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Lesson No.

2.1 : DRUG ABUSE: TYPES AND ITS EFFECT ON MENTAL AND PHYSICAL HEALTH

2.2 : DRUG ABUSE: CAUSES AND PREVENTION

2.3 : PSYCHOTHERAPY : PSYCHODYNAMIC THERAPY

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DRUG ABUSE: TYPES AND ITS EFFECT ON MENTAL AND PHYSICAL HEALTH

7.1 OBJECTIVES in this lesson, we will come across various types of drug abuse, and its effects upon physical and mental health of an individual.

7.2 What is drug abuse?

Drug abuse, also called substance abuse or chemical abuse, is a disorder that is characterized by a destructive pattern of using a substance that leads to significant problems or distress.

7.3 What is drug addiction?

Drug addiction, also called substance dependence or chemical dependency, is a disease that is characterized by a destructive pattern of drug abuse that leads to significant problems involving tolerance to or withdrawal from the substance, as well as other problems that use of the substance can cause for the sufferer, either socially or in terms of their work or school performance.

7.4 Commonly abused drugs and their effects on physical and mental health.

7.4.1 Stimulants or Amphetamines

Amphetamines are stimulants that accelerate functions in the brain and body. Stimulants are used to stay awake and energetic for long periods of time (e.g. students cramming for exams or long haul truck drivers), to lose weight, as a confidence booster or for a long lasting energetic high. They come in pills or tablets. Amphetamines increase heart and breathing rates and blood pressure, dilate pupils and decrease appetite.

7.4.1.1 Effects & Dangers:

Swallowed or snorted, these drugs hit users with a fast high, making them feel powerful, alert, and energized. They pump up heart rate, breathing, and blood pressure, and they can also cause sweating, shaking, headaches, sleeplessness, and blurred vision. Prolonged use may cause hallucinations and intense paranoia. Amphetamines are psychologically addictive. Users who stop report that they

experience various mood problems such as aggression, anxiety, and intense cravings for the drugs. Its most significant effects are:

Aggression, paranoid behaviour, Anxiety, Dilated pupils, Dry itchy skin, Euphoria, Excessive sleeping at unusual times, Faster breathing rate, Flushed skin, fever, sweating, Heart failure, Hyperactivity, restlessness, excitability, Impaired speech, Insomnia, skipping sleep, Irritability, Long periods of not sleeping or eating, Loss of appetite, fast weight loss, Needle tracks, vein damage, Shaking, convulsions or other uncontrolled movements, Talkativeness, Weight loss.

7.4.2 Sedatives/Barbiturates

Barbiturates are a type of depressant drug that cause relaxation and sleepiness. In relatively low doses, barbiturates and alcohol have very similar clinical syndromes of intoxication. Downers -- Valium, Quaaludes, Librium, Xanax -- also have appropriate medical uses, but are also abused by many users. "Barbs" cause slurred speech, disorientation and "drunken" behavior. They are physically and psychologically addictive. Withdrawal symptoms include anxiety, convulsions, and possible death. They are used as a relaxant and to generate a state of euphoria.

7.4.2.1 Possible noticeable symptoms of use, abuse or withdrawal:

Clumsiness, Difficulty focusing, thinking, talking, Difficulty walking, Needle tracks, vein damage, Poor balance, falling, bruises, Poor judgment, Pupils contracted, Sleepiness, Slurred speech, Weakness, shakiness

7.4.3 Anabolic Steroids

Steroids are artificially produced testosterone, the male sex hormone. These are used to build muscles and improve athletic performance. Side effects include liver and kidney dysfunction, high blood pressure, heart disease, degeneration of the testicles, premature baldness, and acne. Abnormal aggression, mood swings and psychiatric symptoms can also be attributed to steroid use.

