
- Determine the degree of pain and how to minimize it  
- Use alternative methods when possible  

**FEES**  
Fees provide ethical concern. If the center operates with a sliding scale, that information should be given to each client before treatment is initiated. Disclose payment and collection procedures in the initial Informed Consent form. Unless bartering is sanctioned by the community (as in a very rural area), it should not be employed.  

**CONFIDENTIALITY**  
Confidentiality is a significant ongoing ethical issue that derives from ethical principles of autonomy. Although it is understood that content revealed in counseling is to remain confidential, if the client presents a danger to himself/herself or to others, confidentiality must be broken. A therapist who cannot decide whether or not a specific instance requires a breach in confidentiality should consult someone more experienced. If it is determined that information must be given, the guideline is minimal revelation, divulging only enough to keep the client and others safe. When minors are involved, two different ethics must be weighed in the decision making process: the therapist acts to promote the welfare of the client, and the therapist involves the family when possible. Any therapist who is responsible for training subordinates or graduate assistants must include the ethics of confidentiality in that instruction. Ethic codes allow counselors to share confidential information in order to consult with other professionals. Client information is not to be disclosed to the counselor’s significant other or other family members.  

Disclosing confidences takes another twist when AIDS is involved. Typically revelation of AIDS within a counseling session does not change the client’s threat to others. This particular information should not be released to anyone unless the client informs the counselor of intent to infect another person without allowing that person to know of the infection. In that event, the person at risk should be warned.  

**Confidentiality Notes**  
- It is the ethical obligation of the therapist to keep communications between themselves and the client private  
- They may be charged in contempt of court if the therapist refuses to testify about a client  

**Exceptions**  
- Child abuse reporting laws:  
  - Mandated to report the suspicion of child abuse or neglect  
  - In some states, this is required of all citizens not just therapists
Duty to warn:
• If the therapist establishes there is likelihood a client will cause harm to him/herself or to someone else and the therapist knows who that victim may be

Privilege:
• Legal right, owned by the client, which is an exception to the general rule that the public has a right to relevant knowledge in court proceedings
• This means information revealed in sessions is not permitted in court

Appropriate standard of care:
• How most therapists would treat a case under similar circumstances
• Those who do not follow this are at risk for malpractice

Dual relationship:
• Occurs when the therapist does not keep appropriate boundaries, thereby blends personal or business relationships with the therapeutic relationship

Secret policies:
• Are written statements about how information shared privately will be handled by the therapist
• Must be signed by both parties

MULTIPLE CLIENTS
Situations involving multiple clients and groups create a different set of ethical issues. Before therapy is begun, it must be understood who the actual client is, whether a whole family, the spouse or a certain sibling. When constructing therapy groups, the clinician is responsible to protect each client from harm by screening the clients who are included in the group and then placing only compatible ones together. Furthermore, the therapist is responsible to discuss the limits of confidentiality in a group situation and to follow up with members after the group sessions via phone call or other contact.

When a client is also seeing another therapist, a release must be obtained from the client in order to speak with that clinician about the case. If at all possible, the other therapist should be approached with a positive collaborative attitude and an attempt to correlate treatment goals.

Stereotyping Clients By Group
• May be unintentional
  • The therapist researches the “group” and what the group beliefs are, according to research, but in so doing, generalizes and may miss something about the individual sitting in front of them
• Inappropriate selection of techniques
  • Therapists often depend upon a high level of verbal exchange to achieve therapeutic progress
• Inappropriate selection of tests and measurements
  • Many test reviews have only been done on the majority population type and may not be applicable to all cultures, skewing “normal” results
• There should be an investigation of possible differences in validity for ethnicity, sex or other sub-samples that can be identified when the test is given
• What is considered an objective assessment instrument within a majority culture, may not be so within a minority culture or a different cultural orientation
• It is an ethical duty to be aware of this research prior to administering assessments

ETHICAL CONSIDERATIONS WITH CULTURALLY DIFFERENT CLIENTS

Current ethical codes are based on individualism, which is a Western characteristic. There is significantly less focus on the role of family, group identity, lifestyle and religious beliefs that have equal importance to individuality in other cultures. The code of ethics states that therapists do not discriminate against or refuse professional service to anyone on the basis of race, sex, religion, age or national origin.

It is ethical for counselors to know their own biases and how they may impact service delivery. Therapists should be aware of their own cultural competence and recognize the cultural diversity pertaining to each individual. They must understand the role culture and ethnicity play in the sociopsychological and economic development of diverse populations; and realize socioeconomic and political factors significantly impact the psychosocial, political and economic development of ethnic and culturally diverse groups.

The councilor should help clients to understand, maintain or resolve their own cultural identification. It is imperative to understand the interaction of culture, gender and sexual orientation on behavior and needs. Implications for clinicians have no direct rule covering any and all situations. Many ethical codes have not yet adequately dealt with some cultural issues related to technology and assessment or the counseling relationship with culturally diverse clients.

Ethnic minorities will continue to underutilize services, prematurely terminate or fail to show positive treatment outcomes if remedies are not applied and enforced. The goal is to learn how to identify, understand and accommodate the needs of differing clients.

DUAL RELATIONSHIPS

A dual relationship exists whenever a therapist has dealings with the client outside of his/her role as a therapist. In situations of dual relationships, the client should be referred to someone else for therapy if possible. Another option is to modify the relationship to avoid the duality. If neither of these options exist, informed consent, seeking supervision and documentation of the dual nature of the relationship are important ethical responses.

A therapist who switches from working with an agency to private practice should not take clients along when the change is made. Clearly it is ethical for the therapist to continue to monitor the effectiveness of treatment the client is receiving, but to cause the client to leave the agency is not.

SEX WITH CLIENTS

Although it should seem obvious that having sex with former clients is unwise, laws in certain states have been changed to allow for this contingency. Sex with current clients is forbidden in
every situation. A defined period of time must elapse after the termination of counseling before sexual relations are legal. If a therapist has a sexual relationship with a former client, the partner must be informed of the risk incurred by involvement in the relationship. In case notes, the therapist must document the existence of the sexual relationship.

**TERMINATION**

In situations where the client **terminates** therapy prematurely, the counselor is responsible for reasonable follow-up measures. Either making a telephone call or sending a letter inviting a response is a good approach since some sort of contact has been initiated. If a client’s need is known to be outside a therapist’s boundaries of education and competence, the therapist should not begin treatment, but refer the client to someone who can provide effective help.
SECTION 6: DIVERSITY

CULTURAL DIVERSITY

Multicultural counseling encompasses several theories beginning with the roles within the family.

- Egalitarianism in the husband-wife relationship is based on the Euro-American value system
- Division of roles where the husband is the protector and provider, while the wife cares for the home and family, allows both to be influential and make decisions
  - Breaking role division is done only out of necessity
  - A wife would not typically make a family decision without obtaining agreement from her husband
    1. For example: Setting up a family therapy appointment session
  - Therefore, it is imperative the counselor be culturally aware, note this behavior is culturally based and not mistake it for a lack of commitment to therapy

- **Nuclear Family vs. Extended Family**
  - Many times, if a client is asked to describe or even bring along “the family” to a session, more than the nuclear family may arrive
  - In many cultures, such as Latin American culture, extended family and “family” such as long time family friends or godparents play an important moral, religious and spiritual role in the client’s life

- **Classism**
  - The importance of counseling over missing work is a world view that differs between cultures often times:
    1. The counselor may feel it is a necessary requirement for the well being of the client
    2. The lower Social Economic Status (SES) family to whom that time off work has a significant impact on their livelihood would not agree
  - It is important to be aware this work flexibility is a middle-upper class luxury and should not impact our perception of our clients and apply negative behavior traits to them for such inability to be flexible

- **Communication Approach**
  - Based on the assumption family problems are communication difficulties
  - Therapists concentrate not on improving faulty communication, but also interactions and relationships among family members
  - The therapist’s role is active but not dominating
    1. Attempting to show families how they are now communicating
    2. Prodding them to reveal what they feel and think about themselves
    3. And what they want from the family relationship through practicing new ways of responding

- **Structural Approach**
  - Emphasizes the interlocking roles of family members
  - Families are in a constant stage of change in restructuring systems and subsystems
The health of the family is contingent upon the member’s abilities to recognize boundaries, alliances and communication patterns

GENERAL INFORMATION

- “Traditional” psychotherapeutic approaches are most effective on middle to upper class clients of European descent
- The ability of therapists to assess and deal with family dynamics and behaviors is related to their knowledge, understanding and appreciation of the cultural context within which families function
- The goal of therapy is to help the clients become more functional in their society
  - Functionality is culturally determined as well
  - Different cultures require different behaviors of societal success
  - Expressions of abnormality and the underlying psychological causes are bound to culture
- Statistics for success (or not) are as follows:
  - There is a lower rate of utilization of services by Asian Americans and Native Americans than by European Americans and African Americans
  - Minority groups have a higher drop-out rate and poorer treatment outcomes
    1. Found to be due to cultural insensitivity of standard treatment methods
  - There are culturally specific reasons preventing minorities from utilizing available services:
    1. Their perception of effectiveness of counseling
    2. Different world views
    3. Lack of understanding of unique life experiences
    4. Lack of knowledge on cultural systems of healing
    5. Preference seems to be for action oriented therapy and for a therapist with similar cultural background and/or gender
- There is evidence of therapist bias
  - Research shows therapists view clients of different cultures than their own differently
  - Ethnically matched therapists tend to judge clients to a have higher mental functioning than mismatched therapists
- Competencies required for sensitive and effective treatment:
  - Knowledge of diverse cultures and lifestyles
  - Skill & comfort in using innovative treatment methods
  - Actual experience working with culturally diverse clients
  - Awareness of their own cultural beliefs and experiences and how they influence the course of treatment
  - Awareness of strong transference reactions
  - Cognizant of barriers to empathy on the part of the therapist
- Naikan Therapy (Japan)
  - Involves a process of continuous meditation based upon highly structured instruction in self-observation and self-reflection
• Clients are usually placed in a small sitting area and practice their meditation from early in the morning until evening. Interviewers come every hour to discuss progress.

➢ Morita Therapy (Japan)
• Purpose-centered therapy created in the 1930s by Dr. Shoma Morita
• While traditional therapy aims to reduce symptoms, Morita Therapy works at building character to enable one to take action responsively in life, despite symptoms
• Character is determined by behavior
• Dogmatic behavior patterns are replaced with flexibility, courage and empowerment
• Theory is based on the idea that decisions become grounded in purpose rather than influenced by the fluid flow of feelings

➢ Espiritismo (based in Latin America, Caribbean)
• Belief that good and evil spirits can affect health, luck and other elements of human life
• Espiritismo has absorbed various practices from other religious and spiritual practices endemic to Latin America and the Caribbean, especially Roman Catholicism but even African beliefs such as Voodoo
• Goals and methods of the Espiritismo are in the realm of magic and may be considered folk medicine

Multicultural Family
➢ Increasing diversity presents different cultural conceptions of “family”.
• Whether groups value a lineal, collateral or individualist orientation has a major implication for their definitions of family
• One definition cannot be seen as a superior to another
➢ Families cannot be understood apart from the cultural, social and political dimensions of their functioning
➢ The traditional definition of the nuclear family now in the minority:
• Heterosexual parents
• Married
• Raising biological children
• Father as breadwinner
• Stay at home mother
➢ Now becoming the “normal” family description:
• Extended families
• Intermarriage
• Divorce
• Homosexual parents
• Mixed race families
• Single parents
• Both parents working outside the home
➢ When working with minority clients, therapists must make an effort to learn as much as possible about them
• What their definitions of family are
• The values that underlie the family unit
• The therapist’s own contrasting definitions

➢ Therapists must be aware of traditional cultural family structure and extended family ties
  • Non-blood relatives may be considered an intimate part of the extended family system
  • Understanding relationships is crucial, such as:
    1. Husband and wife
    2. Parent and child
    3. Sibling to sibling

➢ Therapists must be careful not to prejudge from an ethnocentric perspective
  • Be aware of culturally patriarchal or egalitarian relationships
  • Division of labor in the home may be a violation of family norms

➢ Minority families view the “wife” role as less important than the “mother” role
  • Existence of children validates and cements a marriage
  • Motherhood is often perceived as a more important role

➢ Therapists should not judge the health of the family on the basis of romantic egalitarian model of marriage

➢ Therapists must not overlook the prospect of utilizing the natural help-giving networks and structures that already exist in the minority culture and community
  • Explore what the minority cultures used as “therapy” prior to actually seeing a therapist

➢ Therapists must recognize helping can take many forms
  • It is important to modify goals and techniques to fit the needs of the minority population

➢ It is important to assess the importance of ethnicity to clients and families
  • Therapists must be aware that acculturation is an important process and has the most impact for the children in the family
  • Many tensions and conflicts between the younger generation and their elders are related to culture conflicts
  • Conflicts are not pathological, but rather normal responses to a transition

➢ The role of the family therapist cannot be confined to culture-bound rules that dictate a narrow set of roles and behaviors
  • Effective multicultural family counseling should include:
    1. Validating and strengthening ethnic identity
    2. Increasing awareness of the natural client support systems
  • The therapist may serve as a cultural broker
    1. Be aware of disadvantages and advantages of being in the same or different ethnic group as the client

➢ The therapist does not need to know everything about the minority ethnic group, but must be careful not to polarize ethnic issues

➢ Therapists must accept the idea that the family therapist must be creative in the development of appropriate interventions when working with the minority population of families
Subtlety and indirectness may be called for
Formality in addressing members of the family, especially the father, may be more appropriate
Sometimes, a more interactional approach rather than a goal-oriented approach must take place
Approaches are determined by a system of factors

MULTI-CULTURAL COUNSELING

➢ The National Conference on Graduate Psychology recommends:
  • Culturally sensitive and relevant counseling strategies be developed
  • Focus on lifestyles, cultural values and socio-political realities of minority clients

➢ Multicultural scholars agree:
  • Therapy techniques used with Caucasians are inherently different from those needed when dealing with specific minority clients
  • Racial minorities under use mental health facilities
    Minorities historically terminate prematurely (generally after one session)

➢ Counselor awareness of personal assumptions, values and biases is necessary
  • The culturally-skilled counselor is one who has moved from being culturally unaware to being culturally sensitive to his/her own cultural heritage, meanwhile respecting the differences of others
  • The culturally-skilled counselor is aware of personal biases and their possible specific effects on the outcome of therapeutic interventions with minority clients
  • Culturally-skilled counselors are comfortable with differences of race and belief that exist between themselves and their clients
  • The culturally-skilled counselor is sensitive to circumstances (personal biases, stages of ethnic identity and socio-political influence) that may dictate the referral of a client to a member of his/her own race and/or culture
  • The culturally-skilled counselor acknowledges personal racist attitudes, beliefs and feelings

➢ Understanding the world view of the culturally-different client:
  • The culturally-skilled counselor must possess specific knowledge about the client’s particular ethnic group
  • The culturally-skilled counselor must have a good understanding of how the American socio-political system operates with respect to minorities
  • The culturally-skilled counselor must have a comprehensive understanding of counseling and therapy
  • The culturally-skilled counselor is aware of institutional barriers that prevent minorities from using mental health services

RELEVANT PROCESSES AND GOALS IN CROSS-CULTURAL COUNSELING

➢ Counselors working with the culturally different clients need to be aware of:
  • Culture, class and language factors that act as barriers to effective therapeutic intervention
• How expertise and trustworthiness can be conveyed to clients who are dissimilar to the therapist
• How to emphasize world-views and cultural identity in the counseling process
• Variations in communication style and other culturally-bound differences among various ethnic groups
• Personal racial attitudes and biases

Three levels of counseling are involved in the conditional process:
• Pre-entry Level
• Entry Level
• Outcome Level

**Four Conditions May Arise When Counseling A Person From A Different Culture**

(This resembles the concept of Johari’s Window.)

- **Condition I:** Appropriate Process/Appropriate Goals
- **Condition II:** Appropriate Process/Inappropriate Goals
- **Condition III:** Inappropriate Process/Appropriate Goals
- **Condition IV:** Inappropriate Process/Inappropriate Goals

**Condition I**
The client is exposed to a counseling process consistent with his/her values, life experiences and culturally conditioned responses.

EXAMPLE: Although the technique of teaching is not necessarily seen a part of the traditional counseling process, the counselor teaches the client specific skills as well as giving advice and information.

**Condition II**
The counselor may choose a specific counseling strategy compatible with the client’s life experiences, but the goals are questionable.

EXAMPLE: If an approach stresses observable behaviors and provides a systematic and structured approach to a problem, this may connect with a client’s expectations and beliefs. However, if the behavioral objectives are actually projections of the counselor rather than desires of the client, the behaviors may not transfer to a real life setting.

**Condition III**
The counselor tends to use inappropriate strategies when working with the culturally different client. Many times, the process is antagonistic to the values of the client and forces violation of some basic personal standard. Although the goals are appropriate, the client is destined to fail because the process is incompatible with personal values.

EXAMPLE: Caucasians are concerned with controlling and mastering the physical world. The more nature is controlled, the better. Native Americans are taught the principle of non-
interference. Manipulation and coercion associated with the Caucasian concept are thought of as rude and hostile by those who are culturally Native American.

Condition IV

The approach chosen by the counselor is clearly inappropriate in terms of both technique and goals. Generally this leads to early termination of therapy.

EXAMPLE: Vietnamese clients may seek vocational information and yet be unwilling to share intimately. By Vietnamese culture, intimate disclosure is reserved for the closest of friends and is not deemed acceptable in a counseling situation. The counselor may determine that deeper psychological concerns are involved. Although this may well be true, the application of techniques geared toward self-revelation may be repulsive to the client and may force the termination of any level of communication with the counselor.

African Americans

Counseling African Americans

- With a population of 23 million, African Americans constitute the largest minority group in the U.S.
- According to census information, 86% live in cities
- Of the national prison population, 42% is African American
- The unemployment rate of African Americans is twice that of Caucasians
- The most prevalent cause of death for African American youth is homicide
- Life expectancy of Caucasian males is five years greater than that of African American males
- Alcoholism is increasing for African American women at a higher rate than it is for Caucasian women
- In 1984, 34% of African American families lived below the poverty level (11% for Caucasian families)
  - Annual income was $12,674 as compared to $21,904 for Caucasian families

Education of African Americans

Disproportionality Task Force findings conclude:

- In high school, 56.3% of African Americans had a GPA below 2.0; for Caucasians this percentage is 20.9%
  - Only 9.67% of African Americans had a GPA of 3.0 or above
  - Caucasians 43.5% had a GPA of 3.0 or higher
- Most educational systems employ a predominantly Caucasian teaching staff
- Typical curriculum does not reflect the experiences of minority children
- Abuse of drugs/alcohol and unconcerned parents contribute to lower school performance in African American children
- A university of Michigan study of racism in higher education found:
  - Declining interest in civil rights issues in the U.S.
• A backlash to advances that have been made by minorities
• Declining levels of financial support
• Emotional support for minorities lacking in the university environment
• Lack of African American faculty members and mentors

AFRICAN AMERICAN YOUTH

➢ African American adolescents experience higher levels of problems related to poverty, racism and illiteracy than their Caucasian counterparts
➢ Unemployment can range from 37% to 50% for African American adolescents
➢ Having few positive experiences with authority figures, African American adolescents feel victimized by the school system
➢ A streetwise youth may attempt to shock the counselor to interrupt the counseling experience
➢ To test commitment, the African American client may attempt to confront or become aggressive with the counselor
➢ Recommendations for working with African American youth:
  • Discuss the youth’s expectations about the usefulness of counseling
  • Negotiate a contract with specific time limits and goals
  • Especially when dealing with verbal abuse, set firm limits

AFRICAN AMERICAN FAMILY CHARACTERISTICS

➢ The typical African American family is described as matriarchal
➢ In 37% of African American families, a woman heads the household (Caucasian 11%)
➢ Of lower class families in the U.S., 70% are headed by African American females
➢ Unwed African American females, the majority of whom are teenagers, account for nearly 60% of the birthrate
➢ More than 50% of African American children have working mothers and, as a result, are generally cared for by relatives, older children and/or close friends
➢ In 1970, 64% of African Americans were married; that percentage had dropped 50% by 1982
➢ Within the typical African American family structure, there exists:
  • Adaptability of family roles
  • Powerful kinship bonds
  • A strong work and achievement ethic
  • A vibrant religious orientation
➢ The self-esteem of African American children is equal to that of Caucasian children
➢ African American males accept the working roles of African American women and are willing to share household responsibilities

FAMILY THERAPY WITH AFRICAN AMERICANS

➢ Counselors working with African American families may have to assume roles of educator, advocate, problem solver and role model
➢ During the first session, African American clients should be told what to expect
Trust must be established
Assessment may need to be made to determine not only how community resources may be utilized, but also socioeconomic issues such as food, housing and areas of strength from family members
If the family is heavily involved with a church, the minister may be enlisted for problems involving internal family conflict, health and family planning
School programs can be developed to discuss child-rearing practices and initiate a support group
If they share their personal experiences, successful African American adults with good communication skills can be a very positive force in effecting other African American families
Studies of African American families in therapy show:
  • Drop-out rate for African Americans is 81% as opposed to 50% for Caucasians
  • Family therapy may become difficult when dealing with issues of illegitimate birth, marital status of adult family members and the paternity of children

AFRICAN AMERICAN BARRIERS
Multiple barriers exist for a Caucasian counselor to effectively counsel African Americans:

Racism or Prejudice
  • At the conscious or unconscious level, the counselor may possess a feeling of superiority over African Americans
  • If a belief that African Americans create their own problems is present, the counselor may fail to see positive aspects and strengths of the client and take a blame-the-victim approach

Color blindness
  • The counselor views the African American client as any other client, refusing to acknowledge the influences of culture and racism
  • Although African Americans have different lifestyles than mainstream Americans, the counselor seeks solutions based upon Caucasian middle class experiences

Paternalism
  • Viewing all problems as stemming from racism or prejudice, the counselor dismisses even severe disorders as reactions to racism
  • Additionally, the therapist may foster dependency by failing to consider the client’s contributions to the problem, thus preventing the client from learning independent problem solving

Unquestioned acceptance of African American power
  • Perhaps as a desire to demonstrate an open acceptance coupled with personal feelings of racial guilt, the counselor believes the client need not consider the rights of others in the achievement of his/her personal goals
  • Therefore, the African American client is allowed to freely express anger or hostility because these feelings are justified
African American Client Variables

There are two major factors in self-disclosure:

- Cultural paranoia – Actually a healthy response to racism, this hesitancy is present because of concern about being misunderstood or taken advantage of
- Functional paranoia – With a behavioral pattern that stems from personal pathology, this individual displays a distrust of all therapists regardless of race

Forms of African American self-disclosure:

- Intercultural non-paranoiac disclosure – The client is willing to disclose to either an African American or a Caucasian therapist
- Functional or confluent paranoiac – Regardless of the ethnicity of the therapist, the client will not disclose
- Healthy cultural paranoiac – The client is willing to disclose to an African American therapist, but remains nondisclosure to a Caucasian therapist

Asian Americans

Facts of Asian American Society

- In comparison to other third world groups, Asian Americans represent the model minority
- There has been a significant reduction in social distance between Caucasians and Asians as evidenced by marriage and intimacy between minor and major majority groups
- Chinese, Japanese and Filipinos have all exceeded the median income levels
- However, analysis of the Asian success story is not exactly as it appears:
  - Asian households have a higher percentage of multiple wage earners than Caucasian households
  - A prevalence of poverty remains despite the higher median income
  - The reliance upon government assistance and welfare is less than in the general population
  - A disparity between income and education still exists
    1. Asians with higher educations earn less than their majority counterparts
- Asian Americans who have lived in America for several generations still suffer from lack of mastery of the English language
- Of the Asian American students at U.C. Berkeley, 50% failed an elementary English examination
- Disgrace, isolation and racist attitudes have all contributed to the language difficulties
- More than tourist attractions, Chinatown, Manila town and Japan town in San Francisco and New York are:
  - Ghettos with a high prevalence of unemployment
  - Locations with higher than average levels of poverty
  - Places with major health concerns
  - Gripped by juvenile delinquency
- Among Asian Americans, tuberculosis and suicide rates are three times the national averages
Mass murders by Chinese juvenile gang members such as the Tong Society are prevalent.