7.4.3.1 EFFECTS:

Aggression, irritability, Baldness, Breast growth in men, Deeper voice and excess body hair in women, Heart attack, Needle tracks, vein damage, Skin eruptions and acne, Weight gain and muscle growth

7.4.4 Cannabis:

More commonly called marijuana, the scientific name for cannabis is etrahydrocannabinol (THC). In addition to the negative effects the drug itself can produce (for example, infertility, paranoia, lack of motivation), the fact that it is commonly mixed ("cut") with other substances so drug dealers can make more money selling the diluted substance or expose the user to more addictive drugs

exposes the marijuana user to the dangers associated with those added substances. Examples of ingredients that marijuana is commonly cut with include baby powder, oregano, embalming fluid, PCP, opiates, and cocaine.

A stronger form of marijuana called hashish (hash) looks like brown or black cakes or balls. Marijuana is often called a gateway drug because frequent use can lead to the use of stronger drugs.

7.4.4.1 Effects & Dangers:

Marijuana can affect mood and coordination. Users may experience mood swings that range from stimulated or happy to drowsy or depressed. Marijuana also elevates heart rate and blood pressure. Some people get red eyes and feel very sleepy or hungry. The drug can also make some people paranoid or cause them to hallucinate. Marijuana is as tough on the lungs as cigarettes — steady smokers suffer coughs, wheezing, and frequent colds.

Using marijuana produces a sense of fuzziness in the brain, which has led to a number of accidents involving motor vehicles and in the workplace. Marijuana abuse during pregnancy leads to low-birth weight babies, and puts the child at increased risk for a form of blood cancer.

7.4.5 Cocaine

Can be found as a fine white crystalline powder or as a small white or off-white crystal-like rock of irregular shape and size. In its powder form it is usually inhaled (snorted) through the nose or dissolved in water and injected. The rock form is usually smoked in a pipe and is generally referred to as crack.

7.4.5.1 Effect:

This drug and its variants are highly addictive and are used as an intense stimulant and euphoric giving a false sense of energy and power. Because the intense euphoria these drugs produce is very short-lived, users typically use again and again trying to recapture that initial "high." Physical effects of cocaine include increases in blood pressure, heart rate, respiration and body temperature. Snorting cocaine can severly damage nasal membranes over time. Continued use produces insomnia, hyperactivity, anxiousness, agitation and malnutrition. Overdoses can be lethal.

A person who is addicted to cocaine may experience the following symptoms and effects.

Confusion, Dilated pupils, Excess energy, Increase in heart rate and blood pressure, Loss of appetite, Paranoia, Rapid heartbeat, Rapid speech, Runny nose, Stuffy nose.

If the cocaine use continues, the addict may experience some serious consequences in the form of long-term effects or serious health issues as a result, including:

Blurred vision, Chest pain, Hallucinations, Heart attack, Heart disease, Seizures, Stroke.

7.4.6 Ecstasy

Ecstacy is also known as tab, ecty, happy face, disco burgers, doves etc. Ecstacy is a tablet that is hand made using very dangerous chemicals. Ecstacy has become a very popular drug taken by hundreds of people around the world. It is mainly taken for the party moods, where one can dance the whole night away.

Ecstacy usually takes effect 20 to 30 minutes after being taken it; it is taken by the mouth and wears off about 3 to 4 hours after it has been consumed. The taker can feel and see things much nicer then it was and also your hearing sounds are better which put one in a dancing mood particularly when the music has a strong rythm. Ecstacy puts you in a relaxing mood, sleepiness, sexual behaviour and in easy temperament.

Afterwards, it can cause exhaustion and depression. The side effects are sweating constantly, chills, blurry vision, increase of the heart rate; it can also cause internal bleeding, damage the liver and kidney and cause heavy period for girls.

7.4.6.1 Effects

Agitation, Anxiety, Changes in eating and sleeping patterns, Chills, Confusion, Cycles of wakefulness and fatigue, Decreased interest in school, work, family or other activities, Depression, Dramatic mood changes, Faintness, Fatigue, Hallucinations, Hyper-alertness, Hyperthermia, Impaired learning and memory function, Involuntary teeth clenching and grinding, Irregular sleep patterns, Jaw-clenching, Needle tracks, vein damage, Panic attacks, Person is more empathetic or affectionate than normal.

7.4.7 Hallucinogens

Hallucinogens or psychedelic drugs are drugs that alter a person's perception of reality by distorting their experience of sight, sound, taste and touch. These drugs are either synthetically manufactured or derived from plants. LSD (lysergic acid diethylamide), PCP (phencyclidine, or 'angel dust'), ketamine and 'magic mushrooms' are all hallucinogenic drugs. Cannabis, ecstasy and other drugs may also have a hallucinogenic effect. LSD, DMT, Mescaline, PCP, and Psilocybin have very unpredictable effects. Users may experience morbid hallucinations and feel

panicked, confused, paranoid and out of control -- or in other words, a "bad trip." The heightened suggestibility and intensified emotions that hallucinogens create can worsen any pre-existing emotional problems. Physical effects of hallucinogen use include dilated pupils, sweating, insomnia, loss of appetite, tremors; and increased body temperature, heart rate and blood pressure. .

7.4.7.1 Effect:

Produces hallucinations, possibly up to 24 hours. Also leads to aggression, Anxiety, Confusion, Delusions, Depression, Detachment, Dilated pupils, distorted time sense, Euphoria, Flashbacks, Hallucinations, Heightened or confused senses, Helplessness, Loss of appetite, Loss of time sense, Mood swings, Panic attacks, Seizures, Self absorption, Sleeplessness, Slurred speech, Sweating, Tired, Tremors, Unexplained fears.

7.4.8 Inhalants:

One of the most commonly abused group of substances due to its accessibility, inhalants are usually contained in household cleaners, like ammonia, bleach, and other substances that emit fumes. Brain damage, even to the point of death, can result from using an inhalant just once or over the course of time, depending on the individual.

7.4.8.1 Effects:

Anxiety, Changes in appetite, Delusions, Disorientation, Dizziness, Drowsiness, Euphoria, Excitability, Hallucinations, Headaches, Holding items or clothes up to the nose, Impaired vision, Irritability, Nausea, Poor, coordination, Poor memory, Red, runny eyes, Restlessness, Runny nose, Slurred speech, Strange breath odor, Unconsciousness, Unexplained sores on the face, especially around the nose or mouth, Watery eyes

7.4.9 Opiate Abuse

Opium, Heroin, Morphine, and Codeine are used legally by the medical profession to relieve pain. But they are abused due to their mood-altering effects. All narcotics are extremely physically and psychologically addictive. Medical problems can include congested lungs, liver disease, tetanus, infection of the heart valves, skin abscesses, anemia and pneumonia. Death can occur from overdose.

Opiates are narcotics, and drugs in this category tend to make the user feel sleepy (downers), as opposed to energized (uppers). Many are powerful and can severely "numb" the user. As medication, opiates are used to relieve moderate to severe pain. The term opiate refers to any of the narcotic alkaloids found in opium, as well as all derivatives of such alkaloids.

People with chronic pain, cancer, or who are recovering from surgery may be prescribed these medications.

7.4.9.1 Effects of Use

Opiate addicts use the drug to feel a sense of well-being that comes in a rush after the drug is taken. After this initial feeling of euphoria, the user goes through alternate periods of feeling alert and then drowsy. Using opiates affects the user's ability to reason clearly. Respiration slows, and reflexes are impaired.

Other effects include:

- Difficulty breathing,
- Fingertips and lips turn blue
- Shallow breathing
- Weak pulse

Over the long term, opium addicts may display these kinds of symptoms:

- Collapsed veins (if the drug is being injected)
- Refusing to eat
- Ignoring basic personal hygiene
- Liver disease
- Pneumonia

7.4.10 Heroin Addiction

Heroin is a narcotic and an illegal drug that is typically injected or snorted by users though it can be smoked. The manner in which the drug, from the opiates family, is ingested has little bearing on the potential for addiction. The fact is that repeated use leads to addiction, whether you are using needles or not.