Mental health services are underutilized because:
- Low socioemotional adjustment exists in this group
- Discriminatory mental health practices continue
- Cultural values inhibit self-referral

FORCES SHAPING THE IDENTITY OF ASIAN AMERICANS

Historical experience in America:
- Of all Asian Americans, the Chinese suffered the most inhumane treatment
  - Caucasians viewed the Chinese as an economic threat after the California Gold Rush subsided and the Transcontinental Railroad was completed
  - Chinese were denied citizenship
  - Their testimony in court was considered inadmissible
- Passed in 1882, the Chinese Exclusionist Act was not repealed until 1943
- The Gentlemen’s Agreement was non-direct legislation that restricted the flow of Asians into the U.S.
- Alien Land Law forbade aliens to own land
- In 1988, President Reagan signed a $20,000 reparations bill
  - By 1990, no monies had been paid
  - The reparations clause was removed from 1990 federal budget by President Bush
- Koreans and Filipinos were not treated any differently until the mid twentieth century

VALUE CONFLICTS IN COUNSELING ASIAN AMERICANS

Differences Between Asian Patients And The American-Trained Therapist

Asians focus on the following:
- Interdependence
- Appropriate social relationships
- Living in harmony with nature
- Keeping treatment short
- Perception of mental illness as a family failure
- Physical complaints, since they are a culturally accepted means of expressing psychological and emotional stress

WORKING WITH ASIAN AMERICANS

- In 1985, there were 5 million Asian Americans in the U.S.
- In 1984 alone 282,000 Asians immigrated to the U.S.
- Immigration laws changed in 1965 allowing more entries into the U.S.
- By numerical rank, the following Asian cultures currently in the U.S. are:
  1. Chinese
  2. Filipino

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3. Japanese
4. Vietnamese
5. Korean
6. Asian Indian
➢ There are 29 different subgroups of Asian Americans that differ in language, religion and values
➢ Other differences include:
  • Degree of assimilation or acculturation
  • Identification with home country
  • Facility with native and English languages
  • Family composition and intactness
  • Amount of education
  • Degree of adherence to religious beliefs

**SPECIAL PROBLEMS OF U.S. BORN ASIAN AMERICANS**
➢ Loyalty to one’s peer group can be in direct conflict with parental values, beliefs and expectations
➢ When culture conflict is present, Asian Americans may tend to over-Westernize, rejecting commonly accepted cultural and traditional values
➢ Many view ethnicity as a disability with possible results of self-hatred and identity crisis
  • Some try to exist marginally between the two cultures and become somewhat contemptuous of their Asian culture
➢ As young people attempted to incorporate parts of their culture into present situations, the Yellow Power Movement arose as a rebellion against parental authority
➢ Increasingly sensitive to forces that shape their identity, Asian Americans have become almost militant in their approach to civil rights and racism

**HISPANIC AMERICANS**

**COUNSELING HISPANIC AMERICANS**
➢ Hispanic American is a term used to identify individuals from Mexico, Puerto Rico, Cuba, El Salvador, the Dominican Republic and other Latin American areas
➢ Not all groups accept the term Hispanic, preferring instead:
  • Latino or La Raza (the race)
  • Mexicano
  • Mexican-American
  • Spanish-American
  • Chicano
    1. The use of the term “Chicano” produces a mixed reception
       a. Certain groups use the word with pride
       b. Others see it as a form of prejudice and racial identity with a less esteemed group
Physical characteristics and appearances vary greatly with resemblance to Native North Americans, African Americans and Europeans

- Mexican-Americans are mostly Mestizo ancestry (Spanish and native Aztec Indian blood)
  - In Mexico the population is 55% Mestizo, 29% Indian and 15% European
- Most Cuban Americans are of Spanish descent with the remainder African American or of mixed ancestry
- Puerto Ricans are generally of Spanish descent, but show influences of African American and Indian cultures
- In Latin America, the mix of ethnicities has produced diverse cultures

**Hispanic Demographics**
- In 1980, Hispanic Americans comprised a population of 14.6 million, nearly 9 million of whom were of Mexican descent
- In 1980, there were over 3 million Puerto Ricans
  - Because of Puerto Rico's status as a territory, Puerto Ricans can travel freely to and from the mainland, making it difficult to determine an actual population count
- In 1980, 1 million Cubans were identified
- Because of the large number of unreported immigrants living in the U.S., the estimated number of Hispanic Americans exceeds 20 million
- It is estimated the Hispanic population could soon be the largest minority group in the U.S.
- Within the Hispanic population, the average fertile age is 10 years younger than Caucasians and 2 years younger than African Americans
- Based on their strong religious beliefs and principles of family unity, the average household is comprised of four or more
- The following percentages indicate the regional diffusion of Hispanics:
  - Arizona - 16% of population
  - New Mexico - 36% of population
  - Denver - 19% of population
  - Hartford - 20% of population
  - Miami - 64% of population
  - Los Angeles - 2 million Mexican-Americans, plus an additional 300,000 Salvadorians (one-half of San Salvador’s total population)
- Primarily in the Great Lakes region, the Southwest and major Northeastern cities:
  - Hispanics are over-represented among the poor, having high unemployment and often living in substandard housing
  - Most are blue-collar workers and hold unskilled or semi-skilled occupations
  - The average Hispanic median annual income is $11,660 (Caucasian median is $15,572)
    1. The average median income of a Hispanic family is $16,900 in comparison to the median Caucasian family income of $35,670
  - With over 40% living below the poverty level, Puerto Ricans appear to be least successful
  - Cubans living in Miami, Florida enjoy an average annual salary of $35,000
Hispanic Family and Values

- Family traditions are an important aspect of family life with a large circle of family and friends considered essential
- Cooperation rather than competition is stressed
- Extended family includes non-blood members:
  - Padrino - best man
  - Madina - maid of honor
  - Compadre and comadre - godparents
- The Catholic Church is a primary influence on the Hispanic culture with many expressing a strong belief in prayer
  - Most participate in mass
- Religious views include:
  - Concept that sacrifice in this world is helpful to salvation
  - Belief that being charitable to others is a virtue
  - View that one should endure wrongs done against him/her
- Being is valued over doing; character is more important than achievement and activity
- Puerto Ricans value prestige and status within the family, whereas Caucasians value achievement in the workplace

Hispanic Family Structure

- With a hierarchical structure to the family, the elderly and parents (males particularly) receive special attention
  - The father assumes the primary role in a family
- Roles are clearly delineated:
  - Children are to be obedient
  - Older children take care of younger children, and the oldest daughter may become almost a surrogate mother
  - Females are not allowed to be sexually active
  - Typically sex is not discussed with the children
  - With certain exceptions, males are free to come and go
  - Seen as stabilizing factors, marriage and parenthood are entered into early in life

Hispanic Client Problems

- Most are externally driven
- Adaptive functioning stressors include:
  - Limited income
  - Lack of food or shelter
  - Inadequate medical attention
- If extrapsychic conflict predominates, therapy aimed at social action, lessening discrimination and dealing with poverty is appropriate
- If intrapsychic conflict is the presenting issue, behavioral therapy is the appropriate treatment
HISPANIC COUNSELING CONSIDERATIONS, STRATEGIES AND MODALITIES

- It is important to consider the psychosocial, economic and political needs of clients.
- The most important form of counseling is bilingual and bicultural.
- Responsible at times for distorted communications, interpreters may present difficulties. Some such difficulties are:
  - The interpreter’s language and translation skills are inadequate
  - The interpreter lacks psychiatric knowledge
  - The interpreter’s attitude toward the counselor may forestall progress
- If an interpreter is needed, it is recommended the counselor meet with the interpreter in advance to discuss goals, assessment and possible sensitive areas.
- Hispanics are accustomed to being treated by physicians; to utilize this familiarity to help the counseling process, the counselor should:
  - Carefully explain the difference between a counselor and a physician
  - Indicate the roles of counselor and client in counseling
  - Discuss goals of counseling
  - Select techniques that are appropriate to cultural norms
- Since the extended family is so culturally significant, family therapy should be strongly emphasized.
- To increase effectiveness, the counselor must consider environmental factors:
  - Determine the country of origin and reason for immigration
  - Discuss needs for food, shelter and clothing
  - Determine if there have been stressful interactions with other agencies
  - Provide assistance in developing environmental supports

Hispanics And Education

- Hispanic students have a high drop-out rate that increases as students get older.
- More than one-half drop out before completing high school:
  - This is double the drop-out rate of African Americans and triple that of Caucasians.
- At greater than 70%, Puerto Rican students have the highest drop-out rate.
- In Texas alone, the number of Mexican Americans classified as learning disabled and placed in special education groups is 300% the total expected.
- Most educational difficulties are related to language:
  - In 1970, over 50% of Hispanic homes spoke Spanish as the primary language.
  - The percentage using Spanish in conjunction with another language was considerably greater.
- More often than not, second generation Hispanics are bilingual but still have a limited command of English.
- In 1974, the Supreme Court (Lau vs. Nichols) ordered public schools to offer programs to provide for meaningful education regardless of language:
  - Lau Remedies were developed by the Office of Civil Rights in 1975.
- In a study by Cummins (1986), it was determined that it is possible to empower students in four ways:
1. Incorporation of language and culture of the minority group into the school program
2. Participation of the ethnic community in the children’s education
3. Implementation of methods to increase student motivation by having them use their first language to achieve greater knowledge
4. Emphasizing professional involvement in assessment to allow those professionals to become advocates for the students

**Hispanic Sex Role Conflicts**
- The man is supposed to be strong and dominant, the provider of the family
- Women are to be nurturing, submissive to males and self-sacrificing
- Obedience by all members of the family to the male or father figure is expected
- Conflicts for males may arise in the following areas:
  - Through interaction outside the family, the man may realize he is not fulfilling his leadership role - guilt may result
  - Since sharing feelings is generally regarded as a weakness, the man may experience feelings of isolation; and depression because of this isolation and the perceived need for strength he feels he lacks
  - Role consistency may be questioned
  - Questions about sexual potency bring anxiety
- Conflicts for females may arise in the following areas:
  - Disparity between role expectations and reality brings dissonance and anxiety
  - Depression may be felt when the woman does not see herself fulfilling her roles properly
  - There is an inability to act out the feelings of anger
  - Women are socialized to feel they are inferior
- The double standard between males and females is decreasing as urbanization increases

**Native Americans**

**Historical Understanding of Native Americans**
- By the end of the eighteenth century, the population of Native Americans was reduced to about 10% of its original size
- Native Americans were exterminated or their lands were seized, and they were forced to move onto reservations in mass numbers
- This mass movement traumatized the Native Americans, resulting in the loss of many cultural traditions
  - The primary loss was tribal cohesion
- For decades, the federal government tried to get Native Americans to forget their heritage and culture
- Both children and adults were forced to learn English and not allowed to speak their native languages
  - Children attended school away from their families for periods of up to eight years
Loss of the extended family was felt
  • Particularly undermined was any sense of identity, resulting in long-term devaluation of the Native American culture

**Native American Values**

- Sharing – Honor and respect are gained through sharing
- Cooperation – Family and group take precedence over the individual
- Noninterference – Native Americans are taught non-interference observation rather than reaction
- Time Orientation – Since they are more focused on the present than the future, planning and punctuality are not really important
- Extended Family Orientation – Strong respect for elders exists; and interrelationships connect large numbers of people
- Harmony with Nature – Native Americans practice acceptance as opposed to trying to control their environment

Such value differences produce numerous problems for the culturally diverse counselor, especially one who approaches life from a non-Native American perspective.

**Native American: The Tribe**

- Native Americans recognize approximately 530 distinct tribes of which the U.S. government acknowledges 478
  • Of these, 280 are land-based reservations
- Tribes vary in language, custom and family structure
- With a mean age of twenty, more than 1 million Native Americans live in the United States
  • Half of them presently reside on reservations
- In the past decade, the birth rate for Native Americans has more than doubled that of the remaining American population
- The government has imposed mandatory blood restrictions on Native Americans, clearly stating that a person must have a blood percentage of at least 25% in order to be considered a Native American
- The influence of the tribe differentiates Native Americans from their non-Native American counterparts
- Native Americans see themselves as extensions of their tribal ancestry
  • This provides for belonging and security, which in turn allows an independent system
- Native Americans self-judge to determine if they are a benefit or detriment to their tribe
- Many times, Native Americans who leave the reservation tend to lose both their sense of personal identity and their tribal identity

**Problems With Children And Adolescents**

- Attempting to reconcile two very different cultures, Native American children struggle between:
  • Trying to meet their parents’ expectations
And the expectations of the majority culture
Developmental problems are common

- Native Americans have high truancy rates
- Failure in school is higher than the national average
- Drug and/or alcohol use is high among Native American youth
- Statistically, the suicide rate is twice the national average

**Native American - Family Characteristics**
- Characterized by a strong role for women, Native Americans also have a high fertility rate and a large percentage of births out of wedlock
- The extended family is the basic unit with aunts, uncles and grandparents often included in the child rearing process
- Many times, the extended family is divided into separate households with fulfillment of tribal customs and traditions shared on a daily basis
- Women head over one-third of Native American families
  - Approximately 25% receive public assistance for an average family of three children
- Counselors who do not understand the extended family culture often perceive the moving around of children as irresponsible parenting and force interventions that are ineffective and misinterpreted by all involved
- High unemployment rates force many to leave the reservations
  - 40% return with a loss of personal and tribal identity

**Sexual or Gender Orientation**
A counselor must always be aware of his/her own sexual discriminations and/or prejudices. Whether it be a male counselor preferring not to work with another man or a female counselor not comfortable working with a male client. Sexual discrimination should not be an issue and is the supervisor’s duty to make sure this is not a factor in the workplace.

Working with GLBT or Gay, Lesbian, Transgender/Transsexual and Bisexual clients provides issues of its own. There are, in fact, very few organizations that offer support, thus it may prove difficult for the counselor searching for adjunct services to aid this particular clientele. Although these differing groups are many times lumped into one category GLBT, they are very diverse and should be treated as such. Another sticking point may be the lack of role models in today’s society. The client may lead a heterosexual ‘normal’ life in public but lead a very different personal life. This double life can become confusing, especially for adolescents and teens.

Not being open about their lifestyle forces most to live a closeted and protected life that may lead to Depression or other Anxiety disorders. Because he/she may be considered socially unacceptable, this clientele tends to be conflicted, demanding the counselor be well versed in dealing with particular social concerns and aware of their own personal bias. Counselors should be aware of where help exists and aid their client to become assimilated into the part of the community that can offer them support.
ELDERLY AND DISABLED

ELDERLY

With parents of Baby Boomers approaching their 80’s and 90’s, counselors are attending to the aged more often. This is another population that tends to be incorrectly stereotyped with many equating ‘elderly’ with ‘senile’. The elderly client very often is accompanied by a caregiver, typically a family member who may need counseling services as well.

Issues the counselor may face include:

➢ Life transitions
  • Adapting to new life roles
  • Outliving a spouse
  • Physical disabilities
  • Adjusting to a loss in previous responsibilities

➢ Losing their independence
  • Moving from their homes to assisted living situations
    1. May often lead to feelings of resentment
  • Having their means of transportation removed
  • Forced to depend upon others

➢ Emotional handicaps and diseases
  • Depression is common in the elderly
  • Fears of mortality creeping up
  • Hospitalization and costs attached to long-term illnesses
  • Often deal with conditions such as Alzheimer’s Disease and Dementia

DISABLED CLIENT

Disabled clients are generally persons having difficulty dealing with recent injuries or adjusting to permanent, life altering conditions as a result of their injuries. Clients with disabilities are often undergoing physical rehabilitation concurrently with counseling. Therefore, counselors should be aware of the physical therapy treatment the client is undergoing, as it is likely to play a large part in the discussion. Counselors should be aware of the physical trauma the client went through and be especially understanding and supportive. It is also very useful to involve family members in the process, as the support of family can improve recovery times.
SECTION 7: GROUP THERAPY

WORKING WITH GROUPS

In 1986, Dagley, Gazda and Pistole defined group as “psychologically interdependent and interactive individuals joined in a common goal”. The purpose of group therapy is to use unconscious needs and past experiences to prompt positive change. Since counseling groups may address neurotic (and in some settings, psychotic) disorders, group leaders typically hold advanced degrees in therapy, psychology, social work or psychiatry. Dealing primarily with personal, career, educational or other conscious problems, group therapy requires skilled, but less advanced training. Group therapy is not long-term; resolutions are expected to come in a relatively short time.

Following are some of the most common group classifications by task:

- **Problem solving groups**: Although these groups deal with problems that could probably have been solved through individual effort, the group adds diverse resources, error safeguards and motivation.
- **Education groups**: Exemplified by study groups and designed to advance learning, education groups should have demographically similar members with different ability levels according to Shaw.
- **Experimental groups**: These include T-groups as well as therapy, encounter, personal growth and sensitivity-training groups.
  - Since the idea is that simply being part of the group will be good for its members, screening is almost always recommended.

TYPES OF THERAPEUTIC GROUPS

Categorized by Corey and Corey as T-groups, therapeutic groups include encounter, awareness, self-help and leaderless groups as well as consciousness raising, sensitivity training and personal growth groups.

- **T-groups**: Emphasizing feedback, problem solving and decision making, T-groups aim to improve organizational relationship skills by focusing on the group process.
- **Personal growth and encounter groups**: Typically meeting for a set time, these groups encourage risk taking for personal growth and development.

Gazda recognizes three types of groups:

- **Guidance**: Primarily for prevention of problems facing high-risk populations, guidance groups focus on improvement of life skills and overall direction of members.
- **Counseling**: For secondary prevention and/or correction, these groups include encounter, sensitivity and organizational development groups.
- **Psychotherapy**: Psychotherapy groups are tertiary prevention groups with the purpose of reeducating, rehabilitating and generally bringing members to healthy function.
UNIQUENESS OF GROUP THERAPY

What makes group therapy unique? Factors include:

- **A sense of belonging:** It is part of the human experience to want to belong to a group; For those who feel they are struggling alone with problems, this is especially true.

- **Shared problems:** Knowing others share experiences, thoughts and feelings can be highly therapeutic; In a group, generally at least one other person "gets it" when an individual discusses problems or issues.

- **Support:** In a skillfully led group, the members provide support, understanding and caring; Individuals feel safe, consequently, they are willing to reveal themselves in ways they do not share elsewhere, knowing others will attempt to nurture them regardless of revelations or actions.

- **A microcosm:** Functioning as a little society, most groups contain those with various personalities; Feedback from the other group members can allow a person to see something about himself/herself as a member of society that would not be revealed alone or in a less supportive setting; Social-skill training can often be easily incorporated into a group because of this quality.

- **Information:** A group can be a vital resource for gaining information and advice; Some groups incorporate more advice and teaching than others; Regardless of the group’s style, shared insights are inevitable.

- **Giving:** Being an active member of a group that helps others contributes to each individual’s feelings of value and purpose; What better way is there to strengthen a sense of self than by helping others?

GROUP PROCESS

GROUP CLIENT SCREENING

Screening is absolutely necessary! Although specific groups call for different components, certain similarities exist among groups.

**Selection Of Members**

It is easier to look at who will not be included, but to frame this more positively, it is important to determine who will be successful in the context of a particular group. The closer we can approximate the therapy group in observing individuals, the more accurately we can predict their subsequent in-group behavior. Inclusion does not mean guarantee of success. Patients will fail if they are unable to participate in the primary task of the group.

Sometimes, certain personalities have strong influences on counter group forces, so watch for these when interviewing group members. All of this, of course, is dependent upon the kind of group and possibly technique.

**What Makes A Good Group Composition?**

- **Heterogeneous** - long-term advantages - microcosm
  - Strive for hetero in conflict areas and patterns of coping
Homogeneous - support or systematic relief over brief period of time - built-in cohesiveness
  • Strive for homogeneity in degree of vulnerability and capacity to tolerate anxiety
  • Some degree of incompatibility to stimulate dissonance or incongruity, and thus, change
  • Focus on interpersonal incompatibility (must have ego strength to withstand the conflict)
  • Age: Louis Ormond highly recommends a 20 year span
  • The briefer and more structured, the less important are compositional issues
  • Place/time/size/preparation

The Task Of Therapy Groups
  • Engage in meaningful communication with the other group members
  • Reveal oneself
  • Give valid feedback
  • Examine the hidden and unconscious aspects of one’s feelings, behavior and motivation

Group Deviant
It is best to screen out people who will become marked ‘deviants’.
  • Deviants represent an extreme in at least one of these dimensions:
    • The youngest
    • Unmarried
    • The sickest
    • The only this or that
  • Issues to consider:
    • How might this person impede that progress of the group?
    • Will this deviance be helpful or lead to early drop out?
    • Will this person get satisfaction from the group?
    • Be valued?

THE INTERVIEW
Groups can be complicated. Groups sizes and formats, how long they are and how often they meet, whether involvement in them is voluntary or not, how groups progress, and members' roles all contribute to group dynamics. The American Therapy Association and American Specialists in Group Work both recommend interviewing each prospective group participant to see if he/she will fit into, and benefit from, the group.

The Interview Does Three Things
  1. Screens out psychopaths and sociopaths as well as those who are hostile, egocentric, domineering or suspicious and those who possess inadequate ego strength for group dynamics
  2. Allows potential members to get to know the group leader (although a potential member may already be a client in individual therapy)
  3. Lets the group leader explain members’ rights and the group's goals and format
Interview Questions
As much as possible, the interview should focus on interpersonal functioning. Suggested questions include:

- What is your earliest memory of your mother? Father?
- Describe your best friends and what has become of them.
- Have you experienced any group involvement? What was it like?
- Tell about your memberships, work and other involvements.
- What is your last remembered dream?

Looking for the DSM diagnosis is the least helpful factor to predict group behavior.

Preparing the Client for Group

Common Group Problems

- What does this have to do with my depression?
- High turnover
- Attendance
- Clients may be frustrated about air time and not feel better right away
- Group leader must anticipate and address the frustration
- Sub grouping

Be positive! People want hope that this will help them (not guarantees or promises). Leader should provide facts, personal experience and a rational explanation to demystify the therapy process.

Group Dynamics

- Communication patterns: Paying attention to verbal and nonverbal communication helps the therapist to effectively move toward group goals
- Cohesiveness: Irvin Yalom argues that group cohesiveness is a major factor in a successful outcome
  - Members' strong affinity for each other and toward the group as a whole makes a more open, supportive and accepting group
- Social control: This involves the norms, roles, expectations and status that let groups function effectively, if not always smoothly
- Norms: Rules of behavior may be tacit or explicit, informal or formal, veiled or overt; the therapist tries to head off automatic conforming responses
- Role expectations: Individual group members perform different functions including task and maintenance roles (helping to keep the group on track) and individual roles (often selfishly at odds with group goals)
- Status: Status outside the group combined with behavior in the group, contribute to ingroup ranking of members; willingness to conform to group norms is affected by this status
- Group culture: Arising from beliefs, customs and values of its members and the environment in which a group is set, group culture influences objectives, tasks, interaction and methods
Additionally, as Yalom observed, the group is a therapeutic social system in microcosm, making the group an agent of change.

**R.W. Toseland and R.F. Rivas** list the five theories important to group practice:

- Psychoanalytic theory (Freud, et al.)
- Learning theory (Bandura)
- Field theory (Lewin)
- Social exchange, or interaction, theory (Blau; Homans; Thibaut and Kelly)
- Systems theory (Anderson; Olsen)

**Cartwright and Zander** add four others:

- Sociometric orientation (Jennings; Moreno)
- General psychology orientation (looking at individual group members)
- Empiricist-statistical orientation, or group syntality theory (Cattell)
- Formal models orientation (French & Snyder; Harary, Norman, & Cartwright; Simon)

**Basic Tasks of a Group Leader**

- Create machinery of therapy
- Set the machinery of therapy in motion
- Keep the machinery of therapy operating effectively
- No technique takes precedence over **CHASE** - the core conditions of Charm, Honesty, Acceptable, Self-disclosure (limited) and Empathy (accurate)

**Creation/Maintenance**

- Preparation before group is crucial
- Gate keeping
- Stability
- Therapist is the primary unifying force
- Deter anti-cohesiveness:
  - Continued tardiness
  - Absences
  - Sub grouping
  - Disruptive extra group formation
- Socialization, scapegoating
- The more members want time, the more energy the group will have
- Effective management of the person who takes over (aka: the group hog)
  - "I wonder what hunches you have about the two new members and how they might be feeling today."
- Physical survival of group takes precedence

**Culture Building**

- Unwritten code of behavioral rules, or norms, must be established
- **Therapeutic factors** help guide norm development:
• In individual therapy - the therapist is primary agent of change
• In group therapy - the group AND the therapist are agents of change

GROUP STAGES
Leadership, communication, decision-making and development stages all help form a group’s dynamics. By noting and adjusting group processes as they occur, the therapist/leader both participates in and steers the group toward its goals. Johnson & Johnson demonstrated therapy skills form a practiced combination for both observation of and participation in the group process.