7.4.10.1 Effects of Use

Along with the rush that takes place shortly after use, heroin addicts also experience these effects:

Decreased ability to cough, Difficulty breathing, Drowsiness, Dry mouth, Heaviness in the extremities, Hypothermia, Nausea and/or vomiting, Reduced anxiety, Severe itching

Heroin abusers are also putting themselves at risk for a number of health issues, including:

- Risk of contracting HIV or Hepatitis C from needle use
- Increased risk of miscarriage
- Increased tolerance over time where the addict must use more of the drug to achieve the same effect

- Heroin overdose

7.4.11 Nicotine:

The addictive substance found in cigarettes, nicotine is actually one of the most habit-forming substances that exists. In fact, nicotine addiction is often compared to the intense addictiveness associated with opiates like heroin. Nicotine is one of the hardest addictions to break.

Nicotine is one of the chemicals that are present in tobacco products, and it is responsible for giving smokers a "rush" within about 10 seconds of taking a drag of the cigarette. The effect doesn't last for very long, which is why a person with a nicotine addiction keeps lighting up. Most people who smoke become addicted to nicotine. Someone who has become addicted to nicotine may have cravings for cigarettes, have difficulty stopping smoking, and have nicotine withdrawal symptoms when they try to do so. Some people feel irritable when they don't have a cigarette, while others find it hard to concentrate without them. Nicotine causes addiction because it affects the brain by making it produce an increased amount of a chemical called dopamine. Dopamine is a neurotransmitter that has a lot to do with how a person feels pleasure. When dopamine levels drop, the nicotine addict may feel down or even depressed and lights up another cigarette to feel good again.

7.4.11.1 Effects of Use

A person who smokes puts an extra strain on their heart every time they have a cigarette. Cigarettes also contain carbon monoxide, which makes it more difficult for your body to get the oxygen it needs. To compensate, blood flow to the extremities is reduced. Smokers have bad breath, stained teeth and fingers, and a lowered resistance to colds and the flu. The nicotine addict's sense of smell and taste are less sensitive than a non-smoker's are. Appetite is reduced as well.

About half of people who smoke will die as the result of their habit. Smoking causes cancer in several parts of the body, including the lungs, mouth, throat, and voice box. It also increases a person's chances of developing heart disease or having a stroke. Nicotine addiction has been linked to Chronic Obstructive Pulmonary Disease (COPD), which is emphysema and chronic bronchitis. Nicotine addicts lose their hair and develop wrinkles at a younger age than non-smokers. Men who use smoke may have fertility problems, and women who use tobacco products are at increased risk of miscarriage, having a low birth weight baby, or going into labor early. Painful menstrual periods or an irregular cycle may be caused by smoking.

7.4.12 Benzodiazepines

Other Names: Benzos, date rape, downers, forget-me pill, Librium®, Rohypnol®, roofies, stupefy, tranks, Valium®, valo and Xanax®.

These are common prescription drugs that usually come as capsules and tablets in various shapes and colors. Sometimes found as a liquid.

7.4.12.1 Effect:

Along with prescription uses, these are used as relaxants and to enhance the effects of other drugs. One of this class of drugs, Rohypnol®, is known as the 'date rape' drug as, when mixed in a drink, it can cause amnesia and the victim has no recollection of what happened to them.

Possible noticeable symptoms of use, abuse or withdrawal:

Amnesia, Difficulty focusing, thinking, talking, confusion, Difficulty walking, Dizziness, poor balance, weakness, shakiness, Nausea, Sleepiness, fatigue, lethargy, Slurred speech, Vomiting.

7.4.13 GHB

Other Names: G, gamma-hydroxybutyrate, Georgia home boy, grievous bodily harm, easy lay, liquid ecstasy, liquid X, organic Quaalude and salty water.

This is also a date rape drug. It is usually swallowed. It is often taken with alcohol.

7.4.13.1 Effect:

It is a sedative that can have an effect similar to that of alcohol. It can produce hallucinations and euphoria. It can also make the user feel energetic, affectionate and sociable, while decreasing inhibitions and increasing sexual experience.

7.4.14 Methamphetamine

It can be found as a white, yellowish or brownish crystal-like powder. Sometimes it comes in large chunks, which are sometimes clear. It can also be found as small, colored tablets.

It can be smoked or injected.

7.4.14.1 Effect:

Can create feelings of pleasure and increased energy and alertness, elevating the users mood.

Acne, Aggressive behaviour, Anxiety, Anxiousness, Body odor, Chaotic, lifestyle, Delusions of grandeur or power, Depression, Dilated pupils, Euphoria, Excessive talking, Excitement, Hallucinations, Hyperactive behaviour, Impaired coping abilities, Impaired speech, Increased alertness, Insomnia, Irritability, Itchy skin, Lack of interest in friends or sex, Loss of appetite , Mental confusion, Mood swings, Nervousness, Panic attacks, Paranoia, Rapid speech, Rotting, blackened

teeth, Sleeplessness, Sores on the skin, Tendency towards violence, Twitching or other uncontrolled body movements, Vomiting, Weight loss

7.4.15 Cough and Cold Medicines (DXM)

Several over-the-counter cough and cold medicines contain the ingredient dextromethorphan (also called DXM). If taken in large quantities, these over-the-counter medicines can cause hallucinations, loss of motor control, and "out-of-body" (or disassociative) sensations.

Cough and cold medicines, which come in tablets, capsules, gel caps, and lozenges as well as syrups, are swallowed. DXM is often extracted from cough and cold medicines, put into powder form, and snorted.

7.4.15.1 Effects & Dangers:

Small doses help suppress coughing, but larger doses can cause fever, confusion, impaired judgment, blurred vision, dizziness, paranoia, excessive sweating, slurred speech, nausea, vomiting, abdominal pain, irregular heartbeat, high blood pressure, headache, lethargy, numbness of fingers and toes, redness of face, dry and itchy skin, loss of consciousness, seizures, brain damage, and even death. Sometimes users mistakenly take cough syrups that contain other medications in addition to dextromethorphan. High doses of these other medications can cause serious injury or death.

People who use cough and cold medicines and DXM regularly to get high can become psychologically dependent upon them (meaning they like the feeling so much they can't stop, even though they aren't physically addicted).

7.4.16 Prescription Drug Abuse

Prescription drug addiction is a growing problem that many people don't take as seriously as they should. Since the medications were originally prescribed by a doctor, they feel that prescription drug abuse is different than when the person is using street drugs. Prescription drug addicts are addicted, in the same way that those who get hooked on cocaine, heroin, or other types of illegal drugs are.

A prescription drug addict uses medications in a way other than for which they were originally prescribed or to a much greater extent. They come to depend on the drugs to feel better in some way, and experience cravings for them in between doses. The prescription drug use continues in spite of negative consequences for the user, including relationship difficulties, problems on the job, or the risk of physical harm from inappropriate use.

Prescription medications are drugs and they work on the user's brain in the same way their illegal counterparts do. When a person who is addicted to prescription drugs uses them, the medication changes the brain's chemistry, making it less effective at producing chemicals like dopamine or endorphins. Since the brain has stopped producing these chemicals itself, they must be introduced through another source. At this point, the prescription drug addict has become physically dependent on the medication.

Seniors are especially at risk for prescription drug addictions, simply because they are prescribed drugs more often that other groups. For example, a doctor may prescribe a tranquilizer after they have experienced a traumatic event, such as the death of their spouse. The person feels calmer and is able to sleep better with the medication, so they take it more often than the doctor directs. When they run out, they go back to the doctor for another prescription, and this is how the addiction starts.