Group Development Stages
Without slighting any individual’s needs, the therapist should try to move the group through several phases. Corey and Corey presented the following developmental stages:

- Initial
- Transition
- Working
- Final
- Post group

Other Designations Include Tuckman's Progression
- Forming
- Storming
- Norming
- Performing

Klein’s Arrangement
- Orientation and resistance
- Negotiation and intimacy
- Termination

GROUP NORMS
It is the therapist’s function to assist members in the development of group norms by:

- Helping members develop norms both indirectly and directly via guidance
- Active involvement
- Non-judgmental acceptance
- Extensive self-disclosure
- Creating a desire for self-understanding within members
- Promoting an eagerness for change

How To Achieve Norms
- Present the group a list, ask them to determine norms from that list
- If facilitative norms will not evolve automatically, you will have to:
  • Intervene to guide group members to be constructive
  • Provide directions (implicit and explicit, verbalize members’ expectations)
• Realize that the leader powerfully influences norms whether or not that is his/her plan
• Know that norms are difficult to change once established

Therapist Roles

➢ As the technical expert, the counselor will:
  • Employ obvious techniques such as giving explicit directions
  • Be aware of subtle reinforcements and less subtle manipulations used (nodding, attending to some statements and not others)
  • Use cues to reinforce increasingly mature behavior patterns as the working through process is a conditioned learning in which overt/covert responses act as rewards or punishments
  • Model OP conditioning
  • Teach by example

➢ Modeling occurs as clients observe therapists, whether the modeling is intentional or not
  • If counselors model acceptance, the group will follow
  • The counselor models with statements such as, “I don’t think it is healthy to….”
  • Respect and appropriate restraint are necessary; total disinhibition is not
  • Limited self-disclosure is good
  • Humor can communicate acceptance and ability to move on
  • The leader must be aware of personal values as they will be revealed in the process
  • If the group has healthy members, less modeling is required

➢ Certain actions hamper the process:
  • The counselor should not be omnipotent, non self-disclosing, overly self-protective or overly cautious
  • The group process does not require the therapist to be confrontive

EXAMPLES OF THERAPEUTIC GROUP NORMS

Self Monitoring Group

➢ As the group begins to take responsibility for its own functioning, the therapist must not allow clients to become spectators
  • The counselor should teach members about "good groups," then transfer the responsibility for the group to them
  • By asking questions such as "Are you satisfied with group today?" the leader shifts evaluation to group members

Self Disclosure

➢ For group function, self-disclosure is necessary but must be paced
  • The therapist must make self-disclosure an explicit expectation
  • The subjective aspect of self-disclosure is key
  • It should be made clear ahead of time that big secrets need to be let out, otherwise group member may guard every possible avenue that leads to them
  • Delay self-disclosure if necessary, but realize too much delay harms the group
  • Vertical vs. horizontal self-disclosure:
  • Vertical self-disclosure – In-depth revelation of a secret
• Horizontal self-disclosure – Meta disclosure about disclosure (feelings about disclosing)
  ➢ Reactions to self-disclosure are the important factor!

Procedural Norms
  ➢ The ideal procedural norm is marked by unstructured, spontaneous and heart-felt interaction
  ➢ If the first person to speak holds the floor all session, ask: “How does the group feel about this process?” rather than making an evaluative statement
  ➢ Some groups have formal checks in place
  ➢ The downside of procedural norms is that they can evoke a then-and-there meeting
  ➢ Specialized groups often require different procedural norms and rituals

GROUP THERAPY TECHNIQUES

BEHAVIOR
Since applied behavior theory says that behavior is a function of its consequences, behavior therapy groups work by modifying observable and measurable behaviors, rather than thoughts, unconscious conflicts or past events. Using positive and/or negative reinforcement, stimulus control, modeling, extinction and other behavior modification techniques tailored to each member's needs, the group leader helps members to exchange negative behaviors for positive ones.

Therapeutic Aspects Of How Groups Help (Ormont)
  ➢ Groups calm self-destructive behavior
  ➢ Groups enable the members to see how others respond to them
  ➢ Group treatment affords the opportunity for immediate self-definition
  ➢ Groups afford diverse views of behavior
  ➢ Groups afford the chance to practice new behaviors

EXISTENTIAL
Existential group work focuses on the subjective aspects of a member's experiences. The central issues in existential group and individual therapy are freedom, responsibility and the anxiety that accompanies being both free and responsible. People become what they choose to become.

Existential crises are seen as a part of living and not something to be remedied. These crises frequently concern the meaning of life, anxiety and guilt, the recognition of one's aloneness, the awareness of death and finality and the fear of choosing and acceptance of responsibility for one's choices. The crisis is not necessarily pathological; it can be externally alleviated, lived through and understood in the context of a group.

Meaning of Life is sought via confronting mortality. The meaning of death is a productive focus for group sessions; from dealing with the concept of death comes realization of the meaning of living. "What does not kill me can only make me stronger." As members of the group imagine a typical day three years previous, questions arise:
• Are there any major differences in life then and now?
• Was life more meaningful then?
• Were you stuck in your comfort zone?
• Was death a meaningful term for living day by day?
• Could you accept your own death more realistically then or now?
• Does anxiety bring harmony?

Group leaders become active agents in the group. Existential therapy is best considered as an invitation to members to recognize ways in which they are not living fully authentic lives; and to allow them to make choices that will lead them to become what they are capable of being. Existential groups focus neither on curing sickness nor on merely providing problem-solving techniques for the complexities of real life.

Existential Vacuum is the condition of emptiness and hollowness that results from meaninglessness in life. A brand of existential therapy that literally means “healing through reason,” Logotherapy was developed by Viktor Frankl and focuses on challenging group members to search for the meaning in life.

The focus on responsibility rather than on social conditions is a limitation of the existential approach in working with a culturally diverse client population.

GESTALT

Gestalt group work is based on the here-and-now. Ensuring they are fully present themselves, the therapist promotes self-awareness and the ability to take responsibility for one’s actions and behaviors. They must help the group develop the skills necessary to satisfy needs without violating the rights of others or one's own moral standards; and develop the willingness to help others and ask for help when needed, moving from environmental support to internal support. A key concept in Gestalt therapy involves the concept of “contact.” Contact happens when a person interacts with another person or the outside world.

Therapy Process

➢ Promote awareness in client through:
  ▪ Insight
  ▪ Self-acceptance
  ▪ Knowledge of the environment
  ▪ Responsibility for choices, actions and behaviors
  ▪ Paradoxical theory of change
  ▪ Ability to make contact with others

The client is expected to do their own seeing, feeling, sensing and interpreting vs. passively allowing the therapist to give insight and answers.

PSYCHOANALYTIC

In group work, it is particularly important to focus on experiences from the first six years of life, because the roots of present conflicts usually lie there. Group work encourages participants to relive significant relationships. Ideally, the group functions as a symbolic family so members can work through these early relationships.
- **Insight, understanding** and **working through repressed material** should be given primary focus in group therapy
- Due to the reconstructive elements of the analytic group, **group work is usually long-term**
- **Object-relations theory** focuses on predictable developmental sequences in which early experiences of the self shift in relation to an expanding awareness of others
  - It holds that individuals go through phases of autism, normal symbiosis, separation and individuation, culminating in a state of integration
- The group therapist frequently makes **interpretation** for individuals in the group session
- In **analytic group therapy**, dealing with **transference** and **resistance** constitutes the bulk of the work
  - **Resistance** in the psychoanalytic approach is viewed as an unconscious dynamic
- **Uncovering early experiences** is the primary goal of analytic group work
- **Free association** can be used for uncovering repressed material, helping members develop more spontaneity, working on dreams and promoting meaningful interactions within the group
- **Psychoanalytic dream work** consists of interpreting the latent meaning of a dream
  - The manifest meaning of the dream is the actual dream
- **Advantages** of group work with a psychoanalytic approach are:
  - Members benefit from each other's work
  - Multiple transferences can be formed
  - Members learn to identify their own transferences
  - The group can function as a family
- Establishing an identity is an ongoing process during most of a life cycle
- **Group disequilibrium** occurs when members experience too little intimacy (isolation) or too much intimacy (engulfment)
- **Group malequilibrium** exists when group members become so comfortable with one another, they avoid challenging each other's defenses

**Psychodrama**

Here, members act out their problems, experiences, wishes and fantasies, with some or all other members playing assigned roles. Personal change and growth come from encountering buried feelings and experiencing new situations. Since the group leader designs and monitors these enactments, obviously his/her knowledge, skill, judgment and good character are pivotal. (Charles Manson is not the model psychodrama leader.)

**Rational Emotional Behavior Therapy**

REBT groups seek to replace members' irrational, self-defeating beliefs with rational, self-enhancing ones. With the leader pointing out applicable unreasonable beliefs, the group examines the problems of one member at a time, confronting, challenging and persuading. This approach encourages members to examine beliefs that are negative and perhaps irrational. Since screening is a part of this model, the group should not be confronted with a member whose beliefs are completely irrational.
TRANSACTIONAL ANALYSIS (TA)

Rather than beginning as an extension of individual therapy, TA started as a specifically conceived group therapy model with an established framework, structure and nomenclature. Open membership and an honest, egalitarian spirit between therapist and members distinguish TA groups, with each member submitting personal decisions to multiple assessments to learn how to make better choices. (Someone's tendentious insistence on "I'm OK, all the rest of you people are schmucks" might argue for membership requirements, but that's NOT part of the model). Members determine how to implement goals they have chosen. The group leader teaches TA concepts/terms and helps members with their self-critiques, getting them to think about their behaviors in terms of TA “life scripts”.

GROUP PROCESSING

RECOGNIZE BEHAVIORAL PATTERNS IN SOCIAL MICROCOSM

Although group members spend only an hour a week together, psychologically the effect is much greater than time alone indicates. If group members feel safe enough to be real, they will behave in an unguarded, unselfconscious way. The social microcosm is real. Clues of behavior patterns include:

- The responses of other members to the behavior
- Repetitive patterns in a person's behavior
- Consensual validation from the group

ROLES OF CLIENTS IN A GROUP

Three types of roles that group members play are:

- Building and maintenance roles, (not the janitorial staff), which are positive
- Group task roles, which help build the group
- Negative individual roles, which hinder group progress

Some Examples Of Building And Maintenance Roles

- Facilitators: Those who like to make others feel at ease
- Gatekeepers or expediters: Those who like things to stay on track
- Conciliators: Those who smooth out conflicts
- Compromisers or neutralizers: Those who offer thinking solutions
- Observers: Those who like to comment on and sum up what is happening
- Followers: Those who help things along by their agreement although they may be unsure of themselves

Some Important Group Task Roles

- Initiators and energizers
- Information and/or opinion seekers and givers
- Coordinators
- Elaborators
FACTORS THAT EFFECT GROUP DYNAMICS AND FUNCTION

Setting: Members should feel secure and comfortable in a private, non-threatening setting. (Having the agoraphobic's workshop meet on the trading floor of the New York Stock Exchange does not meet this criterion).

Size: Groups should be large enough for dynamic interaction and small enough for individual participation. Having more than 10-12 members decreases the likelihood a group will achieve its goals. Other components that effect group’s functional size are:

- The group leader's experience
- Group's purpose
- Members' ages
  - Whether members are adults, teens or children

Format: An open group allows new members to join as others leave. New members can refresh the group, but may have trouble assimilating and can disturb trust and cohesion among earlier members. A closed group keeps only original members throughout its duration. This exclusivity encourages interaction and trust, but can cause problems if too many leave before the group’s conclusion. (As might happen in that ‘fear of commitment’ group.)

Duration and Frequency: The group dynamic is affected by the frequency and duration of meetings. How often and for how long a group meets can depend on ages of members; adults do well with sixty to ninety-minute sessions once a week, while teens and children usually need shorter but more frequent sessions. At the first session, a closed group should determine the duration of treatment.

Voluntary or required participation: Unlike volunteers, people who are required by a mental health center, court or other institution to attend group are, by definition, not self-motivated. In these cases, the therapist may try to spur motivation during the initial interview by allowing the client to gripe about the requirement of group participation.

Developmental stages: Though groups are idiosyncratically different from each other, they have stages with fairly predictable dynamics. First, a group forms, identifies itself and determines goals. Then it begins to work toward these goals, which participants start to assume responsibility for achieving. It is at the end of this working stage that members begin to move toward terminating the group.

**Transference, Countertransference and Transparency**

In group work, a therapist cannot focus solely on transference while at the same time hoping to utilize other potential therapeutic factors.

**Transference**

- Feelings the client projects onto the counselor
Viewed as new editions of old impulses, transference provides false connections
Providing an analysis of transference is a major task of the therapist
Interpretation is a key aspect of transference
It has to do with relationships the client has experienced in the past
Intensity of feelings has to do with unfinished elements of the client’s life
Client may identify characteristics in the therapist that are reminiscent of the person they are transferring their emotions from
Feelings can be productively explored so the client becomes aware of how they are keeping an old pattern functional in other present time relationships
Therapy becomes an ideal place to become enlightened to patterns in relationship of psychological vulnerability
Clients gain insight into how their unresolved issues lead to dysfunctional behavior
Ask the client to tell more about how the therapist has affected them to elicit additional information about how the client developed the transference
Do not become defensive:
• You might say: “I wonder if I remind you of anyone you have had similar feelings with?”
There is potential for rich therapeutic progress
Carefully take on a symbolic role and allow the client to work through their unresolved conflict

COUNTERTRANSFERENCE
Feelings aroused in the counselor by the client
Feelings have to do with unresolved conflict from other past or present relationships, rather than the therapeutic relationship with this particular client
Discuss how you are affected by certain clients in supervision with a colleague
Get other’s perspectives on whether you are maintaining unconditional positive regard
Self-knowledge is the basic tool in dealing with countertransference
Unacknowledged, this can lead to an unproductive group
• If leaders are not willing to deal with their own issues, how can they expect clients to do so?
Countertransference in groups can be indicated by exaggerated and persistent feelings that tend to recur with various clients of different groups

Yalom On Transference
It does happen
It is important to understand
A therapist who either attends only to transference or denies it is blinded
Some clients require transference; others do not
Attitudes toward therapists are not all distortions
Transference In Therapy Group

- Group therapy may provide a microcosm of how people function in general social settings.
- Most clients have issues with parental authority, dependency, autonomy, rebellion or their relationships to God, any of which may be personified by the therapist.
- To be aware of dependency, the therapist should watch seating patterns.
- Patients distort.
  - Research shows they perceive the therapist in very different manners and perceive each other relatively accurately.
- The therapist needs to beware of favorite child syndrome.
  - Treating all clients as equally as possible, it is important that the leader have no favorites.
  - Particularly because, transference leads clients to see the therapist as superhuman, that his/her actions are important so what you do and don’t do matters.
- At times, members challenge the therapist continuously; other times, they are subservient and compliant.

Why Leaders Are Seen Unrealistically

- True transference or displacement.
- Conflicted attitudes toward authority.
- Existential dread causes members to imbue therapists with godlike qualities.

Approaches To Facilitate Transference

- Transference occurs; resolution is the goal.
- Consensual validation allows members to validate their impressions regarding others in the group.
- With increased therapist transparency, the counselor:
  - Is able to share personal feelings.
  - Refute incorrect motives/feelings attributed to him/her and to examine personal blind spots.
  - It is vital to respect the feedback offered.
- As time goes on, the therapist interacts more with each of the members.
- Interpersonal learning occurs as the therapist and group interact.

TRANSPARENCY

The goal of transparency for the psychotherapist is the demystification of therapy. Greater transparency challenges the old authoritarian model of mystical healer who met the patient’s needs for a superior being.

- Although the therapist must be real, therapeutic factors are equal to or more important than the illumination provided by transparency.
- Some therapists fear escalation.
  - Thinking the group will continue to demand increasing self-revelation.
  - Actually, group members want to retain the therapist as somewhat mystical.
- Autonomy and cohesiveness are increased as authoritarianism decreases.
Pitfalls Of Transparency

- Extreme freedom and spontaneity achieve tyranny rather than freedom
- The balance between transference and transparency must be found

Research Indicates

- Group members tend to prefer leaders who disclose personal and professional ambitions or goals and emotions such as loneliness, anger or sadness
- Negative emotions expressed to one member or about the group experience (such as boredom) tend to be received negatively

Is It Healthy To Be Completely Transparent?

According to Yalom:

- No, some concealment helps retain social order
- Freedom to self-disclose should be balanced by responsibility
- As delineated by Frankl:
  - Freedom is possible only when coupled with responsibility
  - People can be destructive
- Responsibility, rather than total disclosure, is the superordinate principle
  - For this reason, the therapist should not be completely self-disclosing
  - Holding back can be an aid to the group
  - The therapist should not disclose if unsure that it is best for the group
  - Processing must follow disclosure

When Receiving Negative Feedback

- The therapist must take it seriously by listening, considering and responding to it
  - To do otherwise, increases the patients’ sense of impotence
- The next step is to obtain consensual validation, determining what other members feel
  - Is the feedback primarily a transference reaction, or does it closely correspond to reality about the therapist?
  - If it is reality, the therapist must confirm it
  - Otherwise, comparison is preferable to facilitate a patient’s reality testing
- Another check is internal experience
  - Does the feedback fit?
  - What questions does it answer and why?

COHESIVENESS

Research indicates that individual therapy works and so does group - but WHY?

- The quality of treatment is not dependent on theoretical orientation
- Cohesiveness is provided by factors that propel a person to remain in group therapy; conditions for cohesion include:
  - Warmth
  - Comfort
• Sense of belonging
• Value placed upon the group
• The feeling of being unconditionally accepted
  ➢ Esprit de corps and individual cohesion (the attraction of an individual to the group) are interdependent
  ➢ Cohesiveness can be considered as the sum of feelings of togetherness of all members

Understanding Group Cohesiveness

By definition, cohesiveness refers to the attraction that members have to their group and to its members. Members of cohesive groups are supportive and accepting of each other and inclined to form meaningful relationships within the group. Cohesiveness seems to be a significant factor in successful group therapy outcomes.

Those with a greater sense of solidarity or wellness value the group more highly and will defend it against internal and external threats via voluntary attendance, participation in sessions, mutual help and upholding the group standards.

Cohesiveness As A Therapeutic Factor In Group Psychotherapy

Being accepted by others despite personal fantasies of being unacceptable or unlovable is a potent healing force. Provided a person adheres to the group’s procedural norms, the group will accept that individual regardless of his past life transgressions or perceived social failings. Deep human contact is experienced.

Responding as if the group were watching actions outside sessions, individuals may internalize the group’s attitudes and standards. Often therapeutic changes persist and are consolidated because the members are disinclined to let the group down.

Yalom concluded, group cohesiveness is in itself of therapeutic value and is essential for perpetuation of the group.

Common Group Tensions
  ➢ The struggle for dominance
  ➢ The antagonism between mutually supportive feelings and sibling rivalries
  ➢ The conflict between greed and selflessness in helping others
  ➢ Choices between the desire to immerse oneself in the comforting waters of the group and the fear of losing one’s precious individuality
  ➢ Choices between the wish to get better and the wish to stay in the group
  ➢ Choices between the desire to see others improve and the fear of being left behind

These tensions may be quiescent for months until some event wakens them.

Primary Task And Secondary Gratification

Simply stated, the primary task of the patient is to achieve his/her original goals: relief of suffering, improved relationships with others or a fuller and more productive life. Goals may be unconscious or, even if conscious, well hidden from others; they do not form part of the patient’s initial contract. In fact, much therapy may need to occur before a patient can formulate an
appropriate primary task. In each instance, the patient’s pathology obstructs pursuit of the primary goal. Certainly patients recreate their interpersonal worlds in the social microcosm of the group.

**Resistance And Acting Out**

To Yalom, acting out differs slightly from resistance. To express feelings in the therapeutic process, the therapist must have reasonable confidence in their appropriateness. When the counselor responds unrealistically to a patient (on the basis of countertransference or possibly because of pressing personal problems), the presentation of feelings may even become anti-therapeutic. It is vital for the therapist to know himself/herself and to trust personal feelings as guidance for recognition and understanding of the group process. Personal psychotherapy may be needed.

Throughout therapy, patients are asked to think, to shift internal arrangements and to examine the consequences of their behaviors. It is hard and frightening work, and often unpleasant. The therapist needs to get the group involved in the describing process. Interpretative interventions should be positive, supportive and inquisitive.

**How Does Process Illumination Lead To Change?**

- Through feedback and later through self-observation, members learn to see themselves as they are seen by others
  - “Here is how your behavior makes others feel.”
- Members learn about the impact of their behaviors upon other members
  - “Here is how your behavior influences the opinions others have of you.”
- Members learn that others value them, dislike them, respect them and avoid them all because of their behaviors
  - “Here is how your behavior influences your opinion of yourself.”

Once patients reach the understanding that some behaviors are not in their own best interests and that relationships to others result from their own actions, they have come to a crucial point in therapy. At this point, the therapist can help remove encumbrances including disturbing motive, reactive motive and solution.
SECTION 8: PROFESSIONAL TOPICS

PROFESSION DEFINITIONS

➢ Neuropsychologist
  • Conducts behavioral test on people with brain damage or brain diseases to determine what the person can and cannot do and to monitor improvements or deterioration over time
  • Most neuropsychologists work in hospitals or clinics and have a mixture of psychological and medical training

➢ Behavioral Neuroscientists
  • Investigate how functioning of the brain and other organs influence behavior

➢ Neuroscientist
  • Studies the anatomy, biochemistry and physiology of the nervous system

➢ Neurologist
  • Treats people with brain damage or diseases of the brain

➢ Neurosurgeon
  • Performs brain surgery

Neuropsychology

An area of psychology and neurology, neuropsychology focuses on understanding the structure and function of the brain as it relates to the psychological processes as well as overt physical behaviors.

In practice, a neuropsychologist can be:

➢ Clinical researchers
➢ In clinical settings assessing or treating patients with neuropsychological problems
➢ In forensic settings
  • Assessing people for court cases
  • Working with offenders
  • Appearing in court as expert witness
    1. Consultants for product design
    2. Managers of pharmaceutical clinical-trials research for drugs that might have a potential impact on CNS functioning

GENOGRAMS

First developed and popularized in clinical settings by Monica McGoldrick and Randy Gerson, genograms were developed principally within the context of Murray Bowen’s intergenerational family systems theory. Genograms offer an efficient and effective process for explaining repetitive behaviors and patterns. Essentially, genograms are graphic representations of an individual’s extended family that typically cross at least three generations.

➢ Use of genograms implies a respect for intergenerational family experiences as historical antecedents to contemporary areas of strength and difficulty
Most genograms include basic information about:
- Number of families
- Number of children in each family
- Birth order
- Deaths

Some genograms include information on disorders running in the family such as:
- Alcoholism
- Depression
- Diseases
- Alliances
- Living situations

Genograms reflect an individual’s point of view
- Although most members of a family agree on the basics of a family tree, there may be major differences when describing the relationships among family members

Interpretation is influenced by the creator of the genogram
- There is no absolute “right” genogram for one family
- Different family members may have differing perspectives on the relationships in the family and may therefore construct genograms of the same family very differently

**Scaling Questions**

Used primarily in solution-focused brief therapy, scaling questions are used to track differences and progress in the client.

- Helpful in prioritizing goals
- Ranges of a scale can be defined each time a question is made
- Typically, they range from worst (zero) to the best (ten)
- Client may rate the same question repeatedly as therapy progresses
- Client may be asked to identify times when they felt lower on the scale
- Establishing goals or generating solutions comes from having the client identify what a higher score will look like for them and what they need to achieve it
- Strength focused questions include:
  - “What have you done to get to this (higher) score?”
  - “What has stopped you from slipping one point lower down the scale?”
- Exception questions include:
  - “Have you ever been higher on the scale?”
  - “What is different on the days when you are one point higher on the scale?”
  - “How would you tell that it was a 'one point higher' day?”
- Future focus questions include:
  - “Where on the scale would be good enough for you?”
  - “What would a day at that point on the scale look like?”
**DIAGNOSTIC INTERVIEWING TECHNIQUES**

Individually and culturally appropriate verbal and nonverbal behavior while working with clients is central to good interviewing skills. This demonstrates that you are listening and encourages the client to talk more freely.

**Questioning**
- Ask the patient direct questions in areas determined by interviewer
- Questioning may be open or closed
  - **Open** - allows unlimited answer options, helps the client explore issues and talk at greater length
  - **Closed** - allows for Yes, No or one word answers, leads Client to focused answers, usually relatively short

**Reflection**
- Restates the patient’s cognitive or emotional material
- Identifies and feeds back the underlying emotional experience
- Demonstrates empathic understanding
- Some therapists rely heavily on patient reflection
- Overuse is counterproductive - important areas are left unaddressed
- Reflection is a type of intervention that clarifies and joins themes

**Restatement (Paraphrasing)**
- Rephrase what the client says
- Accurately "give back" to that person what he/she has said
- Demonstrate you are actively listening
- Paraphrases can serve three purposes:
  - Convey to the client that you are with him
  - Crystallize a client's comment by making it concise
  - Provide a check on the accuracy of the perceptions of the session

**Encourages**
- Brief responses such as head nods, "uh-huh" and single words or phrases
- Lead the client to explore in more depth
- Feeds back what the client has said
- Provides a check on accuracy and lets client move on

**Clarification**
- Accompanied by utilizing other techniques such as questioning, paraphrasing and restating
- Shows understanding of the client in the interview
- If done from a not knowing stance, it should not invoke defensive response

**Confrontation**
- May be used to call a patient out on discrepancies
- It is often used with substance abusers in order to break denial and/or rigid defenses
Confrontation also may increase anxiety and avoidance, but is necessary and can be constructive.

**Self-Disclosure**
- The sharing of personal experiences by the therapist to the patient relative to the session with the purpose of helping them understand.
- It is intended to help the patient be more readily open and more comfortable disclosing personal issues.
- However, it should be used minimally.
- The therapist must be careful not to cross boundaries.

**Silence**
- While this may occur unintentionally, there are many benefits if it is used correctly.
- Provides both the patient and therapist time to process what is being understood.
- Timing is essential.
- Promotes introspection.

**Exploration**
- Therapist tests the limits of what the client is willing to process.
- May be used to determine the client’s level of insight.

**Reframing Or Cognitive Reframing**
- Allows for a different perspective.
- Used to challenge negative self-concepts and harmful thinking patterns.
- The purpose of reframing is to lead to behavioral change.

**Summarization**
- Overall feedback of longer statement.
- Used in key segments of session.

**Integration Of Skills: Five Interview Stages**
1. Accentuate the positive (but be aware of the negative).
2. Be careful of only seeking war stories.
3. Be careful of rescuing (not letting the client "feel bad").
4. If therapist avoids hard issues, so will the client.
5. Focus on the positive; search for positive assets in the client and the situation.

**Keys For Effective Helping: Respect Yourself And The Client**
- In the beginning, develop a solid theory and philosophy of helping.
  - Respect and have confidence in yourself.
  - Develop your own style, make sure it feels right to you, be natural.
  - Respect the client.
- Are you willing to listen and to learn from the client?
  - Avoid the temptation to solve the problem immediately.
  - You must be willing to do the work to be an effective listener.
- Basic attending skills, cultural empathy and basic trust.
Building a Successful Relationship With a Client

As the first phase of treatment, the initial interview provides the opportunity for a counselor to establish rapport, trust and effective communication. This goal is primary. The second goal is discovery of the problems and the expectations of the client. And third, the counselor should strive to ascertain what therapy goals should be completed and create a contract with those in mind.

In order to accomplish these goals, it is fundamental that the counselor and client communicate effectively. When building this relationship, it is vital to radiate an air of comfort and emotional warmth. By exhibiting a personal interest in helping while trying to ascertain what skills the client has, the counselor can convey respect for the client. One effective technique is striving to understand the client’s feelings regarding seeking professional help. Most important is comprehension of the client’s problems, an understanding that makes problem solving more effective. Additionally, identifying potential barriers to effective communication and treatment is essential.

Responses Of The Counselor To The Client

Throughout the entire counseling relationship, techniques of response to the client are important. Responses must be appropriate to the therapy being used. If reality therapy is being employed, confrontation may be appropriate early in counseling; if some other form of therapy is being used, such as client-centered counseling, then confrontation may not be part of therapy. Common appropriate responses by counselors include the following:

- Attending
- Paraphrasing
- Reflecting
- Clarifying
- Leading
- Summarizing
- Supporting
- Approving
- Confronting
- Interpreting
- Informing
- Instructing
- Assigning tasks and contracting
In the first response, **attending**, the counselor needs to merely listen closely to the client. Sitting forward slightly in a relaxed manner and making eye contact with the client are components of the response.

In **paraphrasing**, one basic task is to hear the client clearly and let them know they have been heard. The counselor takes a statement the client has made and restates it in more condensed terms and in different words. For example, the client might say, “My husband’s death caused my entire life to fall apart. So I began drinking a lot to cope with all the decisions that were placed on me. My husband used to make all the decisions. Now I need a job to support my children, and I’m in too bad a condition to get one.” A good response on the counselor’s part might be, “After your husband died, you had all the responsibilities and decisions placed on you.” When paraphrasing a client’s message, the counselor should not include emotional aspects of the client’s statement. The objectives of a paraphrase are to allow the client to see that the counselor comprehends the message, as well as enabling the client to remain focused on a particular topic and to consider it more deeply.

**Reflecting** involves restating the effective section of the client’s message. In reflection, the goal is to demonstrate emotional awareness of the content so the client feels understood by the counselor. This in turn increases openness and emotional expression by the client. It has been shown, reflection allows anger on the part of the client to diminish.

**Clarifying** is one response method used by counselors to define vague or perplexing words clients use in their conversations. Some messages that may need clarifying are made up of inclusive terms, such as the pronouns ‘they” or ‘them,” ambiguous phrases such “you know,” or words that have more than one meaning such as “stoned” or “trip.” For example, a client may declare, “I simply want to get away from it all sometimes.” An appropriate clarifying response from the counselor could be, “Describe to me, if you can, what you mean by getting away from it all.” Any time a counselor feels the message is unclear, he/she may use clarification to extend comprehension. Clarification also assists the client in better understanding the actual meanings of statements made.

**Leading** is a response method used by counselors whereby the counselor encourages the client to discuss a specific aspect of himself/herself or an experience by directly or indirectly inviting a verbal response. In a direct lead, the counselor identifies the specific subject matter and encourages the client to continue in the same vein. For example, if a client declares, “My wife believes that my drug use is a cover so I can avoid sharing my real feelings with her,” a counselor responding with a direct lead might counter, “How did you feel when she said that?” Indirect invitations provide open parameters within which the client can express feelings and thoughts. If a client states, “I actually feel good today for the first time in a while,” and the counselor responds, “Please continue,” the counselor has used an indirect lead.

**Summarizing** is an effective method for responding to a client by connecting several topics and feelings. Summarization should center on the themes that the client mentions more than once, connecting several components of a message or calling attention to a familiar theme from multiple messages. If a client is rambling or speeding over multiple issues, summarizing can bring focus to a counseling session. A client declares, “It’s hard for me to be friendly with my supervisor because he’s always bossing me around. The reason I drink during lunch break is
because of him. I can do my job better than he can. It’s not fair. This isn’t the first time I’ve been in this situation; it’s happened at every job I’ve had.” The counselor might summarize, “Bosses who wield power over you seems to be the major difficulty you have with jobs.” In this example, the counselor summarizes past statements and includes several components from the current one.

The summarization skill may be helpful to:

- Begin a session: "In our last session we talked about__." 
- Clarify what is happening, particularly when the session is complex: "Could we stop for a moment and see where we are at this point?
- Provide smooth flow from topic to topic during the session: "So far you've been saying__." 
- Bring together what has been happening in the session over the entire period of a session: "Today, we talked about__." 
- Bring together threads of data over several sessions: "Last week you said ___ and today you say___."

Supporting can be used to demonstrate that the counselor has listened to what the client has said and does not believe the thoughts, feelings or behaviors to be odd. When dealing with a client who expresses intense concern, anxiety, frustration or panic, a supportive response can help decrease the feelings. For example, a client remarks, “There’s no way anyone can help me because I have so many problems. Drugs and alcohol are only a piece of the picture. I’m on the edge all the time, and I don’t know why. What’s wrong with me?” The counselor’s supportive response may be, “Right now you are feeling tense and upset and have thoughts that you don’t grasp. People who have problems like this find talking to a counselor helps them to resolve their issues.”

An effective technique for reinforcing concrete and ideal alterations in a client’s feelings and behaviors is approving. This is a response most commonly used in the latter stages of counseling. A client reveals, “After a while, I just got plain sick of allowing criticism from my husband when I didn’t actually know what I’d done wrong to offend him. So I finally just asked him what I’d done and whether or not it was so bad that he needed to criticize me so strongly.” The counselor using approval may reply, “That was handled well. You questioned him instead of just accepting his criticism.”

An example of confronting is demonstrating to a client discrepancies found in a single verbal message. A client relates, “Every weekend my husband gets drunk with his friends when he’s out. So the next day when he’s with me, he’s too hung over to do anything. It seems like our relationship should be more special to him than it is, but I don’t mind very much what he does because he works hard and needs a break.” In confrontation, the counselor could respond, “You mentioned first you don’t care about his behavior, but then you said you are distressed that your relationship is more important to you than it is to him.”

Differing from reflection, clarification, paraphrasing and summarization, interpreting deals with the implicit components of a client’s statement. It is important for interpretational responses to be used only after a solid relationship has been developed between a client and the counselor. For example, a client may remark, “Things are dull right now. I’d sure feel good if I had some good
friends, good drugs and some money.” An appropriate interpretational response from the counselor could be, “I take it you feel you need friends, money and drugs to be happy and experience positive self-image feelings.” Of course, interpretive responses from counselors are based at least somewhat on their theoretical orientations. The example above reflects an Adlerian orientation; counselors using other approaches may interpret the client’s message in another manner.

A counselor who is informing gives a client important information regarding alternatives, decisions or plans the client is considering. If a client states, “Despite the fact I know the consequences of my actions, it’s hard for me to say ‘no’ to drugs,” the counselor may respond by giving information - not advice. “Let’s look at how your family reacted to things when you were younger. Habits we use as adults are frequently patterns we picked up from our families. Frequently, this happens without us recognizing it.” Giving information is different from giving advice because it allows the client to retain responsibility for their action and choices. By providing the facts, alternatives or available resources, the counselor gives the client the right and responsibility to choose which information he/she will use. Information is most effectively provided when the client has needs the information specifically addresses. Under no circumstances is information to be used to force the client to act in a certain way.

Instructing is designed to enable the client to identify behaviors suitable for certain circumstances. Useful for situations when a client is striving to meet a goal or when a client needs to learn an adaptive reaction, instruction can sometimes be effectively achieved by role-playing. In an example of role-playing, the client pretends to approach someone of the opposite sex by saying, “Hi. How are you doing today, Melissa? I noticed you weren’t at work yesterday. I hope everything was okay and you weren’t sick or anything like that.” Taking the part of Melissa, the counselor responds, “Hi, John. No, I wasn’t sick yesterday; I had a dentist appointment. But thank you for asking, I appreciate your concern.” After the role-play, the counselor gives his/her opinion regarding the client’s performance. This particular role-playing example is directed toward meeting the client’s objective of relieving anxiety around members of the opposite sex.

The last method that a counselor can employ when responding to a client’s message is assigning tasks and contracting. This may be done via a written or spoken formal or informal contract. This response encourages the client to implement changes in real life that have been learned in counseling sessions. Until it has been practiced and rehearsed in counseling, a task should not be assigned by the counselor. A formal contract may include specific goals. If tense situations have previously caused a client to abuse alcohol or drugs, the contract may specify details and timing of visualization or muscle relaxation exercises to be performed instead. On the other hand, a contract may be very non-specific and informal, providing only general guidelines to block thoughts that pertain to using alcohol or drugs.
REFERENCE MATERIALS

MEDICATION SIDE-EFFECTS AND CLASSIFICATION WEBSITES

- AllPsych Online
  http://allpsych.com/meds.html
  - One of the largest psychology websites on the Internet
  - Holds over 920 individual, cross-referenced web pages and an estimated 3000 pages of printed material
  - It is referenced by over 100 colleges and universities in ten countries
  - It provides:
    1. Drug name
    2. How they work
    3. What they treat
    4. Possible side-effects

- SEDBASE
  - This is a full text database which critically analyzes the published drug side-effect literature on drugs currently in use
  - Drug class chapters are prepared by recognized authorities who critically assess published literature each year
  - The goal of the database is to document every drug known to have a side-effect reported in the literature
  - It is organized by drug class chapters and does not contain any speculative or unsubstantiated statements
  - Some of the specific areas covered include:
    1. Adverse drug reactions
    2. Drug interactions
    3. Drug toxicity
    4. Special risk situations
    5. Pharmacological or patient-dependent factors associated with the occurrence of side-effects

MEDICATIONS USED IN TREATMENT

Attention-Deficit Hyperactivity Disorder (ADHD)

Medication

- Most Common
  - Brand Name
  - Methylphenidate
    - Ritalin
      - Helps to better focus their attention
      - Always be aware of a patient taking this medication (how much, how often, when) it could affect counseling sessions
  - Atomoxetine
    - Strattera
      - Increases levels of norepinephrine and helps control behavior
• Do not give to patients with heart problems as Atomoxetine may cause sudden death

**Conduct Disorder**

**Medication**

- **Most Common**
  - **Brand Name**
  - Methylphenidate: Ritalin
    - Alleviates aggression, sudden changes in mood and disobedience
    - Most effective in children five to eight
  - Divalproex: Depakote
    - Helps reduce belligerence and anger
  - Lithium: Lithobid
    - Helps reduce aggression

**Elimination Disorders: Enuresis**

**Medication**

- **Most Common**: Heterocyclic Antidepressants
  - **Brand Name**
  - Imipramine: Tofranil
    - Antidepressant that helps reduce frequency of wetting
    - Should only be used for a maximum of 3 months

**Separation Anxiety Disorder**

**Medication**

- **Most Common**: SSRIs (Antidepressant)
  - **Brand Name**
  - Fluoxetine: Prozac
  - Sertraline: Zoloft
  - Paroxetine: Paxil
    - Helps to relieve anxious symptoms and calms nerves

**Delirium**

**Medication**

- **Most Common**: Neuroleptics
  - **Brand Name**
  - Haloperidol: Haldol
  - Risperidone: Risperdal
  - Olanzapine: Zyprexa
    - Help to alleviate symptoms of Delirium such as severe agitation and hallucinations

- **Most Common**: Benzodiazepines
  - **Brand Name**
  - Diazepam: Valium
    - For Delirium due to drug withdrawals
Dementia

Medication

- **Most Common:** Hydroxyzine
  - Brand Name: Vistaril
  - For those who develop increased irritability, a mild tranquilizer used for short-term treatment to help alleviate tension and nervousness

- **Most Common:** Memantine
  - Brand Name: Namenda
  - Helps to improve cognitive and mental abilities such as memory, language and logic in Alzheimer patients
  - Helps to provide more clarity in thought processes
  - (Note: Alzheimer drugs can only reduce symptoms but cannot cure the disease itself)

- **Most Common:** Donepezil
  - Brand Name: Aricept

- **Most Common:** Ticlopidin
  - Brand Name: Ticlid
  - Serves as an antiplatelet drug to help with Vascular Dementia

Substance Related Disorders

Medication

- **Most Common:** Alcohol Withdrawal
  - Brand Name: Valium
  - Diazepam
  - Oxazepam
  - Chlordiazepoxide
  - Benzodiazepines used in treatment of Acute Alcohol Withdrawal symptoms work on the central nervous system to create a calming effect

- **Most Common:** Opioid Abuse
  - Brand Name: Dolophine
  - Methadone
  - Methadone Maintenance Therapy is used against heroin, morphine and other narcotic addictions
  - The downsides to this drug are:
    1. The many side-effects, including death when mixed with certain other drugs
    2. The fact that it too can trigger dependence and its own withdrawal symptoms

Schizophrenia And Other Psychotic Disorders

Medication

- **Most Common:** Antipsychotics
  - Brand Name: Thorazine
  - 1st Generation
  - Chlorpromazine
  - Haloperidol
  - Olanzapine
  - Clozapine
  - 2nd Generation
  - Zyprexa
  - Zyprexa
  - Clozaril
  - Clozaril
  - (Note: Clozaril must be monitored biweekly - danger for major drop in white blood cells)
• Antipsychotics help to better control psychotic effects - 2nd Generation drugs are now preferred due to less side effects

**Depression**

**Medication**

- **Most Common:** SSRIs (*Antidepressant*)  
  - Fluoxetine  
  - Sertraline  
  - Paroxetine

  - These *selective serotonin reuptake inhibitors* (SSRIs) are antidepressants that inhibit the uptake of serotonin

- Other antidepressants are the *tricyclic* class such as Tofranil, Elavil, and Anafranil

- And the *Monoamine Oxidase (MAO) Inhibitors* such as Parnate, Nardil and Marplan
  - These, like the heterocyclics, help improve the patient’s mood, alleviate anxieties, boost energy and help the patient sleep more normally
  - However, tricyclics have more possible side-effects than SSRIs
  - And MAO Inhibitors carry strict dietary regulations (patients cannot eat foods rich in the amino acid tyramine)

**Major Depressive Disorder**

**Medication**

- **Most Common:** SSRIs (*Antidepressant*)  
  - Fluoxetine  
  - Sertraline  
  - Paroxetine

  - Usually prescribed are SSRIs similar to ones used for Depression or *tricyclic* antidepressants for extremely severe cases

**Dysthymic Disorder**

**Medication**

- **Most Common:** SSRIs (*Antidepressant*)  
  - Fluoxetine  
  - Sertraline  
  - Paroxetine

  - Tricyclic antidepressants can be used if SSRIs are not effective

**Bipolar Disorders**

**Medications**

- **Most Common:**  
  - Lithium

  - Brand Name: Lithobid
• Helps to stabilize mood and to control the typical switching from depressive to manic stages

➢ **Most Common:** *Anti-convulsants*  
  **Brand Name**  
  Divalproex  
  Depakote  
  • For mild Bipolar Disorder  
  • Stabilizes mood, prevents mania and to a certain extent depression

➢ Neuroleptic medication in small doses may help hypomanic episodes  
  • Larger doses may be needed to treat any mania

*Please make note:* These and other psychotherapeutic medications offer special concerns with children, elderly and women who may be pregnant (the latter being advised to stay away from them while pregnant or nursing).

**Generalized Anxiety Disorder (GAD)**

**Medication**

➢ **Most Common:** *Antidepressants (Anxiolytics)*  
  **Brand Name**  
  Diazepam  
  Valium  
  Alprazolam  
  Xanax  
  • Helps patient to relax, think clearer, sleep better and lead a more normal life

  **Nortriptyline**  
  **Tricyclic Antidepressants**  
  **Pamelor**  
  **Amitriptyline**  
  **Elavil**  
  • Tricyclic antidepressants have been found to be as effective as anxiolytics in the treatment of GAD
  • Tricyclics seem more efficacious in treatment of the negative effects and cognitions, while anxiolytics seem to act on somatic symptoms

  **Buspirone**  
  **BuSpar**  
  • Alleviates anxiety and is less addictive than other drugs

**Panic Disorder**

**Medication**

➢ **Most Common:** *Antidepressants*  
  **Brand Name**  
  Fluoxetine  
  Prozac  
  Sertraline  
  Zoloft  
  Paroxetine  
  Paxil  
  • Inhibit the uptake of serotonin, relieving symptoms of anxiety

  **Diazepam**  
  **Benzodiazepines**  
  **Valium**  
  **Alprazolam**  
  Xanax  
  • Benzodiazepines have a rapid response time so they are ideal in treating patients with extreme symptoms
  • Very addictive and difficult to cease taking these drugs
Obsessive-Compulsive Disorder (OCD)

Medication

- **Most Common:** *SSRIs (Antidepressant)*  
  - Fluoxetine  
  - Sertraline  
  - Paroxetine  
  - Inhibit the uptake of serotonin

Posttraumatic Stress Disorder (PTSD)

Medication

- **Most Common:** *SSRIs (Antidepressant)*  
  - Fluoxetine  
  - Sertraline  
  - Risperidone *Antipsychotic/Mood-stabilizer*  
  - Risperdal  
  - All medications are used to alleviate the symptoms of PTSD such as reoccurring memories, shock and emotional numbness

Somatoform Disorders

Medication

- **Most Common:** *SSRIs (Antidepressants)*  
  - Fluoxetine  
  - Sertraline  
  - Amitriptyline *Tricyclic Antidepressants*  
  - Elavil  
  - Used primarily to help alleviate Pain Disorder

Factitious Disorders

Medication

- No medications are used to treat Factitious Disorder

Dissociative Fugue

Medication

- Medications are generally not used to treat Dissociative Fugue, though antidepressants or antipsychotics may be used to treat certain symptoms

Eating disorders: Anorexia Nervosa

Medication

- Medications have no direct use with Anorexia Nervosa
Bulimia Nervosa

Medication

- **Most Common:** SSRIs \(\text{(Antidepressants)}\)
  - **Brand Name:**
    - Fluoxetine: Prozac
    - Sertraline: Zoloft
  - Helps to improve mood and lower occurrences of binges

Sleep Disorders

Medication

- **Most Common:**
  - **Brand Name:**
    - Zolpidem: Ambien
  - Helps patient fall asleep quicker and easier by slowing brain activity
- **Most Common:** Antidepressants
  - **Brand Name:**
    - Trazodone: Desyrel
  - Causes some sleepiness
- **Most Common:** Benzodiazepines
  - **Brand Name:**
    - Diazepam: Valium
    - Alprazolam: Xanax
  - Helps to better parasomnias such as Night Terror and Sleepwalking

**INTERNATIONAL STATISTICAL CLASSIFICATION OF DISEASES AND RELATED HEALTH PROBLEMS (ICD)**

- Classification system for diseases including a directory of symptoms, complaints and external causes of injury or illness
- Published by the World Health Organization
- Used by hospitals and healthcare facilities to best describe clinical assessment of a client

**RELATIONAL DIAGNOSTIC TESTS**

- **Marital Satisfaction Inventory (MSI)**
  - Assesses the nature and extent of conflict within a marriage or relationship
  - It is a tool to use at the beginning of marital therapy to guide subsequent treatment
  - It helps couples communicate hard-to-express feelings, providing an easy, economical way to gather information about a broad range of issues
  - It also helps identify relationship issues that may be contributing to individual or family problems:
    1. Depression
    2. Substance abuse
    3. Trouble with children or adolescents

- **Dyadic Adjustment Scale (DAD)**
  - 32-item measure of marital quality & marital adjustment
  - Four subscale measures:
1. Marital satisfaction
2. Cohesion
3. Consensus
4. Affective expression
   • Can be used to evaluate dyadic adjustment in distressed and non-distressed relationships
   • Important areas of dyadic functioning such as marital finances and communication

➢ **Family Environment Scale (FES)**
   • 90-item true/false measure
   • Assesses how family members perceive their family environment along three domains:
     1. Relationships
     2. Personal growth
     3. System maintenance
   • Developed to measure social and environmental characteristics of families
   • Based on a three-dimensional conceptualization of families:
     • Real Form (Form R) measures people’s perceptions of their actual family environments
     • Ideal Form (Form I) rewords items to assess individuals’ perceptions of their ideal family environment
     • Expectations Form (Form E) instructs respondents to indicate what they expect a family environment will be like under, for example, anticipated family changes

➢ **The Family Questionnaire (FQ)**
   • Brief measure of perceived criticism and over-involvement

➢ **The Family Assessment Device (FAD)**
   • 60-item scale that assesses the six dimensions of the McMaster Model of Family Functioning
   • This includes:
     1. Communications
     2. Problem solving
     3. Effective responsiveness
     4. Effective involvement
     5. Roles of each family member
     6. Behavior control

➢ **Interview-Based Family Assessment Instruments**
   • More labor intensive and require rater training
   • Provide an outside perspective on how a family functions, compared to other families

➢ **The Camberwell Family Interview**
   • Requires extensive training
   • Used to assess levels of criticism and over-involvement

➢ **The Five Minute Speech Sample**
   • Method of assessing expressed emotion in relatives of patients with psychiatric disorders

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The McMaster Clinical Rating Scale (MCRS)
- Based on a family interview conducted by a rater
- Assesses the same six dimensions of family functioning as the FAD, in addition to assessing the overall health or pathology of a family
- Inter-rater and test-retest reliability as well as concurrent and discriminative validity
- Can take from 45 to 90 minutes depending upon the experience of the rater

Personal Assessment of Intimacy in Relationships (PAIR)
- The PAIR inventory is a 36-item instrument that assesses five types of intimacy:
  1. Emotional
  2. Social
  3. Sexual
  4. Intellectual
  5. Recreational
- It can be used for a variety of relationships from friendship to marriage
- The scale measures both expected and realized intimacy
- In the first step, people respond 'as it is now' (perceived) and then 'how he/she would like it to be' (expected)
- Response is on a 5-point agree/disagree Likert Scale

STANDARDIZED PSYCHOLOGICAL ASSESSMENT TESTS

Achievement and Aptitude tests
- Seen in educational or employment settings
- They attempt to measure either:
  1. Achieved knowledge - particular subjects
  2. Aptitude or ability to master material in a particular area

Intelligence tests
- Measure the basic ability to understand the world, assimilate to functioning and apply knowledge to enhance the quality of life
- Intelligence is a measure of a potential, not a measure of what one has learned (as in an achievement test)
- It is supposed to be independent of culture
- However, most intelligence is not culturally unaffected

Neuropsychological tests
- Measure deficits in cognitive functioning
- The ability to think, speak and reason which may result from brain damage, such as a stroke or a brain injury

Occupational tests
- Match personal interests and talents with the interests and talents of persons in known careers

Personality tests
- Measure basic personality style
- Most used in research or forensic settings to help with clinical diagnoses
- Two of the most well-known personality tests are:
1. Minnesota Multiphasic Personality Inventory (MMPI), or the revised MMPI-2
   - Composed of several hundred “yes or no” questions
     1. Rorschach (the “inkblot test”)
     - Composed of several cards of inkblots
     - Clients give a description of the images and feelings experienced by looking at the blots
   ➢ Myers Briggs Type Indicator
     - Measure preferences by personality types
       1. Extroversion or introversion
       2. Sensing or intuition
       3. Thinking or feeling
       4. Judging or perceiving
     - Occupations are recommended based on a person’s four letter code
   ➢ Psychological tests
     - Administered and interpreted by a psychologist
     - Counselors who have appropriate academic courses and supervision may administer occupational tests or achievement & aptitude tests

USE OF TECHNOLOGY

Everyone uses some form of new technology in his/her practices. All sources must be secure and confidential.