7.4.16.1 Effects of Using Prescription Pills Excessively

A person who is addicted to prescription drugs may experience the following:

- Anxiety
- Depression
- Difficulty sleeping or sleeping too much
- Loss of interest in relationships with friends or family members
- Withdrawal symptoms when they try to stop using the medication on their own

When it comes to prescription drug addictions, the most important complication is of drug interaction. If ones doctor or pharmacist is not aware of everything one is taking, they may give a medication that will produce side effects when combined with ones prescription medication. Vitamins and herbal remedies fall into this category as well.

When one consumes alcohol and prescription drugs, the combination of the two can produce some nasty side effects. If one is taking a sedative or a painkiller and drink alcohol, the combination of the two may affect the central nervous system, leading to respiratory distress or failure, or even death.

7.5 Reference

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Lesson no. 2.2 **Writer: Dr. Damanjit Sandhu**

DRUG ABUSE: CAUSES AND PREVENTION

8.0 Objectives

In this lesson we will study the various factors calling drug abuse. Also, we will review what kind of steps can prevent the drug abuse problem. The role of family, school and community will be highlighted. Also, a preview of various successful process already conducted in this direction will be discussed.

8.1 CAUSES

8.1.1 EXPERIMENTATION AND CURIOSITY:

Experimentation and curiosity are the first factors that draw many people into trying drugs. They want to feel that "high", the sense of euphoria that comes with drug use. While this may lead to recreational use of drugs (using only in certain situations), it rarely leads to actual addiction unless other factors are present. However, some drugs (like heroin) have are more likely to cause addiction than others resulting in an addiction from simple experimentation alone.

8.1.2 PRESCRIPTION DRUGS:

Prescription drugs can turn people into addicts because they have conditions in which they need to take drugs in order to get relief. People become hooked on prescription drugs when they take more than the recommended dosage, take it more frequently than recommended and continue using the drug after their initial medical condition clears up. A 2009 survey from the Centers for Disease Control and Prevention shows that prescription drug abuse is on the rise, with 20% of teens saying they have taken a prescription drug without a doctor's prescription.

8.1.3 SPORTS PERFORMANCE:

Elite athletes are susceptible to using drugs. They use them for performance enhancing abilities. An above steroids can make muscles bigger, while amphetamines help reduce or numb pain and allow people to play injured.

8.1.4 COPING WITH STRESS:

Others turn to drug use to cope with problems in their real lives. Whether it is past abuse (physical or sexu al), school problems, work problems or relationship issues, drug use can help a person temporarily escape the realities of his/her life. People try to escape from reality, for they do not want to deal with their current situation, emotions or circumstances. Many such victims feel they can not deal with their current surroundings or their emotional state, due to a series of past bad experiences in their lives that finally caught up with them.

8.1.5 DRUG USAGE BY FAMILY / FRIENDS:

We are all a product of our parents. If the parents have addiction struggles, chances are one is more susceptible to addiction. That's why drug abuse is more common in some families than in others. Drug abuse causes one generation to pass it on to the next, genetically. Being around drugs and being exposed to addicts can also lead to drug addiction. If a family member or close friend uses or is addicted to drugs, it seems more acceptable for other members to engage in similar behaviour. It becomes a tolerated activity. Association with drug-abusing peers is often the most immediate risk for exposing adolescents to drug abuse and delinquent behavior.

8.1.6 Peer pressure:

Peer pressure is also a factor in turning people into drug addicts. Contrary to popular belief, peer pressure can happen at any age. Adults fall prey to peer pressure to fit into new social classes, new workplaces and new neighbourhoods. Teenagers fight peer pressure on everything from looks to alcohol to sex to drugs. In fact, using crystal meth is becoming a way for many teenage girls to fight the pressure that comes with needing to be thin and attractive. Teenagers can also fall prey to the rebellious attitude that they need to do anything their parents or those in authority say is bad.