➢ Examples include:
   • Personal computers to write and store case notes
   • Fax and email attachments to transmit confidential data
   • Confidential conversation on wireless phones
   ➢ It is ethically acceptable to use a phone for crisis situations

Make Sure Your Computer Is Secure

➢ Do not permit unauthorized access to patient information
➢ Retain a record of communications to and from the system
➢ Prevent alterations in or loss of data entered
➢ Wire your system with back up and batteries to ensure it recovers completely and effectively from unexpected disruptions

Internet Therapy Relationship Is Tricky

➢ A system must be in place to ensure the therapy is not violated by an imposter, on either the part of the therapist or the client
➢ When counseling minors online, the parent or guardian must consent and identity must be verified
➢ The therapist is responsible for explaining to the client how to reach them in cases of emergency when the therapist is not online
➢ A plan must be in place to continue counseling during times of technical difficulty, to ensure there is no possibility of client neglect
As part of the counseling orientation process, the Internet therapist explains to clients how to cope with potential misunderstandings when visual cues do not exist.

- Local crisis assistance must be identified prior to the beginning therapy.
- The therapist’s website must be barrier-free for clients with disabilities.
- Cultural awareness is still an important issue.

**Confidentiality In Internet Therapy**

- The Internet therapist informs Internet clients of encryption methods being used to help insure the security of client, therapist and supervisor communications.
- Clients must be informed of how long online information is saved.
- Session data may include:
  - Internet counselor/Internet client e-mail
  - Test results
  - Audio/video session recordings
  - Session notes
  - Therapist/supervisor communications
- Authorization releases are still applicable.
SECTION 9: RESEARCH

Research is systematic study designed to add to or verify existing knowledge. It is different from practice theory in that it relies on standardized, formal procedures in the search for new knowledge. When procedures are standardized, systematic and orderly methods are used for collecting data; those methods can be both described in detail and replicated by others.

RESEARCH PROCESS

Problem Formulation is the process by which researchers develop a precise statement that can be used in an experiment. The problem must be formulated in such a way that ultimately lends itself to measurement. Since research is cumulative, the research problem is connected through a literature search to related problems and knowledge.

Development Of Questions Or Hypotheses For Study

- This includes the development of conceptual frameworks and operational concepts.

Selection Of A Study Design To Guide The Collection Of Data

Selection of a study design incorporates many concerns including:

- Research resources available
- Ethical concerns
- Time available
- Level of certainty needed for the particular research
- Whether human subjects are involved
- Receipt of informed consent
- The ability to complete research without harm to clients
- Awareness that denial of an intervention may constitute harm
- Issues of confidentiality
- Methodology: Includes selection of measurement techniques to be used, choice of the setting where research is to be conducted and determination of the population to be studied
- Ratio scales: Interval scales with an absolute zero point
- Standard deviation: A measure of variability
- A dependent variable: One that is the consequence of an antecedent variable
- Threats to internal validity: Include maturation, regression and experimental mortality
- Survey research: May be either descriptive or ex post facto
- Event: Includes any specific collection of the possible outcomes of a random phenomenon
- Frequency of an event: The number of times an event occurs in a sequence of repetitions of a random phenomenon
- Relative frequency of an event: The fraction or proportion of repetitions during which the event occurs; always expressed as a number between 0 and 1
- Probability of an event: If in a long sequence of repetitions the relative frequency of an event approaches a fixed number, that number is the probability of the event
• A probability is always a number between 0 (the event never occurs) and 1 (the event always occurs)

CLASSIFICATION OF DATA
Data may be characterized and classified in four separate ways:

- The type of data: continuous/discrete
- The scale of measurement: nominal/ordinal/interval/ratio
- The number of groups from which data arise: one group/two groups/many groups
- The variables: univariate/bivariate/multivariate

DESCRIPTIVE STATISTICS - MEASURES OF CENTRAL TENDENCY

MEAN, MEDIAN AND MODE

The mean is the average, for a set of observations the arithmetic average. It is the sum of the observations (\(n+n+n+n\)) divided by the number of observations (\(n\)). Every score in the distribution affects the mean. The mean can be used only on interval and ratio scales of measurement.

The median is the typical value. It is the midpoint of the observations when data are arranged in increasing order, the score that divides the distribution in half. The value of the median is not even affected by extreme scores. Median can be used on ordinal, interval and ratio scales of measurement.

As the value having the highest frequency among observations, the mode is the most frequent value. When two or more numbers occur at the same frequency in a set of numbers, the set is either:

- Bimodal: a distribution with two most frequently occurring scores, or
- Multimodal: two or more frequently occurring scores

When all scores occur equally, the distribution does not have a mode. Mode can be used on any scale of measurement: nominal, ordinal, interval or ratio.

Normal Curve Or Bell-Shaped Curve

- The largest cluster of scores falls in the center, and frequency decreases with progress towards the extremes in both directions
- The bell curve is bilaterally symmetrical with a single peak in the center
- Most distributions of human traits approximate the bell curve
- In general, the larger the group, the more closely the distribution will resemble the theoretical normal distribution
- The mean, median and mode fall at the same point in a normal curve
- A distinguishing feature of a ratio scale is an absolute zero point
- There is a .025 probability of error on either side of the normal curve when the alpha level is set at .05
- Standard deviation is associated with the mean
In A Normal Distribution
- Half the observations fall above the mean and half fall below
- Sixty-eight percent (68%) of the observations fall within one standard deviation of the mean
  - Half of these (34%) fall within one standard deviation \textbf{above} the mean
  - The other half (34%) fall within one standard deviation \textbf{below} the mean
- Another 27% of the observations fall between one and two standard deviations away from the mean
  - So 95% (68% plus 27%) fall within two standard deviations of the mean
- In all, 99.7% of the observations fall within three standard deviations of the mean

Note: Observations expressed in standard deviation units about the mean are called \textbf{standard scores}. For example:

- Standard score = observation - mean standard deviation

\textbf{INTELLIGENCE TESTS}

The \textbf{Deviation IQ}: allows for comparison between individuals. Deviation IQs from different tests are only comparable when they use the same or a similar value of standard deviation. Although intelligence tests still vary in SD, test publishers are trying to adopt a uniform SD of 16 in new tests.

\textbf{Fluid intelligence}, as defined by Cattell, is general to many fields and is used in tasks requiring adaptation to a new situation. Heredity is an important factor. The \textbf{Culture Fair Intelligence Test} is designed to measure fluid intelligence.

\textbf{Crystallized intelligence}, again as defined by Cattell, is more specific to a given field such as education. This type of ability depends more on environment than heredity.

\textbf{Uses Of Intelligence Tests}
- Scores provide a frame of reference for determining cognitive abilities to make placement decisions
- Results are also used for descriptive and predictive purposes

\textbf{Classification Of IQ Scores By Range}
- 130 and above: Very superior
- 120-129: Superior
- 110-119: High average
- 90-109: Average
- 80-89: Low average
- 70-79: Borderline
- 69 and lower: Below average

\textbf{Intelligence Tests}
- Stanford-Binet
WAIS-IV (Wechsler Adult Intelligence Scale)

WISC-IV (Wechsler Intelligence Scale for Children)

Note: A high verbal IQ on a WAIS-IV over a performance IQ (15 points or greater) indicates right hemisphere damage or diffuse brain damage or neurosis (especially Depression). A low verbal IQ over a performance IQ suggests language or educational deficit, left hemisphere damage, juvenile delinquency or sociopathy.

EXPERIMENTATION

- **Units**: The basic objects on which the experiment is done. When the units are human beings, they are called **subjects**.
- **Variable**: A measured characteristic of a unit. A valid measure of a property, assuming it is relevant or appropriate as a representation of that property.
- **Dependent variable**: A variable the changes of which are being studied; a response variable.
- **Independent variable**: A variable with an effect upon dependent variables being studied. An independent variable in an experiment is called a **factor**.
- **Treatment**: Any specific experimental condition applied to the units. A treatment is usually a combination of specific values (called levels) of each experimental factor.
- **Validity**: In statistics, validity is concerned with the applicability of the measure to the characteristic being evaluated. This goes hand-in-hand with reliability. The conclusion of a study for the subjects of the study themselves is sometimes called **internal validity**. Generalization of the conclusion of a study to a larger population is sometimes called **external validity**.
- **Double-blind technique**: When both the subjects and those who evaluate the outcome are ignorant of which treatment was given, a double-blind experiment exists.
- **A measurement process**: Is unbiased if it does not systematically overstate or understate the true value of the variable. Additionally, a measurement process is reliable if repeated measurements on the same unit give the same or approximately the same results. If a scale always weighs 10 pounds heavy, it is biased, but reliable. If a scale gives widely different readings each time exactly the same weight is placed on it, it is considered unreliable.

The Basic Ideas In Statistical Design Of Experiments

- **Randomization**: The random allocation of experimental units among treatments, most simply, by assigning a simple random sampling (SRS) of units to each treatment.
- **Control**: Taking account of extraneous factors in the experiment design, most simply, by the use of equivalent groups for comparison.

FORMAL STATISTICAL REASONING

A **parameter** is a number describing a population. For example, the proportion of the population with some special property is a parameter that may be called \( p \). In a statistical inference problem, population parameters are fixed numbers, but their values are unknown.
A statistic is a number describing the sample data. For example, the proportion of the sample with some special property is a statistic that is called $p$. Statistics change from sample to sample. Observed statistics provide information about unknown parameters.

**FREQUENCY TABLES**

The frequency of any value of a variable is the number of times that value occurs in the data. Therefore, frequency is a count. The relative frequency of any value is the proportion or fraction or percent of all observations having that value.

- Data are univariate when only one variable is measured on each unit
- Data are bivariate when exactly two variables are measured on each unit
- Data are multivariate when more than one variable is measured on each unit

**GRAPHS**

- **Line graphs** show the trend of a variable over time.
- **Bar graphs** compare the values of several variables. Often the values compared are frequencies or relative frequencies of outcomes of a nominal variable.
- **Scatter plots** are used to graph bivariate data when both variables are measured in an interval/ratio or ordinal scale. Units for one variable are marked on the horizontal axis and units for the other on the vertical axis. If one variable is independent and the other is dependent, the independent variable should always be placed on the horizontal axis.

**VARIABILITY**

A variable is an attribute that is regarded as expressing some concept or construct that takes on different values. Dependent variables are those that are consequences of antecedent variables and that are the objects of research studies. Independent variables are antecedent variables that are manipulated in research studies to determine their effect on the dependent variables. Standard deviation is a measure of variability.

**Measuring Spread of Variability**

Measures of variability indicate dispersion of the scores and the extent of individual differences around the measures of central tendency. When the median is used to measure center, variability or spread is often indicated by giving several percentiles.

**The percentile**: Percentile of a set of numbers is a value such that $p$ percent of the numbers fall below it and the rest fall above. Percentiles are derived scores expressed in terms of percentages.

Some percentiles are important enough to have individual names:

- The 25th percentile is called the first quartile
- The 75th percentile is called the third quartile
- The 50th percentile is called the median
The most common measures of spread or variability are variance and standard deviation. These should be used only when the **mean represents center**, as they are specifically measures of spread about the mean as a center.

- **Variance**: The mean of the squares of the deviations of observations from their mean. Variance is not as reliable as standard deviation in describing the variability.
- **Standard Deviation (SD)**: The positive square root of the variance. Describes the variability found within the distribution. The larger the SD, the greater is the dispersion of scores around the distribution’s mean. SD is an excellent source of variance, especially when N is more than 120, but is also used when N is less than 120.
- **Range**: Highest score minus the lowest score +1. A crude device that can be misleading when a distribution contains a very high or very low score, range is based only on highest and lowest scores.
- **T-Test**: A formula for evaluating the means of two groups. It is used in comparing two groups such as in an experiment that involves controlling a variable in each group and looking for a difference in outcome. It is computed using a ratio of the difference of each group's mean (average) to dispersion of the scores.

**RELIABILITY**

**Reliability** is the degree to which a test is consistent, dependable and repeatable. In other words, reliability is the "degree to which test scores are free from errors of measurement." A reliability coefficient is expressed as a number from 0 to 1; the higher the coefficient, the more reliable the test is. It is usually paired with validity.

**Methods of Assessing Reliability:**

- **Test/retest**: The same test is given twice with a time interval between tests. The coefficient measured by this is stability. Problems related to this procedure include the effect on memory, the effect of practice and change over time.
- **Alternate form**: Equivalent forms of the same test are given with time between tests. This measures both equivalence between the two forms and stability. Development of equivalent test forms may be difficult. Additionally, changes in behavior over time may have an effect on reliability.
- **Internal consistency or split half method**: After splitting a single test into two parts, one test is given at a time, and the correlation between the halves is calculated. This measures internal consistency and equivalence. The **Spearman-Brown Formula** is used to determine if splitting the test has any effect on its reliability. This formula identifies the effect of shortening the length of a test on its reliability. The more homogeneous a test is, the greater is its reliability.
- **Inter-rater reliability**: Reliability is determined by the rater’s judgment in essay tests, behavioral observational scales or projective personality assessments. The correlation between two or more raters is discovered. Problems with this method include lack of motivation on the part of the rater or rater bias as well as characteristics of the measuring device itself.
Factors That Effect Reliability

- **Length of test**: Generally the longer the test, the larger the reliability coefficient.
- **Range or variability in scores**: The larger the range of scores, the higher the reliability.
- **Guessing**: When the probability of guessing correct answers increases, the reliability of the test decreases. Therefore true/false tests generally have lesser reliability than multiple-choice exams, and they, in turn, have lesser reliability than free recall tests when all other factors remain the same.
- **Interpretation of reliability coefficient**: A reliability coefficient of .84 indicates that 84% of the variability of the test scores was due to true score differences between exams and the other 16% was due to measurement error. Usually a reliability coefficient of .80 and above is considered acceptable.

The **Kuder-Richardson Formula 20** is a mathematical formula used to estimate internal consistency reliability. If scores pile up at one end of the scale or the other, the distribution is said to be **skewed**.

**STANDARD SCORES**

These scores express distance from the mean in terms of standard deviation of the distribution. Being continuous and having equality of units, they allow for comparison between individuals.

**Standard Scores**

- **Z Scores**
  - Mean of a Z score = 0
  - Standard deviation of a Z score = 1.0
  - The range of standard deviation scores is -3 to +3; \( Z = \frac{\text{raw score} - \text{mean}}{\text{standard deviation}} \)
- **T Scores**
  - Mean of T Score = 50
  - Standard deviation of a T Score is = 10

**CORRELATION COEFFICIENT**

A **correlation coefficient** examines the degree to which variations or differences in one variable are related to variations or differences in another. Although a statistical measure of relationship demonstrates a relation exists between two sets of data, it does not show causation. The Pearson \( r \) is the most commonly used tool to predict correlation on interval and ratio data. The correlation coefficient can range from +1 (positive correlation) to -1 (negative correlation). When a correlation exists, a second score may generally be predicted from a known score.

Typically, the researcher gathers data from two variables for each individual and then calculates a correlation coefficient.

- **Perfect correlation** = +1.00 or -1.00

It is helpful to plot the pairs of scores on a **scattergram** to visually inspect the relationship. The straight-line vector that connects those points is termed the **line of regression**.
One variable correlates meaningfully with another only when a common causal bond links the phenomena of both variables.

**REGRESSION**

A major purpose of testing is prediction; **regression** is the primary statistical tool for this purpose. Regression analysis provides an equation that describes the relationship between the two variables.

**ORGANIZING DATA**

**Solomon** is identified with the concept of a research design with three or four groups, while **Charles Spearman** is responsible for the concept of a coefficient of correlation for rank-ordered data. Calculated and critical T values are compared to determine whether or not to reject the null hypothesis. In general, research is theory oriented while evaluation is outcome oriented.

**SCALES OF MEASUREMENT**

Nominal and ordinal scales of measurement are **qualitative**; interval and ratio scales of measurement are **quantitative**. A nominal scale places objects of individuals into categories. Semantic differential scales give the person taking the test a response choice such as good/bad or hard/easy.

**Association in bivariate data** means systematic connection links changes in one variable and changes in another. When an increase in one variable tends to be accompanied by an increase in the other, the variables are positively associated. When an increase in one variable tends to be accompanied by a decrease in the other, the variables are negatively associated.

The **correlation coefficient** \( r \) makes sense as a measure of association; it is positive when the association is positive, and negative when the association is negative. The correlation coefficient \( r \) always has a value between -1 and +1. The extreme values of \( r = -1 \) and \( r = +1 \) indicate perfect straight-line association. In particular \( r = -1 \) means that all the data points fall exactly on a straight line having a negative slope, and \( r = +1 \) means that all the data points fall exactly on a straight line with positive slope.

The correlation coefficient \( r \) measures how tightly points on a scatterplot cluster along a straight line. That is, \( r \) does not measure association in general, but only straight-line association. Correlations approaching either +1 or -1 indicate that the points fall close to a straight line. When \( r > 0 \), the scatter plot shows a trend from lower left to upper right (\( / \)), and the line about which the points cluster has positive slope. For \( r < 0 \), the trend is from upper left to lower right (\( \_ \)), and the slope is negative.

**STATISTICAL SIGNIFICANCE**

In a test of significance, the statement being tested is called the **null hypothesis** (Ho). The test of significance is designed to assess the strength of the evidence against the null hypothesis. Usually, the null hypothesis is a statement of no difference or no effect. The probability of observed outcomes equaling the expectation if Ho were true is called the p-value. The smaller the p-value, the stronger the evidence is against Ho provided by the data.
Because the strength of the evidence provided by the data is measured by the p-value, an acceptable p-value must be determined. This decisive value is called the **significance level**.

If the required significance level is set at 0.05, the data evidence against Ho must be so strong that the occurrence being tested would happen no more than 5% of the time (1/20) when Ho is really true. If the value is set at 0.01, stronger evidence against Ho is required, such that it would appear only 1% of the time (1/100) if Ho is true. A common way to state significance at level 0.01 is \( p < 0.01 \). Here \( p \) stands for the p-value.

**Steps In A Test Of Significance**
- Choose the null hypothesis Ho and the alternative hypothesis (H1 or Ha). Design the test to assess the strength of the evidence against Ho. H1 is a statement of the acceptable alternative if the evidence enables rejection of Ho.
- Choose the significance level, a statement of how much evidence against Ho will be accepted as decisive.
- Choose the test statistic on which the test will be based. This is a statistic that measures how well the data conform to Ho.
- Find the p-value for the observed data. This is the probability that the test statistic weighs against Ho at least as strongly as it does for these data if Ho were in fact true. If the p-value is less than or equal to the level of significance, the test is statistically significant at the chosen level of significance.

If Ho is rejected (H1 accepted), when in fact Ho is true, this is a **TYPE I error**.

If Ho is accepted (H1 rejected) when in fact H1 is true, this is a **TYPE II error**.

**Type I Error (Error of the First Kind):** Usually associated with a null hypothesis. This error occurs when an observer detects a false positive. That is to say, the observer perceives that the evidence supports rejecting the null hypothesis when in fact the null hypothesis is correct.

**Type II Error (Error of the Second Kind):** Usually associated with a null hypothesis. This error occurs when an observer detects a false negative. That is to say, the observer perceives that the evidence supports accepting the null hypothesis when in fact the null hypothesis is wrong.

**RESEARCH SELECTIONS**
- **Population** – The entire group of objects about which information is desired.
- **Unit** – Any individual member of a population.
- **Sample** – A part or subset of the population used to gain information about the whole.
- **Sampling frame** – The list of units from which the sample is chosen.
- **Variable** – The characteristic of a unit to be measured for those units in the sample.

Selection of units in a population that are not necessarily random but easily accessible is called **convenience sampling**. Samples obtained in this way are often not representative and may lead to deceptive conclusions about the population as a whole.

When a sampling method produces results that consistently differ from the truth about the population in the same way, the sampling method is said to be **biased**.
A simple random sample (SRS) of size \( n \) is a sample of \( n \) units chosen in such a way that every collection of \( n \) units from the sampling frame has the same chance of being chosen. It is fair or unbiased.

A table of random digits is a list of the ten digits 0, 1, 2, 3, 4, 5, 6, 7, 8, 9 having the following properties:

- In any position in the list, a digit has the same chance of being any one of 0, 1, 2, 3, 4, 5, 6, 7, 8, 9
- The digits in different positions are independent in the sense that the value of one has no influence on the value of any other

A parameter is a numerical characteristic of the population. Although it is a fixed number, its value is usually unknown.

A statistic is a numerical characteristic of the sample. The value of a statistic is known when the sample has been taken, but it changes from sample to sample. Put simply, \textbf{parameter is to population as statistic is to sample}.

- Example: If out of 1220 people, 1098 of this sample size replied “yes” to a specific question; then \( p = \frac{1098}{1220} = 0.90 \)

It is reasonable to use this proportion \( p=0.90 \) as an estimate of the unknown population proportion \( p \). If a second sample size of 1220 is taken, it is almost certain that there will not be exactly 1098 positive responses. So the value of \( p \) will vary from sample to sample. This is called \textbf{sampling variability}.

\textbf{So, How Is Reliable Data Obtained?}

In repeated sampling, a sample statistic from an SRS has a predictable pattern of values. This pattern is called the \textbf{sampling distribution} of the statistic. Knowledge of the sampling distribution allows for statements about how far the sample proportion \( p \) is likely to wander from the population proportion \( p \) owing to sampling variability.

Two basic types of error are associated with any method of collecting sample data: \textbf{bias} and \textbf{imprecise sampling}. Bias is a consistent and repeated divergence of the sample statistic from the population parameter, always in the same direction. Lack of precision in sampling mean values of the sample statistic are spread or scattered, resulting in a sampling that is not repeatable.

\textbf{Sampling errors} occur in the act of taking a sample, causing sample results to be different from the census of a population.

\textbf{Non-sampling errors} are those not related to the act of selecting a sample from the population. These errors may accurately reflect a census. Some common non-sampling errors are:

- \textbf{Missing data} – May be due to inability to contact a subject or to the subject’s refusal to respond
- \textbf{Response errors} – Errors concern the subject’s response
- \textbf{Processing errors} – Mistakes on mechanical tasks such as math, coding or data assembly
- \textbf{Collection errors} – The effect of the method used to collect data can be large
The all-inclusive framework for sampling is called the **probability sample**. A probability sample is a sample chosen in such a way that every unit in the sampling frame has a known non-zero chance (or probability) of being chosen.

To obtain a stratified random sample, proceed as follows:

- Divide the sampling frame into groups of units, called **strata**. The strata are chosen because there is a special interest in these groups within the population or because the units in each stratum resemble each other.
- Take a separate SRS in each stratum and combine these to make up the stratified random sample.
SECTION 10: SUPERVISION/MANAGEMENT/HEALTHCARE

SUPERVISION

As middle management, supervisors oversee all counselors in an agency and keep them connected to upper management who handle business matters. Their job is to ensure counselors and divisions within an agency offer the best and most effective service to the clients. Coordinating all aspects of direct contact with clients, supervision works to secure counselors who are efficient and ethical in all their work encounters. They provide the skills training, assistance and company resources, as well as advice and evaluations of the counselor’s work.

As the link that facilitates counselors and upper management to function effectively within an agency, supervisors should be respected for their knowledge and expertise. They provide co-optation and structure for counseling programs by coordinating assignment of cases as per the skills of each counselor, while ensuring compatibility of clients and counselors whenever possible. As overseer, supervisors should always be consulted when a counselor has an issue or ethical problem.

Supervisors provide three main functions within an agency:

- Administrative duties, including workload aspects for each counselor
- Educating counselors to aid them in job performance
- Assistance and support

Supervisors

- Offer training programs to better equip their counselors
- Provide company resources
- Evaluate counselors in their jurisdiction
  - Sitting in on sessions offering advice
  - Observing through a 2-way mirror
- Plan programs
- Make sure programs are implemented
- Liaison between counselors and upper management

Accountability

Supervisors are held “accountable” in an agency when problems arise. The performance and quality of counselors under their jurisdiction reflects back on the supervisor. Ultimately, supervisors have the responsibility and control over their employees/counselors and thus are held legally responsible for any mistakes made by them. If a client files a malpractice suit against a counselor, their supervisor can be included in that suit. This liability differs when the supervisor is serving only in a consultant capacity, in which case they are not legally responsible.

ADJUNCT SERVICES

With regard to the exam itself, each question is written from the viewpoint of an outpatient mental health therapist in private practice. The indication of the client’s stressors and the demands of the
client’s level of functioning are vital considerations. If the case study presents a client who does not need therapy, that client will need **adjunct services** as determined by the stressors and client’s level of functioning. Including both coordination of aid and recommendation of services to follow up treatment, the goal is to continue the client’s improvement and to eliminate stressors where appropriate.

**Direct services** are those provided by therapists and, therefore, not considered to be adjunct services. Career counseling, art therapy (drawing, music, poetry), sex therapy, hypnotherapy and biofeedback training are all considered direct services. Individual counseling, premarital counseling, couples or family counseling and group counseling are all aspects of direct therapy.

While assuming the therapist may place people into therapy groups to reduce symptoms and increase functioning, **support groups**, which may well be vital to the process, are considered to be outside the realm of the mental health therapist. If Axis IV indicates the client has a need to find services to aid function and reduce psychosocial stressors, then adjunct services are key.

Adjunct services fall into several main categories:

- Self-development
- Personal growth
- Peer support
- Living accommodations
- Medical and psychological services
- Other health-related services
- Organizations for socialization
- Other professional services
- Governmental or social services

Within the larger area of **self-development**, tutoring, study skills training, academic remediation and preparation services for standardized tests are available. An organization specializing in SAT or GRE preparation or a learning center would be included in this type of adjunct service. College courses, specific vocational preparation and adult education courses (whether job related or for the development of personal interests, such as dancing or foreign language) provide significant opportunities for self-development. Training in relaxation, effective parenting and skills related to job searches (resume writing, interview techniques) are also components of this cluster.

Related but somewhat different, adjunct service providers in the area of **personal growth** include assertiveness training, communications training, values clarification, image-building workshops, problem solving workshops and relationship enhancement courses.

**Peer support** groups are numerous and readily available. From Alcoholics Anonymous and Gamblers Anonymous to Vietnam Veterans and Compassionate Friends (for families who have faced death of a child), a support group can be found to fill nearly any need. Groups exist for men or women, abusers or abused, children or adults. The resourceful counselor should be able to find a support group to fit the specific needs of the client.
When a client needs **living accommodations**, the counselor seeking adjunct services has multiple options. Children and pregnant adolescents may need foster homes. Halfway houses for psychiatric patients, former substance abusers and ex-offenders provide solutions in some cases, as do group homes for troubled adolescents, the mentally retarded or the physically disabled. Low-income housing is an option in some situations for the elderly or disabled client and day treatment centers provide relief for caregivers. Shelters for abused women and their children or clients without homes also exist.

Many **medical and psychological services** are outside the realm of the mental health counselor. If the need is for a physical examination, chemotherapy, hospitalization, evaluation of sexual dysfunction, intelligence testing or psychological testing, the clinician will need an adjunct service.

Other **health-related services**, such as weight control programs, exercise classes, physical rehabilitation, yoga or meditation, are included in the realm of adjunct services.

When seeking an **organization for socialization** or leisure activity, the choices are many. From relevant professional organizations to dating or social clubs and from religious organizations to cultural societies, the range is wide enough to accommodate the needs of nearly any client. Organized sports teams and special interest groups (bridge clubs, garden societies) meet many needs. Groups like the Sierra Club provide nature-oriented activities for interested clients.

At times, a client will need **other professional services** such as legal assistance, financial planning, divorce mediation, speech therapy, an employment service or information about starting a business. Additionally, social services and **governmental agencies** provide services that may be helpful. These include aid to dependent children, food stamps, social security and unemployment compensation.

**HEALTHCARE INSURANCES**

**HEALTHCARE SYSTEM**

Medical and health care can be categorized as either skilled or unskilled. Skilled care is administered by a professional health care worker, with the expectation of improvement and achievement of treatment goals, and the implication of an eventual lack of requirement for care services. Unskilled care is mostly administered by nonprofessional workers, with the acknowledgement of an unlikelihood for improvement. The aim in unskilled care is to maintain the patient's current health state (often care involves assistance with tasks of daily living, such as bathing, eating, etc.) Levels of care may be categorized as acute, sub acute, skilled nursing, home health care and rehabilitation. Acute care is characterized by the requirement of ongoing skilled care. Sub acute provides a lower intensity of care than acute. Daily skilled care is typically administered at a nursing home or skilled nursing facility. Home care provides intermittent skilled care. If the patient meets a criterion that includes the ability to undergo three hours of rehab five days a week, he/she may qualify for inpatient rehabilitation care. If the patient fails to meet criteria, rehab may also be available in other facilities.
Types Of Insurance

Medical insurance can be purchased for groups or individuals. Many employers purchase health insurance at a group rate (which is much less costly than individual insurance.) The four basic categories of private health insurance are as follows: indemnity or fee-for-service (offers no controls on cost), HMO (managed care), and PPO and POS (managed care with less restriction and more choice than HMOs). Medicare and Medicaid offer public insurance. CHAMPUS (a generous indemnity plan now restructured as TRICARE) is public to the U.S. military and their beneficiaries.

There are also categories of health insurance according to whether an employer purchases the insurance directly from an insurance company or whether the employer chooses to insure his employees himself, known as self-insuring or self-funding (which has become a growing trend). To protect the self-funding employer from catastrophic claims, most purchase stop-loss insurance to allow for when the cost of an individual claim goes above a specific amount. Employers may also buy aggregate stop-loss insurance in case the claims of the group reach a certain amount.

Third Party Administrators (TPA), or Administrative Services Only (ASO), help provide administrative services to arrange for claims processing that most employers are not designed to handle. Some also provide other services, including case management.

The Employment Retirement Income Security Act (ERISA) is a law exempting self-insured companies from state insurance regulations. Federal Law also states that an employer must offer terminated employees the option to purchase his health insurance at the employers group rate for up to eighteen months (according to the Consolidated Omnibus Budget Reconciliation Act, or COBRA.)

MEDICARE

Medicare (paid for through funds received from Medicare taxes) is health insurance for the aged and disabled, and is administered by the Center for Medicare Services (CMS). Initially, when it was implemented in 1966, Medicare operated as a fee-for-service system. However, in attempts to cut escalating health care costs, Congress passed a series of acts (Title IX 9 of the Social Security Act, Balanced Budget Act) which changed Medicare to a prospective basis. Today Medicare covers health care to an estimated 95% of the American aged and disabled. All US citizens or permanent residents aged 65 or over who have paid Medicare taxes out of their paychecks for at least ten years are eligible for Medicare. However, an individual under 65 with a disability or requiring dialysis for end stage renal disease or kidney failure may also be eligible for Medicare.

Part A Medicare is characterized by HI (hospital insurance), a basic benefit of Medicare including: inpatient room, hospital services, psychiatric hospitalization, inpatient rehabilitation, nursing facility, home health services, hospice and blood transfusions (for which the patient must replace or pay for the first three units per year). When a Medicare patient begins an inpatient hospital stay, his benefit period begins; this period does not end until the patient has been discharged from the hospital or has not received nursing care for a duration of 60 days. The patient may, if necessary, begin a new benefit period - he is allowed an unlimited number of benefit periods. Medicare covers a 90-day benefit period during which the patient is responsible for a co-pay per day for each hospital day 60 through 90. After this 90-day period, the patient may receive benefits from his lifetime reserve.
**MEDICAID**

Medicaid, brought into effect by Title XIX 19 of the Social Security Act, provides medical assistance for uninsured children, low-income population members, the disabled and the elderly, as well as a large portion of long-term nursing home care recipients. Many state Medicaid plans initially functioned as indemnity plans, however, due to increasing health care costs and growth of the Medicaid-eligible population, many Medicaid plans are now managed care plans. Medicaid is funded by both federal and state governments. SCHIP (State Children's Health Insurance Program) was a result of the 1997 Balanced Budget Act and implements a Federal agreement to match state funds for Medicaid (given a state plan for enrollment of uninsured children).

Unlike Medicare, Medicaid does provide for long-term custodial care. However, to financially qualify, a recipient must deplete his assets and income. Assets do not include the recipient's home, car or personal possessions such as clothing, furniture or jewelry. A Medicaid enrollee is not permitted to give away assets or income (unless they are given to a spouse, a blind or disabled child, or a trust for a blind or disabled child). If the recipient gives away assets or income, a transfer penalty (length of time during which recipient is ineligible for Medicaid) will be incurred; duration of transfer penalty is relative to amount given away.

**BAD-FAITH CLAIMS**

Are based on inappropriate denial of benefits (insurance companies are required to act in "good faith and fair dealing"). An insurance company is liable if it does not have a reasonable basis for benefit denial (a company is also liable if the insurance company is aware of an inappropriate denial but does not act to correct it, or if an ineptitude or bureaucracy results in dangerous claims processing delays). To avoid such claims, a counselor might document the reasons given for benefits denial, review all information that might affect the claim with their supervisor, encourage the patient to attempt and document an appeal and process the claim on time.

If a counselor refers a patient to a provider who then acts in negligence, the counselor (and their supervisor) may be held responsible. Therefore, either the patient should choose the provider or the counselor should offer multiple provider choices, providing objective information for each provider and not disclosing a personal preference. A counselor should know the credentials and quality of a referred provider as well.

A counselor should also be cautious of breach of confidentiality (harm to a patient due to unauthorized release of information). Because a patient-counselor relationship is considered privileged, a counselor should maintain confidentiality of patient information and patient medical records. In instances involving drug or alcohol use, mental health, sexually transmitted diseases and abortions, the counselor may disclose information, given a patient consent form. Counselors should be aware that generally care providers or claims processors are usually authorized to review medical records under normal circumstances (a patient signs a consent form authorizing disclosure of information from the start of any inpatient or outpatient treatment).
SECTION 11: SAMPLE EXAMS

SAMPLE EXAM 1

1. Bob and Betty Burbson and their three children - Billy (5), Bambi (7) and Brooke (9) - are attending therapy for the first time. 7-year-old Bambi is sitting between Mom and Dad, and looks to her mom before she answers any questions. Bob, who can't wait till this is over, just shakes his head when his daughter Bambi looks toward his wife. Brooke and Billy, sitting on the floor, seem bored and disengaged. Which of the following would a structural therapist probably do?

   (A) Point out the isomorphism between the two family coalitions by having mother and daughter switch seats with the 5-year-old and 9-year-old children
   (B) Get the mother to say how she feels when her daughter looks at her
   (C) Direct the 7-year-old to sit next to her brother and sister, and ask the parents to sit next to each other
   (D) Arrange to see the mother and 7-year-old daughter alone

2. Anne, a 72-year-old active senior, is facing retirement and feeling restless about how she will make the transition because she has worked since the age of 15. What do you address in your first treatment plan?

   (A) Assess for fear
   (B) Feelings of depression
   (C) Positive self-talk to build self-esteem
   (D) Life cycle transition

3. The three aspects of David Olson's Family Circumplex Model are . . .

   (A) Cohesion, flexibility and communication
   (B) Power, acquiescence and agreement
   (C) Cohesion, communication and acceptance
   (D) Isolation, communication and bonding

4. In the rational choice model, which alternative is the most likely to be selected?

   (A) The lowest net value ratio, representing efficiency
   (B) The highest net value ratio, representing efficiency
   (C) Zero sum value ratio
   (D) The most economically feasible
5. A woman is referred by her primary care provider and presents with a diagnosis of Hypochondriasis. What is the FIRST crucial step in treatment?

(A) Establishment of trust and appreciation for the patient's problems  
(B) History taking  
(C) Education about the link of stress, emotions and lifestyle to physical health  
(D) Treatment planning

6. According to the Discrimination Model (which falls under integrated supervision models), which of the following is **not** one of the three supervisory roles a supervisor would fall under?

(A) Consultant  
(B) Teacher  
(C) Counselor  
(D) Discriminator

7. Which value orientation is consistent with universal service provision?

(A) Liberal value orientation  
(B) Conservative value orientation  
(C) Independent value orientation  
(D) Critical value orientation

8. A group of experimenters seeks to determine the effect of cell phone usage has on a person's health. In this example, which variable is dependent?

(A) Gender of the subject  
(B) Cell phone usage  
(C) Type of cell phone  
(D) The subject's health

9. The process of physically training someone to return to a specific job is called:

(A) Occupational replacement  
(B) Job examination  
(C) Work hardening  
(D) Job clubbing

10. A document that details the therapist's policy regarding the extent of confidentiality is:

(A) A contract  
(B) A way of getting around the law  
(C) A disclosure statement  
(D) Required
11. Client: "I am really afraid that my grandmother might die. If she dies, I don't know whom I will live with." Seeking to reflect the feeling, the social worker's best response would be:

(A) You're feeling scared.
(B) Sounds like an unpleasant experience. I bet it's difficult to decide which way to turn.
(C) You're upset and afraid of what will happen to you.
(D) Are you really scared?

12. Eating disorders, such as, Anorexia and Bulimia have been found to be highly correlated with:

(A) Paranoia
(B) Depression
(C) Drug usage
(D) Enuresis

13. It is necessary to obtain informed consent prior to giving out data about a patient. Which of the following statements is MOST correct regarding this issue?

(A) You must obtain informed consent from your patient in most situations, but not in all situations.
(B) If a significant other requests information about your patient, you may release it without informed consent.
(C) If you are going to consult with a colleague, you must have informed consent from your patient.
(D) You must always have informed consent from your patient.

14. Jeff, an 8-year-old boy who is a middle child of five, was suspended from school for being very aggressive with other students and defiant toward his teachers. He is the only child in the family whose behavior has caused concern. His parents appear to be well-adjusted, stable, intelligent people. In family therapy terms, Jeff is the IP. This means he is the one:

(A) Who needs therapy the most
(B) Whose behavioral manifestations reflect the family's dysfunction
(C) Who is the problem vector
(D) Who needs to be removed from the family

15. A 38-year-old wife and mother of three has a recurrence of breast cancer four years after a lengthy, painful battle involving radiation, chem-therapy and mastectomy. She has been offered the opportunity to participate in a new treatment, likely her only option for survival, but it is invasive and carries a high risk for significant side-affects. She denies treatment. What is your NEXT step?

(A) Abide by her decision and let her die
(B) Recommend to the spouse he work with the doctor and the legal system to enforce
treatment because of the minor children
(C) Confirm that all information needed to make an informed decision was available and
offered; offer counseling, links to palliative care and hospice
(D) Remind her the children and her spouse need her and it is best to exhaust all options
before giving up

16. What is always the FIRST step in any therapeutic relationship?

(A) Assessment
(B) Intervention
(C) Research
(D) Evaluation

17. Young Tom had a rich fantasy life full of secret agents, astronauts, pilots and heroes of all
kinds. He drew comics about them. His schoolmates considered him to be a geek and made
fun of him. Tom went into acting and became a very successful leading man, able to act out
all of his fantasies.

(A) Regression
(B) Projection
(C) Sublimation
(D) Rationalization

18. If a client is suffering from panic attacks, which of the following interventions, along with
breathing exercises, would probably prove to be most beneficial:

(A) Analysis of Resistance
(B) Implosion
(C) Interoceptive Training
(D) Reaction Formation

19. Client: "I'm really bummed out. I've lost my hair at a much quicker rate than I thought
possible. I'm so embarrassed to go out in public. It makes me feel sick just thinking about my
baldness. I'm in a constant state of anxiety and uneasiness. " Social Worker: "You're anxious
and uneasy about the transformations that are a natural process of aging." The social worker's
response is:

(A) Encourager
(B) Summarization
(C) Paraphrase
(D) Reflection of feeling
20. Major administrative trends exist in the field of social services. One is the existence of more competitive behaviors. Traditionally, welfare agencies worked more cooperatively with one another. Which of the following is NOT a reason for the change?

(A) Competition for clients  
(B) Competition for new revenue sources  
(C) Competition for developing new products and services  
(D) Increase in privatized resources

21. Mack was in an automobile accident, which nearly claimed his life, leaving him in intensive care for 2 months followed by 3 months of physical rehabilitation. What is your FIRST intervention strategy?

(A) Facilitate involvement with others who have shared a common experience to decrease isolation  
(B) Advocate for stricter safety requirements on automobiles  
(C) Explore the experience of all five senses  
(D) Facilitate him telling his story and personal truth

22. According to the DSM, the following disorders are most closely related:

(A) Schizophrenia / Depersonalization  
(B) Dissociative identity / Schizophrenia  
(C) Dissociative identity / Depersonalization  
(D) Depersonalization / Antisocial personality

23. A 10-year-old girl was overheard telling a friend she would like to jump in front of the train that runs behind her house. She has been referred to you, a therapist. The LEAST appropriate intervention would be to:

(A) Provide individual therapy.  
(B) Dismiss her behavior as attention seeking.  
(C) Counsel with her parents.  
(D) Facilitate a team of family members and school personnel.

24. "Sacral" refers to:

(A) Four vertebrae in the lowest portion of the back.  
(B) Twelve vertebrae in the upper portion of the back.  
(C) Five vertebrae in the lower portion of the back.  
(D) Seven vertebrae in the neck.

25. SOAP is the abbreviation for:

(A) Subjective findings, Objective findings, Assessment, Plan
26. The most likely diagnosis of a 16-year-old female who has lost 25 pounds from her usual weight of 120 and continues to feel overweight is:

(A) Bulimia Nervosa  
(B) Anorexia Nervosa  
(C) Personality Disorder  
(D) Conduct Disorder

27. What legislation authorizes medical personnel to enter an environment and conduct an exam to determine if a communicable disease is present following the exposure by a health care worker, public safety officer or other person to bodily fluids that may transmit infection?

(A) Duty to protect  
(B) Duty to report  
(C) Deemed consent to treat  
(D) Required consent

28. A woman who has been in an abusive marriage for 10 years comes for counseling. She reports a history of emergency room visits, intense emotional and verbal abuse, and sexual coercion. What is your SECOND step after reviewing limits of confidentiality and assessing for imminent danger?

(A) Advise her to leave her spouse immediately because abusive behavior always escalates  
(B) Do not offer advice about leaving or staying; encourage her to tell her story and say what she wants from counseling  
(C) Tell her to set a plan for leaving in the next two weeks, helping her to identify a safe place to go  
(D) Strongly encourage her to file a police report and attempt to have her spouse arrested

29. You are providing crisis debriefing at a large-scale event and make many contacts with individuals and families. You are nearing the end of your shift, what is your next step?

(A) Participate in a debrief yourself with another volunteer  
(B) Gather names and numbers for follow up  
(C) Reschedule for your next shift  
(D) Refer those in need to outside services
30. You have worked with a 10-year-old boy and his family using a crisis counseling model throughout the course of his hospital stay for Leukemia. Treatment was tough on the entire family. With the Leukemia finally in remission, the family desires to continue services with you when they leave the hospital. What is the BEST course of action?

(A) Review treatment gains, review indicators for termination of services, terminate and refer
(B) Continue seeing the family indefinitely, until they determine their needs are met
(C) Encourage them to share their story with you, normalize feelings associated with the crisis of a cancer diagnosis and access resources
(D) Contact your supervisor to request ongoing work with the family as your previous relationship makes you the best person for continuity of care

31. An individual who is androgynous will display characteristics:

(A) Of males and females
(B) That are determined by the shadow id part of the personality
(C) That are genetically determined
(D) Of the dominant parent

32. The DSM defines Expansive Mood as:

(A) An unpleasant mood, such as sadness, anxiety or irritability.
(B) A pervasive and sustained emotion that colors the perception of the world.
(C) Mood in the "normal" range, which implies the absence of depressed or elevated mood.
(D) Lack of restraint in expressing one's feelings, frequently with an overvaluation of one's significance or importance.

33. If a social worker realizes an individual on the nursing staff has been administering a dying patient more pain medication than the physician has prescribed, the social worker should:

(A) Talk to the nursing staff to find out what is going on with the patient
(B) Talk with your own supervisor and have them deal with it through appropriate channels
(C) Without hesitation, contact the state medical ethics board
(D) Go to the administrator of the hospital and let them know what is going on

34. Which of the following is NOT a reason to change therapeutic methods for the elderly?

(A) Cohort effects
(B) Challenges specific to late life
(C) Context effects
(D) Developmental differences

35. How do you find the median of a set with an even number of items?

(A) The larger of the two middle numbers is the median.
(B) The two middle numbers are both medians.
(C) Find the average of the two middle numbers.
(D) A set with an even number of items does not have a median.

36. A woman presents for therapy after the death of her brother. You lost your brother last year and have difficulty maintaining your composure during the session. What is your BEST course of action?

(A) Maintain professional relationship with the client while seeking counseling services for yourself
(B) Realize you better than anyone can empathize with the client situation and schedule a follow up session
(C) Refer the client to someone who can maintain emotional boundaries
(D) Interrupt the session, tell the client you just lost your brother and terminate services

37. When a person with Lupus (SLE) becomes depressed, which system has most likely been affected?

(A) Cardiovascular
(B) Digestive
(C) Respiratory
(D) Central nervous

38. Which of the following is not an example of a social policy targeting the regulation of behavior?

(A) Regulating the school lunch program
(B) Regulating licensing of family therapy providers
(C) Monitoring behavior of criminal offenders
(D) Monitoring behavior of parents who abuse their children

39. A young, beginning social worker has some intrapersonal and interpersonal struggles with men in authority positions that stem from his poor relationship with his father. The social worker's client is a 50-ish, commanding figure, a male CEO of an Internet start-up. The social worker is likely to struggle in therapy due to:

(A) Countertransference
(B) Counter-resistance
(C) Transference
(D) Resistance

40. A young man presents with a pattern of social anxiety, timidity and shyness in social situations, which prevents him from having friends outside his immediate family circle or in promoting in his work setting. He defines his primary goal as the ability to interact with others without being afraid or anxious. What is your NEXT step?
(A) Intervene by building skills that overcome shyness and social awkwardness
(B) Assess for Schizoid Personality Disorder
(C) Educate on the potential deficits in life if he is unable to overcome current obstacles
(D) Facilitate involvement of significant others

41. Accessibility to benefits may cause problems for a client who has a right or entitlement to a service, program or benefit. Tom is in need of outpatient alcohol treatment, but needs to maintain his full-time job. To participate in the program, he will have to take a leave of absence, which will leave his family without enough resources to pay their rent. This is an example of what accessibility issue?

(A) Scheduling
(B) Quality
(C) Location
(D) Affordability

42. GAF stands for what in the DSM?

(A) Global Assessment of Functioning Scale
(B) Greater Assessment of Functioning Scale
(C) Gretsky's Average Functioning Scale
(D) Good to Average to Fair Scale

43. In supervision, which of the following is not an example of a learning objective for communication skills?

(A) Uses multiple sources of data to gather client information
(B) Attends to client's nonverbal behaviors
(C) Able to facilitate communication between group members
(D) Able to recognize own nonverbal behaviors and their impact in group

44. The primary approach to intelligence taken by information processing is:

(A) Content as opposed to process
(B) Verbal rather than non-verbal
(C) Alterations in schemes and abilities
(D) Developmental stages

45. A client says she is going to get her shotgun and teach her mother-in-law a lesson she'll never forget. What should you do?

(A) Call the mother-in-law only
(B) Make no calls and discuss alternative actions with your client
(C) Do nothing, because she is only venting her emotions
(D) Remind the client about your duty to warn, then call the police and the mother-in-law.

46. According to contextual therapists:

(A) Family dysfunction is caused by multidirectional partiality.
(B) Family dysfunction is caused by low levels of equity and trust.
(C) Family dysfunction is caused by disruption in the "pecking order".
(D) Family dysfunction is caused by dysfunctional behaviors in the family.

47. According to Bowen, what is differentiation?

(A) The ability to recognize thoughts and feelings as things different from one another
(B) The significance of diversity of self in the highest possible functioning within a family
(C) The degree to which someone has achieved separation from his or her family
(D) Generational differences in how families are arranged

48. Marsha is not doing well in her high school math class. She is very angry about this and despises her teacher. She claims her teacher is giving her bad grades because he hates her. This is an example of:

(A) Projection
(B) Rationalization
(C) Regression
(D) Sublimation

49. A therapist feels he can no longer treat a patient suffering from Hypochondria because he believes the client's secondary gain is too great to overcome. What does this mean?

(A) The client's symptoms are primarily related to preconscious thought.
(B) The symptom is reducing the tension or conflict.
(C) The client is expressing unconscious impulses in actions.
(D) The advantages derived from the illness outweigh the discomfort created by the illness.

50. When treating elder adults with Depression, the BEST approach to treatment is:

(A) Cognitive behavioral therapy coupled with family interventions
(B) Significant reliance on psychiatry because medication management is most important
(C) Treatment with elder adults is similar to other adults so no significant alterations are needed
(D) Coordination between medical and mental health due to the influence of medical conditions on psychiatric symptomatology

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SAMPLE EXAM 3

51. According to Beck, a depressed person does not see the positive aspects of their situation because of:

(A) Dysfunctional schema
(B) Precipitating factors
(C) Lack of support
(D) Lack of adaptive coping strategies

52. Shauna, an African-American high-school student, has been experiencing stereotype vulnerability. What does this entail?

(A) She is transferring negative stereotypes onto her peers
(B) She is perceiving and expecting negative stereotypes
(C) She is attributing negative stereotypes to white students
(D) She is experiencing negative stereotypes about her gender

53. Which supervision approach is driven by the supervisee's case needs, focusing on case planning and problem-solving as a primary area of work?

(A) Contemporary Field Instruction
(B) The Articulated Approach
(C) The Apprenticeship Approach
(D) The Academic Approach

54. A 29-year-old woman presents for therapy when her spouse began pressing her to start a family like they had planned years ago. She is frightened about becoming a mother, fearing the abuse she experienced as a child will make her a bad mother. What is your BEST course of treatment?

(A) Assure her she has nothing to worry about because of her current awareness
(B) Refer her to parenting classes while you assess the depth of the abuse
(C) Assess her history of abuse and current fears, then make a positive parenting plan
(D) Educate on the generational patterns of abuse, and refer to parenting classes

55. The following antidepressants should be prescribed with extreme caution to patients with history of seizures:

(A) Sinequan and Prozac
(B) Bupropion and Ludiomil
(C) Imipramine and Nardil
(D) Bupropion and Doxepin
56. You are counseling a young adult in a college campus setting who is dealing with adjustment issues. During the current session, she discloses she is 18 weeks pregnant and wants to abort. She is asking for help securing resources to travel to a state that will allow an abortion at 19 or 20 weeks. You have significant concerns about her safety and believe she is acting based on fear. What is your NEXT step in the session?

(A) Tell her the plan is not safe and you will not aid her with travel resources
(B) Gently explore how she sees the plan working, and take a directive role in reassessing problem solving
(C) Refer her to Planned Parenthood
(D) Encourage her to relinquish the baby for adoption

57. Which of the following would be a goal in treatment for a child with Autism?

(A) Promote the child's social development
(B) Analyze the parental role in the family
(C) Maximize behaviors that interfere with functioning
(D) Create unstructured, free-form activities and schedules

58. Myocardiopathies requiring prolonged care will most likely lead to this psychological disorder:

(A) Agoraphobia
(B) Depression
(C) Psychosis
(D) Antisocial Personality Disorder

59. Which of the following is not an underlying assumption of interest group theory?

(A) Family policy is influenced by interest groups
(B) Compromise, bargaining, formulation of coalitions, negotiations and overlapping interests maintain group balance
(C) Influence of a particular group is largely determined by wealth, cohesion and access to key policy makers, size and power
(D) Opinion elites are key to the process, accessing policy makers

60. A patient indicates that since her husband left her, her entire life has turned upside down. She has had to support the rest of the family completely on her own and misses her husband. As a social worker, you respond to her saying, "When your husband left, you were forced to confront things on your own, whereas previously you and your husband had done them together." In this scenario, what you have done is called:

(A) Paraphrasing
(B) Self-disclosure
(C) Reflection
(D) Confrontation
61. Ellie says, "I singed a song good" to her teacher. This is an example of:

(A) Generalization  
(B) Age-appropriate language  
(C) Regularization  
(D) Over-regularization

62. Of the following, which is more likely to be a symptom of Depression rather than basic grief?

(A) Depleted serotonin  
(B) Healing tends to be very responsive to the passing of time  
(C) Intense sadness without a significant decline in self-esteem  
(D) Sadness specifically related to a loss

63. When a social worker becomes sexually attracted to the patient he is working with, his supervisor should:

(A) Sit down with the social worker and determine exactly what type of attraction he might be experiencing.  
(B) Make a referral to another social worker to work with the social worker.  
(C) Direct the social worker to end therapy immediately with this patient.  
(D) Determine if this is a pattern he has with all of his patients.

64. In any group, the most popular child (in terms of birth order) is most likely to be the:

(A) Youngest  
(B) Smartest  
(C) Middle  
(D) Oldest

65. A social worker has been doing therapy with a patient every week for approximately 18 months. The patient suffers from fairly intense feelings of depression brought on after his wife of 47 years died. The patient is open to discuss his feelings, but there has been no progress for the patient during the 18 months in therapy. The social worker might:

(A) Call a colleague on the phone and discuss the situation to get a second opinion.  
(B) Look over JAMA and other current literature that might shed some light on how to treat your patient.  
(C) Talk to the patient about referring him to another social worker who might help him move forward in dealing with his depression.  
(D) Consider increasing the frequency of visits per week.
66. The following is NOT an MAO inhibitor:

(A) Elavil  
(B) Parnate  
(C) Nardil  
(D) Marplan

67. A diagnosis of Mental Retardation in the DSM includes the following criteria EXCEPT?

(A) Congruent appropriate functioning in age or cultural groups before the age of 18  
(B) An approximate score of 70 or below on an IQ test  
(C) Concurrent deficits or impairments in adaptive functioning  
(D) Onset before the age of 18

68. A referee of a boxing match involving Iron Mike Tyson is forced to step in and stop the match due to excessive biting. The referee experiences arousal during the intervention. Which part of the referee’s nervous system is involved in returning his body to homeostasis?

(A) Psychosomatic  
(B) Sympathetic  
(C) Autonomous  
(D) Parasympathetic

69. Professional ethics and professional values differ in which of the following:

(A) Values are a subset of ethics.  
(B) Values deal with what is right or wrong in practice, and ethics deals with the principles of practice.  
(C) Values and ethics are basically the same and are evaluated based on the specific situation.  
(D) When a social worker makes a judgment that is ethical, you can assume it is a judgment that also upholds professional values.

70. A 12-year-old boy who is physically challenged has been treated as an outpatient at a local hospital. According to his social worker, he needs to have more contact with kids his own age, but this is difficult due to his disability. Additionally, his mom and dad are so controlling they won't even let him go to the bathroom by himself, let alone play with other children outdoors. The boy has shown an interest in cartoons and seems to have a flair for computer graphics. The social worker would talk to his parents and recommend:

(A) That he attend a six-week cartoony class during the summer  
(B) Buying a computer so the boy can practice cartooning at home  
(C) Transferring the client to a magnet graphic arts center  
(D) Having a graphic artist from the local university tutor him at home
71. What is an advantage to art therapy?

(A) It helps clients to release deeply repressed emotions.
(B) It helps clients become comfortable with their bodies.
(C) It improves blood flow.
(D) It can only be used as a diagnostic tool.

72. A new trend in Depression therapy is Interpersonal Psychotherapy. Which of the following is one of the four common problem areas addressed in this intervention?

(A) Faulty childhood
(B) Role Transitions
(C) Social strengths
(D) Cause and effect relationships

73. The DSM defines Dyskinesia as:

(A) Imperfect articulation of speech due to disturbances of muscular control
(B) The inability to maintain attention, that is, the shifting from one area 01 topic to another with minimal provocation, or attention being drawn too frequently to unimportant or irrelevant external stimuli
(C) Distortion of voluntary movements with involuntary muscular activity
(D) A disruption in the usually integrated functions of consciousness, memory, identity or perception of the environment; the disturbance may be sudden or gradual, transient or chronic

74. Halle has a habit of simply repeating back her teacher's words when she is asked a question. What is the term for this symptom?

(A) Echolalia
(B) Echidna
(C) Echolocation
(D) Echovirus

75. A client has been working through childhood sexual abuse issues with you in therapy. Child Protective Services (CPS) removed her from the home for several months, and the perpetrator, an older cousin who resided in the home, went to treatment. The cousin now works in a daycare setting and the client strongly suspects he is molesting some of the children. The client is unwilling to make a report to CPS. What is your BEST course of action?

(A) Review mandated reporting laws to ensure you know what is required, inform the client you must report and terminate services with the client
(B) Review mandated reporting laws with the client and your requirements, inform the client you must report and provide her the opportunity to make the report with you
(C) Make the report without informing the client you will do so, knowing she may never learn from where the report initiated
(D) Abide by the client's wishes to not report - the cousin completed perpetrator treatment, he had to disclose it when hired and sexual abuse perpetrators are listed in accessible public registries, so the daycare is already aware and informed

**SAMPLE EXAM 4**

76. Upon receiving an F in his college psychology class, Phil is heard to say, "That professor is a real jerk. The tests he gives are dirty tricks that are intended to make undergrads suffer." This is an example of:

(A) Rationalization  
(B) Projection  
(C) Regression  
(D) Devaluation

77. Marie and her children are attending family therapy. Their therapist asks them questions regarding the lessons they may have learned from past experiences and what the family feels are their best characteristics. The therapist is doing what?

(A) Group identity questioning  
(B) Structural questioning  
(C) Solution-focused questioning  
(D) Model emphasis questioning

78. During a natural disaster, what macro-level social work activities are best when practicing early intervention?

(A) Needs assessment, activating command structure, resource assessment and resource deployment  
(B) Attend to the mental health needs of individuals and families  
(C) Attend to the mental health needs of the workers  
(D) Contact the media to develop and establish a means for communication

79. A 33-year-old man presents for help establishing a meaningful intimate relationship with a woman. He is afraid he will fail as a result of sexual abuse by an older cousin when he was ages 9-12, though it stopped when the cousin moved away, never to be heard from again. After assessing his current situation and past abuse, what is your NEXT step?

(A) Facilitate his entering the dating scene for direct feedback on issues as they occur  
(B) Set goals and objectives for treatment  
(C) Advocate he report his cousin to authorities because the cousin may have children  
(D) Intervene by developing self-soothing and relaxation skills
80. If you were conducting a study on the effects of alcohol on motor skills, you would make sure to give your control group:

(A) No alcohol  
(B) The same amount of alcohol as the experimental group  
(C) A motor skill pretest  
(D) A high dosage of alcohol

81. Asking a client who, what, when, where, how and why:

(A) Is a formula that needs to be followed with all clients  
(B) Can be useful as a preliminary diagnostic tool to evaluate the client  
(C) Will give the social worker a handle on significant cultural discrepancies  
(D) Is useful for a bartender, but not for a trained social worker

82. If research includes grouping subjects based on religious and political memberships, what kind of information is being used?

(A) Ratio  
(B) Nominal  
(C) Correlational  
(D) Ordinal

83. Which one of the following measurements would have the highest frequency of reliability?

(A) Weight  
(B) Beck's Depression Inventory  
(C) Intelligence  
(D) Personality

84. A person who is aggressive to animals, destroys property, steals and violates rules, could be said to have a:

(A) Conduct disorder  
(B) Antisocial disorder  
(C) Mood disorder  
(D) Oppositional defiant disorder

85. What type of family policy seeks to alter the behaviors of individuals, families and entities in a manner deemed proper or preferred by society?

(A) Regulatory  
(B) Structural  
(C) Definitional  
(D) Procedural
86. In treating individuals with Depression who have a high suicide risk, frequent panic attacks along with seizures, which of the following medication is most appropriate?

(A) Maprotiline  
(B) Bupropion  
(C) Fluoxetine  
(D) Doxepin

87. What is the first thing to assess in on-site basic crisis intervention, such as in the aftermath of a natural disaster?

(A) Immediate needs for physical safety, food and clothing  
(B) Trauma response  
(C) Future mental health risk  
(D) Needs for various concrete services (e.g. transportation, alternate housing)

88. Developmental models of supervision usually follow the idea that there are three levels of supervisees: beginning, intermediate and advanced. Which of the following is not a concept that helps to define these levels?

(A) Awareness  
(B) Reliance  
(C) Motivation  
(D) Autonomy

89. A 51-year-old actress insists that she can play the role of a teenage rock star in spite of her obvious matronly appearance.

(A) Denial  
(B) Projection  
(C) Regression  
(D) Reaction Formation

90. Which type of supervision method views the supervisor's role as to assist the supervisee in editing the client's story and help the supervisee develope his/her own personal professional story?

(A) Social Role Supervision Models  
(B) Systemic Supervision  
(C) Narrative Approaches to Supervision  
(D) Person-Centered Supervision
91. A Head Start teacher’s aide reported that 4-year-old Carissa stiffens up when a child in the class cries and a staff worker approaches the child. Carissa's behavior is an indication of possible:

(A) Child physical abuse  
(B) Conduct disorder  
(C) General anxiety Disorder  
(D) Mental retardation

92. A soldier with combat-related Posttraumatic Stress Disorder desires to return to combat. What is the first thing you should do?

(A) Allow the soldier full self-determination, returning when the soldier deems appropriate  
(B) Inform the client that return will likely cause an increase in symptoms and is not advised  
(C) Contact the commanding officer to determine if this is an option for the soldier  
(D) Assess progress in treatment and current level of functioning

93. In the design and development of a psychological experiment on grief, you have concluded that the deception of the participants regarding the nature of the experiment is essential. The experiment would be considered ethical, as long as you:

(A) Tell subjects what the deception was after the experiment  
(B) Use willing, paid subjects  
(C) Clear the procedure with the director of the department  
(D) Indicate to the subjects before the experiment any possible risk or discomfort they might experience

94. Minuchin and other like-minded theorists point out one commonality between very tightly enmeshed families and very loosely tied, disengaged families (particularly those who are uneducated, inconstant and poor). Choose the answer that BEST reflects this commonality.

(A) The families will have a higher incidence of abuse of their children  
(B) The families will have a higher incidence of alcoholism  
(C) The families will have a higher incidence of Autism in their children  
(D) The families will have a higher incidence of delinquency in their children

95. Most treatment failures with antidepressants are due to:

(A) Inappropriate diagnosis  
(B) Patients not taking medication  
(C) Side effects  
(D) Inadequate dosage
96. What are the best objectives to address treatment resistance with a client who is diagnosed with Paranoid Personality Disorder?

(A) Explain the alternative of keeping current symptoms and the associated costs
(B) Develop a trust in the therapeutic relationship and avoid any ambiguity in communications with the client
(C) Develop a trust in the therapeutic relationship and clearly explain the purpose for working cooperatively together
(D) Identify gains in overcoming paranoia and have unambiguous communications

97. Beth is 21 and Ginny is 65. Both are lesbians and each has come to you for therapy. Why would the same therapeutic approach not necessarily work for these two individuals?

(A) Homosexuals of different generations have developed different personality traits and habits
(B) No therapeutic approach should ever be the same as one used before
(C) A therapist should never counsel two patients with similar problems
(D) A therapeutic approach loses its effectiveness once it has been used

98. What was determined in the Tarasoff v. Regents of the University of California (1976) court case that impacts social workers in the mental health sector?

(A) Mandatory reporting to child protective services, impacted by mentally ill parent
(B) Duty to warn if there is imminent danger to another because of mental health status
(C) Mandatory reporting to adult protective services, impacted by mentally ill caregiver
(D) Involuntary admission for danger to self or others, or inability to care for self due to mental illness or incapacitation

99. Pamela had such a problem with twirling her hair with her fingers that her parents got her professional help. It apparently helped her quit for many years. Recently, however, the pressures of being a mother have been getting to her. She is again having problems with this behavior. This would be an example of:

(A) Projection
(B) Regression
(C) Suppression
(D) Sublimation

100. From the elite theory of social policy development, how does the fixed model regard power?

(A) Changing from one hierarchical position to another
(B) Widely dispersed and fluid
(C) Attached to specific person or group of people for an unlimited timeframe
(D) Located within a position, not within a specific person or people
# Answers to all Sample Exams

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<tr>
<td>1</td>
<td>C</td>
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<tr>
<td>2</td>
<td>D</td>
<td>The treatment plan should reflect issues related to life cycle transition.</td>
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<td>3</td>
<td>A</td>
<td></td>
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<tr>
<td>4</td>
<td>B</td>
<td>The rational choice model uses the net value ration to determine the alternative that maximizes all values, not just economical, to be the most efficient; therefore the alternative with the highest net value is the most likely to be selected.</td>
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<td>5</td>
<td>A</td>
<td>Establishing trust and a show of appreciation for the individual's physical suffering is the first step. Individuals with this diagnosis are often experienced as &quot;difficult&quot; because they are reluctant to engage in psychological intervention and habitually report medical complaints with a need for reassurance.</td>
</tr>
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<td>6</td>
<td>D</td>
<td>The Discrimination Model combines an attention to three supervisory roles with three areas of focus. Supervisors might take on a role of teacher, counselor and/or consultant. Each of the three roles is task-specific for the purpose of identifying issues in supervision.</td>
</tr>
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<td>7</td>
<td>A</td>
<td>Liberal value orientation is consistent with universal service provision.</td>
</tr>
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<td>8</td>
<td>D</td>
<td>The variables interested in this experiment are the cell phone usage and a person's health. The type of cell phone and the gender of the subject being studied can both be considered as extraneous variables. The dependent variable here, however, is the subject's health since it can be influenced by the subject's cell phone usage.</td>
</tr>
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<td>9</td>
<td>C</td>
<td>&quot;Work hardening&quot; refers to facilitating the return of a worker to the work force. Work Hardening programs have become full service programs to address the needs of returning the patient to gainful employment.</td>
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<td>10</td>
<td>C</td>
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<tr>
<td>11</td>
<td>C</td>
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<td>12</td>
<td>B</td>
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<tr>
<td>13</td>
<td>A</td>
<td>The reality of providing information to patients so they can make &quot;informed &quot; decisions is extremely complex. It is often difficult to determine in advance what information will be needed by a particular client. On the whole, it is probably better to give too much rather than too little information. However, there are times when a client may not be in the position to make an informed judgment. Examples of this include: legal constraints, disabling mental status, youth, time pressures and emergencies. Consent may also be limited because of judgment by the professional that the risks of harming the patient through disclosure of information may outweigh the benefits to be gained by involving the patient in a particular decision.</td>
</tr>
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<td>14</td>
<td>B</td>
<td>The identified patient (IP) is the family member with the symptom that has brought the family into treatment. The concept of the IP is used by family therapists to keep the family from scapegoating the IP or using him or her as a way of avoiding problems in the rest of the system.</td>
</tr>
<tr>
<td>15</td>
<td>C</td>
<td>Treatment may not be mandated under the circumstances (e.g. treatment is risky or experimental, has small chance of success, quality of life will be significantly affected, treatment only post-pones imminent death, religious beliefs). Patients may be mandated to receive treatment under some circumstances (e.g. treatment is...</td>
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relatively minor, quality of life would not be adversely affected, treatment would not impose chronic limits or pain following treatment, responsibility for minor children). The role of the therapist is to make sure full information was available to make an informed decision, honor self-determination unless professional paternalism dictates otherwise and provide needed resources to support the client and family system.

16 A Assessment of the client, family, community or client system in the most important initial phase in a therapeutic process, which will inform the type of treatment provided. Assessment is done throughout the therapeutic process, and is crucial in any and all situations, modalities and duration of treatment.

17 C

18 C Interoceptive Training is a type of conditioning technique where the therapist helps the client become more capable of recognizing and coping with the social cues, triggers and early signals of a panic attack. Cognitive interventions are then used to counteract the exaggerated or catastrophic thinking that characterize these types of disorders.

19 D

20 D Competition will continue to increase for resources in all sectors.

21 D The first intervention strategy is to facilitate him telling his story.

22 C

23 B

24 A The sacrum is the portion of the vertebral column between the lumbar vertebrae and the structures of the coccyx.

25 A Regardless of the reason for not following the traditionally accepted SOAP note format, you will be wise to follow this traditionally accepted method of note charting. Regardless if you like or dislike insurance companies and the personnel assigned to process your patient claims, if you supply readable and understandable copies of your records in the traditional SOAP format on a regular monthly basis, you'll do a lot to garner their favor.

26 B Anorexia nervosa is the relentless pursuit of thinness and is characterized by: a person's refusal to maintain normal body weight for age and height, weighing 85% or less than what is expected for age and height, in women menstruating periods stop, in men levels of sex hormone fall, young girls do not begin to menstruate at the appropriate age, denial of the dangers of low weight, terror of becoming fat, reporting feeling fat even when very thin, and often include depression, irritability, withdrawal and peculiar, compulsive behaviors.

27 C Deemed consent to treat may be imposed without an individual authorizing consent to treat if a health care worker, public safety officer or other person is exposed to bodily fluids that may transmit infection.

28 B Clients come to counseling to deal with the issues they are facing, not to be given advice. If she is told to leave or to stay and follows through with the advice, no matter the outcome, it is not her fault or her strength that enabled change.

29 A At the close of an event in which you have provided crisis debriefing, it is important you debrief with another volunteer prior to leaving.
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<tr>
<td>30</td>
<td>A</td>
<td>Review treatment gains and indicators for termination of services, then terminate and refer on if indicated is the best course of action. Families often do not want to say goodbye or feel unprepared to move on to the next phase of life.</td>
</tr>
<tr>
<td>31</td>
<td>A</td>
<td>Androgynous characters are common in contemporary music, theater and art; androgyny has always been of fascination to poets, artists and musicians and is rooted in ancient mythologies of both west and eastern civilizations.</td>
</tr>
<tr>
<td>32</td>
<td>D</td>
<td>The other choices refer to: Dysthymic Mood, Mood (in general) and Euthymic Mood.</td>
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<tr>
<td>33</td>
<td>A</td>
<td>It is usually best to talk with the people who are involved directly at first, to give them an opportunity to explain what they have or have not accomplished.</td>
</tr>
<tr>
<td>34</td>
<td>D</td>
<td>Methods of treatment for the elderly must take into account the different skills, values and experiences of different generations (cohort effects); the specific challenges the elderly encounter that younger generations do not; whether or not the patient is in a long-term or primary-care facility (context effects). Age should not come into account when dealing with each individual's differences in development.</td>
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<td>35</td>
<td>C</td>
<td>When there is an even number of items in a set, the median is the average of the two middle numbers.</td>
</tr>
<tr>
<td>36</td>
<td>C</td>
<td>You are ethically obligated to refer the client to someone who can best assist her and is entitled to a provider who is not compromised.</td>
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<tr>
<td>37</td>
<td>D</td>
<td>The central nervous system is the system connected most primarily with emotion.</td>
</tr>
<tr>
<td>38</td>
<td>A</td>
<td>School lunch program is a component of distribution of resources, not of a behavioral regulation.</td>
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<td>39</td>
<td>A</td>
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<tr>
<td>40</td>
<td>A</td>
<td>The next step is to intervene by building skills that overcome shyness and social awkwardness.</td>
</tr>
<tr>
<td>41</td>
<td>A</td>
<td>Scheduling is the primary issue for Tom. A question the agency must ask: whether or not ordinary people can use the program without having to sacrifice their jobs.</td>
</tr>
<tr>
<td>42</td>
<td>A</td>
<td>The Global Assessment of Functioning Scale is given on Axis V. It reports the clinician's judgment of the individual's overall level of functioning and is done via the assignment of a numerical score.</td>
</tr>
<tr>
<td>43</td>
<td>A</td>
<td>Using multiple sources of data for client information is not consistent with a supervisee's learning objective for a communication skill set.</td>
</tr>
<tr>
<td>44</td>
<td>C</td>
<td>One-Way to understand how the mind works is to analyze how information is processed. Given all the sensory input that your mind must deal with on an ongoing basis, you'd quickly find yourself swamped if you ever tried to remember everything. Either consciously or unconsciously, your mind will process what comes in, often providing some kind of connection or organization so that new information that you want to recall is tagged to something you already know or placed within some kind of hierarchical organization.</td>
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<td>Secondary gains refer to perceived advantages that are allowed to a patient due to</td>
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<td>Coordination with the medical provider(s) is important because of the influence of medical conditions and medication interactions in elder adults.</td>
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<td>Stereotype vulnerability entails a person's tendency to expect and perceive negative stereotypes about one's race or social standing and be influenced by them.</td>
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<td>Contemporary Field Instruction is driven by the supervisee's case needs, focusing on case planning and problem-solving.</td>
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<td>54</td>
<td>C</td>
<td>The best course of treatment is to assess her history of abuse and current fears, setting goals for parenting accordingly and addressing other issues as they arise.</td>
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<td>Bupropion has a stimulant type of effect and is used primarily for the treatment of major depression. Bupropion can also be used to treat ADHD, Bipolar Depression, to treat Chronic Fatigue Syndrome, in reducing cocaine craving, to help kick smoking and to reduce lower back pain. Since about 0.04% of people taking this drug will experience seizures, it should be prescribed to people with seizures with extreme caution. Ludiomil is used to treat Depression, including the depressed phase of manic-depressive illness (Bipolar Disorder), psychotic depression (Unipolar Depression) and involutional melancholia. It should not be used in patients with known or suspected convulsive disorders. Maprotiline lowers the seizure threshold.</td>
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<td>The ethical standard of self-determination may be curtailed by a therapist's professional judgment if the path a client is on has foreseeable, imminent risk, either to themselves or to others. The client appears to be making a decision based on fear that could lead to harm. Becoming active and directive in re-engaging the problem solving process is appropriate to assist her in making a better informed decision based on her wants and needs rather than a sense of fear or crisis.</td>
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<td>Because Autism is a severe, chronic developmental disorder, the goal of treatment is to promote the child's social and language development while trying to minimize behaviors that interfere with functioning and learning. Behavior therapy and structured environments appear to help the child acquire self-care, social and job skills.</td>
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<td>It is common for individuals who require prolonged care due to heart muscle disease (and often as the result of a heart attack) to suffer depression.</td>
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<td>Opinion elites are part of elite theory, not interest group theory.</td>
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<td>When the child says, &quot;I fall down and hurted myself&quot; it's not mimicking because you never said that to the child. It's because the child has his own or her own internal grammatical system. This internal system doesn't factor in the irregularities of grammar. Usually children's grammar is much more sensible than adult grammar; they don't know all those complicated past tenses in English. They regularize things. It's called over-regularization. Children do that regularly.</td>
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| 62 | A | Serotonin is a hormone manufactured by the brain. It is a neurotransmitter, involved in the transmission of nerve impulses and is manufactured in the body using the amino acid tryptophan. Release of serotonin or other drugs (depending on the type
of nerve) causes the other nerves to fire and continue the message along the "cable". Certain aminos cause people to have better feeling of wellbeing. Serotonin is a chemical that helps maintain a "happy feeling," and seems to help keep our moods under control by helping with sleep, calming anxiety and relieving depression.

63 A Ethical standards are clear: sex with a current client is unethical and prohibited by the ethical standards of psychologists, psychiatrists, social workers and marriage and family counselors. Sex here does not refer only to sexual intercourse, but refers to any form of physical contact including kissing or fondling. Moreover, since it is virtually impossible to be objective about sex, it is important to confide a sexual attraction with an objective third party, optimally a clinical supervisor. Note: Sonne and Pope (1991) found that clients who have engaged in sex with their therapists respond in ways similar to incest victims (experiencing a sense of betrayal of trust, role confusion, guilt, etc.).

64 A Alfred Adler speculated about a whole series of personality characteristics based on birth order. In Adler's schema, for example, the only child has difficulty sharing with peers and prefers adult company; the oldest child may become authoritarian and feels power is his right; the second child may be even-tempered, and the youngest child is frequently spoiled, may have huge plans that don't work out and can stay the "baby".

65 C The therapist has the responsibility to continue to treat and not to "abandon" clients who are still in need of treatment. "Abandonment" in the medical arena refers to the failure either to treat or to appropriately refer a patient who needs treatment when the provider knows that continued treatment is necessary. If 18 months have passed and the patient has made no progress in treatment, it would be prudent to assume this particular patient is unable to progress under the care of this particular professional and needs to be referred elsewhere.

66 A Elavil (amitriptyline) belongs to a class of similar drugs called tricyclic antidepressants. Elavil is prescribed to treat Depression, Bulimia Nervosa (an eating disorder characterized by bingeing and purging), chronic pain from a variety of conditions including fibromyalgia, reduce the incidence of chronic headache or migraine, ulcers, uncontrollable hiccups, primary (childhood onset) insomnia and to control the involuntary crying and laughing experienced by individuals with Multiple Sclerosis.

67 A To make a diagnosis of Mental Retardation, the onset of symptoms must occur before the age of 18. The criterion that is NOT an appropriate criterion is the one stating that functioning was age or culturally appropriate before the age of 18.

68 D

69 B Ethical standards focus (in theory) on behavior and on motivations that aim at the highest ideals of human behavior. Legally, the special obligations of the professional are known as "Fiduciary"- denoting the special obligation or duty to care for the welfare of those who have become one of clients or patients.

70 A Drawing, painting and sculpting help many people to reconcile inner conflicts, release deeply repressed emotions, and foster self-awareness as well as personal growth. Some therapists employ art therapy as both a diagnostic tool and to help
**treat disorders such as Depression, abuse-related trauma and Schizophrenia. Coloring Therapy is a simple intervention to use. The activity of coloring itself is used as a way to begin to quiet the mind, listen inwardly and open up to higher knowledge, healing and creativity. This alternative to formal meditation practices can help people of all ages in recovery improve coping and awareness skills through an enjoyable activity.**

| 72 | **B** | Interpersonal psychotherapy utilizes a time-limited approach, where the emphasis is in the here and now. It centers on the four common problem areas of: role disputes, role transitions, unresolved grief and social deficits. Research conducted over the last few years has suggested that this type of therapy may be just as effective as using antidepressants in mild to moderate depression cases. |
| 73 | **C** | The term "Dyskinesia" is most often seen together with the word "tardive". Tardive Dyskinesia (late stage Dyskinesia) is a neurological syndrome caused by the long-term use of neuroleptic drugs. Neuroleptic drugs are generally prescribed for psychiatric disorders, as well as for some gastrointestinal and neurological disorders. Tardive Dyskinesia is characterized by repetitive, involuntary, purposeless movements. Features of the disorder may include grimacing, tongue protrusion, lip smacking, puckering and pursing and rapid eye blinking. Rapid movements of the arms, legs and trunk may also occur. Impaired movements of the fingers may appear as though the patient is playing an invisible guitar or piano. |
| 74 | **A** | Echolalia is a symptom of certain forms of mental disorder in which the individual repeats words from a question he/she has been asked, much like a parrot. |
| 75 | **B** | The Social Work legal and ethical mandate is to report. Clinically it is most appropriate to review the limits of confidentiality given at the onset of service delivery, clarify your mandated requirement and offer the opportunity to the client to make the report (a potential empowering event). |
| 76 | **D** | Solution-focused family therapy focuses on developing strengths and competencies as opposed to attempting to understand the cause of problems. |
| 77 | **C** | When practicing social work on a macro-level during a disaster, the activities involved in early intervention are needs assessment, activating command structure, resource assessment and resource deployment. |
| 78 | **A** | The next step is to set goals and objectives for treatment. |
| 79 | **B** | You would make sure to give your control group no alcohol. The purpose of a control group is to prevent factors other than those being studied to affect the outcome. With the control group observed under ordinary conditions as opposed to the alcohol-receiving group, you can easily study the effects of alcohol on motor skills. |
| 80 | **A** | The use of nominal measurement is used to put objects with similar characteristics in the same group. Therefore, if research includes grouping subjects based on characteristics such as religious and political views, nominal information is being used. |
| 82 | **B** | Weight measurement would have the highest frequency of reliability. In statistics, reliability is the consistency of a set of measurements. It is the extent to which the |
measurements of a test remain consistent over repeated tests of the same subject under identical conditions. A measurement is reliable if it yields consistent results of the same measure. The weight of a particular object is not as likely to be subject to change as Beck's Depression Inventory, intelligence or personality; therefore, it has the highest frequency of reliability.

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Just as in the heterosexual population, different generations experience different things and therefore develop differently. For example, Ginny would have experienced both the women's rights and civil rights during the height of the formation of her sexual orientation.

The Tarasoff case is the foundation for duty to warn if a client poses a threat to another because of their mental health status.

The fixed model regards power as attached to a specific person or group of people for an unlimited timeframe.
SECTION 12: DEFINITIONS/TERMS

Abandonment: In the medical arena refers to the failure either to treat or to appropriately refer a patient who needs treatment when the provider knows that continued treatment is necessary.

Acting-in: A member being passive due to personal issues and unwillingness to share. Example: Sitting with crossed arms and legs and not speaking could reflect lack of trust. The member is possibly new. He/she could have brought negative personal residue to the session.

Acting-out: Overreacting that expresses a personal problem. Usually it is a call for attention. Can be vocal or physical. The member may be drawing attention to himself out of fear and distrust or it may be out of narcissistic boredom. Example: Name-calling, arm-waving, moving about in a threatening manner, being verbally abusive or disruptively loud.

Activity Group: Few people getting together to achieve a certain goal, either within the group or without. Example: An activity may be pursued within group at the direction of the facilitator, such as an introductory exercise. Outside the group, members may decide to go to certain skills type classes. This will allow them to continue to be with people that have common interests/concerns.

Advanced Accurate Empathy: Is an accurate understanding of a client based on an active listening and responding to the information (self-disclosure/feedback). In rational-emotive therapy, Ellis talks about the importance of accurate empathy. This is a continuing theme in therapeutic approaches. It relates to the congruency of the therapist. Example: When a therapist has a genuine grasp of what the client is trying to convey.

Art Therapy: Using art to reveal the unconscious or to express emotions the client cannot otherwise articulate. Example: Painting a picture of your family to reveal family dynamics or sculpting ones inner feelings or drawing to express oneself. Drawing, painting and sculpting help many people to reconcile inner conflicts, release deeply repressed emotions and foster self-awareness as well as personal growth. Some therapists employ art therapy as both a diagnostic tool and to help treat disorders such as Depression, abuse-related trauma and Schizophrenia.

Assertiveness Training: Figuratively speaking, learning to stand without being pushed down or pushing back. Assertiveness is not aggression. It does not have to be loud. Group therapy can be a safe setting for practicing assertiveness. Example: Rehearsing saying "no" to group members. Rehearsing repeating the same statement over and over while a group member attempts to sway you from your position. Rehearsal may allow the member to feel comfortable enough to continue this behavior outside the group setting.

Bibliotherapy: Use of books, poems and any written material to help personal growth. Example: Reading poems about death to deal with grief. This can lead members to realize they are not alone in their feelings.

Bupropion: A drug that has a stimulant type of effect and is used primarily for the treatment of Major Depression. Bupropion can also be used to treat ADHD, Bipolar Depression, Chronic Fatigue Syndrome, in reducing cocaine craving, to help kick smoking and to reduce lower back pain. Since about 04% of people taking this drug will experience seizures, use extreme caution when prescribing to people with seizures with. Note: Maprotiline lowers the seizure threshold.
**Catharsis:** Release of accumulated emotions. Catharsis is used in Gestalt therapy. One of the potential dangers of Gestalt therapy involves catharsis. Sometimes an inexperienced therapist may lead a person to the point of catharsis, releasing intense emotion without knowing how to take the client from there. It is very important that a therapist know what to do in the face of the potential unleashed anger or rage or sadness. Example: Sudden outburst of crying or laughing. The client may just have broken down one of the defense mechanism that he has used for years. Once the catharsis has taken place, if cognitive direction is provided, behavior change can take place.

**Closed (or Closed-Ended) Group:** A group therapy structured to begin and end within previously designated time frame. No new members are admitted within that time frame. Example: A 6-month, once a week, weight-loss support group.

**Cohesion:** A goal, a value that provides a feeling of belonging and unity. Beginning building cohesion is the task of the first group session. Example: The trust experienced within the group for one another.

**Coloring Therapy:** Is a simple intervention to use. The activity of coloring itself is used as a way to begin to quiet the mind, listen inwardly and open up to higher knowledge, healing and creativity. This alternative to formal meditation practices can help people of all ages in recovery to improve coping and awareness skills through an enjoyable activity.

**Core Conditions:** Main and necessary conditions for change including empathy, positive regard and congruence.

**Core Group:** The group that stays the same regardless of the movement of other members.

**Corrective Emotional Experience:** The replacement of an old emotion with a new, more productive and positive one.

**Couples Group Therapy:** Several couples meet in a group to work out problems they have in common. Example: A group comprised of couples whose marriage has been threatened by the death of a child.

**Curative Factors:** Term used by Yalom to describe the therapeutic processes that bring about change. Example: These include instillation of hope, universality, imparting of information, altruism, corrective recapitulation of the primary family group, development of socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis and existential factors.

**Early Childhood Recollections:** One’s memories of early childhood. In Freudian psychoanalysis, these early recollections are key in resolving adult conflicts or neurosis. Freud believed that when early childhood trauma is repressed, difficulties in adult functioning follow. The repressed memories are in the unconscious. The goal of therapy is to bring those memories to the conscious. When the repressed memories are brought to the conscious, the adult problems will be resolved.

**Echolalia:** Is a symptom of certain forms of mental disorder in which the individual repeats words from a question he/she has been asked, much like a parrot.
Elavil (amitriptyline): Belongs to a class of drugs called tricyclic antidepressants. Elavil is prescribed to treat Depression, Bulimia Nervosa (an eating disorder characterized by bingeing and purging), chronic pain from a variety of conditions including fibro myalgia, reduce the incidence of chronic headache or migraine, ulcers, uncontrollable hiccups, primary (childhood onset) insomnia and to control the involuntary crying and laughing experienced by individuals with Multiple Sclerosis.

Encounter Group: A term coined by Carl Rogers for an experiential group that helps people discover knowledge about human relations and themselves. An effective leader provides emotional stimulation, caring, meaning attribution and performs administrative functions. Example: A socially isolated college student joined an encounter group to learn social skills in a safe setting.

Evaluation Research: Research that relies on subjective observation rather than an objective statistically standardized instrument. It does not rely on a statistical standardized tool. Example: Self-reporting by group members on the value of their group experience. Or, inferring a child’s social attitudes from a clinician’s observations of a child’s social interactions rather than giving the child a written questionnaire to compete regarding his social attitudes.

Existential Issues: In existential therapy, the issues confronted are the meaning of life, freedom and responsibility, anxiety as a condition of life, isolation, death and non-being. Existentialism is predicated on the assumption that we are free to choose and therefore responsible for our own choices. Existentialism notes that it is through our recognition of death that we find meaning in life. Example: Is that all there is? Am I on the right path in my life? Am I really meant to be (a teacher, a doctor, an executive, whatever)?

Experiential Therapy: Focuses on the present situation. Emphasizes activities. Is therapist directed? The therapist designs interventions to enhance here and now awareness of the conflicts the individual is dealing with. Example: A therapist designs an activity to be carried out as a group as a way of testing new ways of thinking, feeling and behaving.

Family Constellation: How the family members are arranged in the perception of the family member.

Fluoxetine: Is in a new class of antidepressant medications that affects chemical messengers within the brain. These chemical messengers are called neurotransmitters. Many experts believe that an imbalance in these neurotransmitters is the cause of depression. Fluoxetine is believed to work by inhibiting the release or affects the action of serotonin. Fluoxetine is used in the treatment of Depression and obsessive-compulsive disorders.

Group Psychotherapy: A process of reeducation that includes both conscious and unconscious awareness and both the present and past. Psychotherapeutic intervention in a group setting. Example: Anorexic teenaged girls meeting daily while hospitalized for eating disorder.

Group Stages: The process for the development of a group, from beginning to end. Example: Stage I is the introductory stage during which rapport is established, confidentiality is explained, parameters are set and cohesion starts being built.
**Group Therapy:** Therapy in which the goals are remediation, treatment and personality reconstruction.

**Heterogeneous:** Consisting of varied characteristics or presenting problems. Example: a group made up of males and females. Or made up of more than one presenting problem.

**Homogenous:** Sharing a common interest or problem or sharing common characteristics. Example: Adolescent males in a group or an all schizophrenic group, though including males and females.

**Humanistic Therapy:** Therapy that emphasizes the client. Emphasizes the relationship between client and therapist. Sees the quality of that relationship as sufficient in itself to effect change. Example: Gestalt, existentialism and person-centered therapy are all types of humanistic therapies.

**IP or the Identified Patient:** Is the family member with the symptom that has brought the family into treatment. The concept of the IP is used by family therapists to keep the family from scapegoating the IP or using him/her as a way of avoiding problems in the rest of the system.

**Integrated Congruent Relationship:** Pertains to perceived genuineness of group members. Example: Suzie reaches out to Martha understanding her problem even though this has not happened to her personally.

**Interoceptive Training:** Is a type of conditioning technique where the therapist helps the client become more capable of recognizing and coping with the social cues, triggers and early signals of a panic attack.

**Interpersonal Leader:** The leader focuses on the group process rather than individuals in the group. Example: Dr. Joe observes the group becoming agitated, some tapping their feet.

**Interpersonal Learning:** Learning via the group process.

**Intrapersonal Learning-Therapeutic Factor:** In group therapy, this leader focuses on an individual as though doing individual therapy in a group setting. Example: Dr. Joe focuses on Jean giving her individual guidance, while the other group members learn vicariously.

**Introspection:** Internal evaluation of thoughts and feelings. Example: self-analysis.

**Leader Roles:** Modeling, helping, identify goals, division of responsibility and structuring. Example: Dr. Joe demonstrates empathy instead of describing it.

**Leader skills:** Refers to the group leader’s competency in interventions that facilitate the group process. Example: Active listening, restating, clarifying and summarizing.

**Leader Style:** A leader’s unique traits often influenced by one’s theoretical preferences. Example: Dr. Joe loves to laugh and tries to insert humor whenever possible.

**Linking:** Helping members bridge common concerns for shared problems and/or solutions and connect the work that the members do. Example: MADD (Mothers Against Drunk Driving).
Ludiomil: Is a drug used to treat Depression, including the depressed phase of manic-depressive illness (Bipolar Disorder), psychotic depression (Unipolar Depression) and Involutional Melancholia. It should not be used in patients with known or suspected convulsive disorders. Note: Maprotiline lowers the seizure threshold.

Marathon Group Therapy: A group therapy session that meets over a long period of time. Requires the group therapist to set clear and realistic treatment goals with the members, to establish a clear focus within the structure and maintain an active role to work in the time frame. Example: Alcoholics Anonymous.

Meaning Attribution: Clarity of group input as well as output to explain change. Members can discover ways in which they have lost direction.

Milieu Therapy: Type of treatment for socially and mentally disordered individuals, usually in an institution. Group counseling is typically the setting. Residential treatment, living the treatment. Example: Lock-up facility.

Neuroleptic Drugs: Are generally prescribed for psychiatric disorders, as well as for some gastrointestinal and neurological disorders.

Nonspecific Factors: Changes in behavior that can not be measured. Example: Generosity, courage, humor, love or hate.

Norms: The acceptable/unacceptable standards of behavior agreed upon by leader and members. Some norms may pose problems for members of different cultural backgrounds. Example: Responsibility or group rules.

Open Groups: Groups in which members join and leave at different times. New members replace leaving members and can add stimulation Example: AA or Narcotics Anonymous.

Personal Integrated Eclectic Model: A therapeutic style that can adapt to each member in a unique way. Perspective based on concepts and techniques from various theories. Example: Person-centered therapy or a popular teacher.

Personality Reconstruction: Therapy where the basic structure of the client is restructured to create an integrated individual. Make the unconscious conflicts conscious and examine them. Example: Analytic group or Boot Camp.

Personhood: The personal style the therapist brings to therapy instead of dry therapeutic skills. Example: Michael Jordan to basketball or Albert Ellis, Fritz Perls and Carl Rogers each bring their own personhood to therapy.

Positive Reinterpretation: Reframing a member’s negative behavior into a positive light. The member is able to view his behavior as more manageable, and the leader is able to see the behavior in compassionate rather than threatening terms. Example: The glass being half-full as opposed to half-empty.

Pre-group Interview: Meeting between members and leaders on an individual basis in order to select members for the group who have common concerns. Time to discuss importance of their own preparation for the group. Example: Job interview or a College Entrance interview.
Primary Empathy: The giving of empathy through thoughtful sincere listening and reception; being sincere enough that once relayed to client what he/she expressed in a fashion that they have been heard and understood. A background that includes a wide range of experiences can help leaders to identify.

Professional Standards: Guidelines created by the Association for Specialists in group work, which emphasizes and focuses on experience, abilities and understanding. The ASGW published an expanded professional standards for the training of Group Workers.

Psychological Education: New teaching techniques for the large groups in the mental health arena. These techniques are provided to teachers, laypersons, counselors, etc. in hopes of giving each of them an insider’s perspective to the symptoms of mental disorders. This foundation reaches a broader population of people who may come into contact with these individuals. Example: Participation in experiential training workshops.

Regression Techniques: The technique of retrieving data from an earlier time in one’s life in order to bring about a possible change in the present. A technique for examining causes and formation. Reaction to members and leader reveal symbolic clues to relationships of significant people in family origin.

Re-socialization Group: Groups that allow individuals to adapt to new social norms, roles, and situations. Examples: New Citizens, prisoners, military personnel and prisoners of war.

Role Playing: Technique used in counseling sessions being group or individual. Involves allowing individuals to assume the role of another individual to allow all involved to see how they are perceived and received. Effective way to practice new skills in interpersonal sites. Example: Children playing grownup roles.

Script: The planning of one’s life by someone or some force from time of birth. Rigid and stereotypical responses. Example: Girls should be polite and never angry.

Secondary Gains: Refer to perceived advantages that are allowed to a patient due to an illness. The therapist feels the advantages gained by this disorder outweigh the discomfort created by this mental illness.


Self-Help Groups: A coming together of people who have the same needs or difficulties in a particular area to vent and grow. Majority of groups are on a voluntary basis for the purpose of personal growth and the need to overcome in a community that everyone has a common ground. Members helping themselves by assuming personal responsibility and taking action to resolve concerns. Example: New Beginnings for the newly divorced.

Sensitivity Group: It’s a group where everyone partakes in hopes of expressing and receiving feelings of others in hopes of becoming more aware of one’s own feelings. Once a member is able to challenge his/her resistance on a feeling level, they are better able to challenge their cognitive level.
Separation Issues: Feelings that arise from some sort of loss, being it death, divorce, relocation or separation. If group closure is poorly handled, members can be left with unresolved issues, without direction on how to bring these issues to closure.

Serotonin: A hormone manufactured by the brain, it is a neurotransmitter, involved in the transmission of nerve impulses using the amino acid tryptophan. Release of serotonin or other drugs (depending on the type of nerve) causes the other nerves to fire and continue the message along the "cable". Certain aminos cause people to have better feeling of wellbeing. Serotonin is a chemical that helps maintain a "happy feeling," and seems to help keep our moods under control by helping with sleep, calming anxiety and relieving depression.

Single-Session Group: A session where the individuals and the therapist generally meet once to focus on one problem. A variety of approaches to brief group treatment have been developed and are effective and economical. Examples: Managed Care.

Social Group Work: Where a group of individuals with similar problems or situations come together to partake in activities as a group. They use reinforcement, modeling, shaping, cognitive, restructuring, desensitization, relaxation training, coaching, behavioral, rehearsal, stimulus control and discrimination training. Example: Sexual Harassment group.

Social Microcosm: The blending of such diverse cultures and/or experiences forming almost a mini world; attempting to reflect in some ways all of the dimensions of the members’ real social environment.

Sociogram: The form in which individuals of a group come together and express how they feel about one another. A diagram representing the pattern of relationships between individuals in a group.

Stereotype Vulnerability: Entails a person's tendency to expect and perceive negative stereotypes about one's race or social standing and be influenced by them.

Structured Exercise: Techniques used for achieving a particular goal in a set amount of time. Can enhance interaction and provide a focus for work or promote member independence on the leader.

Structured Group: Group designed with a particular purpose or agenda in mind. Problem-oriented and short-term.

T-Groups: Groups that help people work on skills and abilities to help them interact and coexist with peers in particular settings. Example: Encounter group.

TACT: Stands for Timeliness, Appropriateness, Consent and Theory, all necessary for good therapy.

The Tarasoff Case: Is the foundation for duty to warn if a client poses a threat to another because of their mental health status.

Tardive Dyskinesia (late stage Dyskinesia): Is a neurological syndrome caused by the long-term use of neuroleptic drugs. Tardive Dyskinesia is characterized by repetitive, involuntary or purposeless movements. Features of the disorder may include grimacing, tongue protrusion, lip-
smacking, puckering/pursing and rapid eye blinking. Rapid movements of the arms, legs and trunk may also occur. Impaired movements of the fingers may appear as though the patient is playing an invisible guitar or piano.

**Task-Oriented Group:** Where the group members stay focused on a particular problem within a short time period. Examples: Task forces, committees, planning groups, community organization, and discussion groups.

**Theme-Oriented Group:** Where the group members stay focused on a particular theme; emphasizes the individual, group and theme. Examples: Compassionate Friends, Hospice.

**Therapeutic Factors:** The sole implementations of skills, techniques and style that facilitate therapy. Factors can be if a member has a supportive family or not, if he/she is employed or not.

**Transactional Analysis:** A therapeutic approach by Eric Berne that focuses on the interactions of people. Relies on the Id, Ego and the Super Ego, theory of personality and an organized system of interactional therapy. We make current decisions based on past premises that were at one time appropriate for our survival.

**Transactions:** The spoken and unspoken communication that takes place between individuals during a session. Examples: Feedback, confrontation and support.

**Unconditional Positive Regard:** This is the position a therapist takes when counseling a client. They believe people are all right despite their actions and the effects on themselves and others. Acceptance of and caring for members. Example: Rogerian therapy.

**Work Hardening:** Refers to facilitating the return of a worker to the work force. Work Hardening programs have become full service programs to address the needs of returning the patient to gainful employment.