8.1.7 EASY ACCESS:

Easy accessibility to drugs and new, lower prices can also lead to drug addiction. Drugs can be found anywhere if a person simply asks. Street corners and alleyways are no longer the only place to find drugs. Schools, workplaces and even the family next door might be new places to find drugs. With more drugs being produced, the price has also been driven down.

8.1.8 Physiological Causes of Drug Addiction

When we take drugs, either for medical purposes or recreation, there is a benefit or reward that we are trying to achieve. For example pain medication is intended to bring relief to an injured or stressed area of our body. The beginning stages of drug abuse causes us to crave more and to use more. The unintended consequences of that is our need to take more and more of the drug to get the same result.

Drug abuse causes the pathways inside the brain to be altered. Physical changes in the nerve cells are brought on by the drug. These cells (neurons)

communicate with each other releasing neurotransmitters into the gaps or synapses between the nerve cells. This makes some drugs more addictive than others. When a person's body becomes addicted to the presence of a drug, not having the drug in the system can cause severe physical discomfort. This is known as a physical dependence, and is thought to contribute substantially to a drug addiction. The physical discomfort that can be experienced when the body does not get the drug it thinks it needs is known as "withdrawal". Withdrawal symptoms can be as mild as a headache and nausea or as severe as seizures and death. To avoid withdrawal, many addicts will continue to abuse a drug-even when their brain is telling them to stop. This is why the physiological causes of drug addiction should be taken just as seriously as the psychological causes.

8.1.9 PSYCHOLOGICAL FACTORS:

Some signs of risk can be seen as early as infancy or early childhood, such as aggressive behavior, lack of self-control, or difficult temperament, poor social coping skills. Depression and poor self-esteem may also be risk factors. People who have low self-concepts, who feel bad about themselves have a higher rate of addiction; People with low self-concepts use psychoactive substances either to enhance or create pleasure in their lives, or to decrease the constant emotional pain they live with. The better a person feels about himself, the less likely he will be to use or abuse psychoactive substances. A society that has easy access to drugs that has a population that is "addiction-prone" due to genetics or emotional pain, and that has pro-use or unclear norms, is a society prone to addiction.

Boredom is another cause of drug use. Teens who can't tolerate being alone, have trouble keeping themselves occupied, or crave excitement are prime candidates for substance abuse. Not only do alcohol and marijuana give them something to do, but those substances help fill the internal void they feel. Further, they provide a common ground for interacting with like-minded teens, a way to instantly bond with a group of kids.

Another reason for drug abuse amongst the teens is rebellion. Different rebellious teens choose different substances to use based on their personalities. Alcohol is the drug of choice for the angry teenager because it frees him to behave aggressively. Methamphetamine, or meth, also encourage aggressive, violent behavior, and can be far more dangerous and potent than alcohol. Marijuana, on the other hand,

often seems to reduce aggression and is more of an avoidance drug. LSD and hallucinogens are also escape drugs, often used by young people who feel misunderstood and may long to escape to a more idealistic, kind world. Smoking cigarettes can be a form of rebellion to flaunt their independence and make their parents angry. The reasons for teenage drug-use are as complex as teenagers themselves.

Overcoming shyness has been reported as another cause of drug abuse. Many shy teenagers who lack confidence report that they'll do things under the influence of alcohol or drugs that they might not otherwise. This is part of the appeal of drugs and alcohol even for relatively self-confident teens.

8.1.10 FAMILY FACTORS:

Children's earliest interactions occur in the family; sometimes family situations heighten a child's risk for later drug abuse, for example, when there is: a lack of attachment and nurturing by parents or caregivers; ineffective parenting; and a caregiver who abuses drugs, and a chaotic home environment.

8.1.11 TRANSITIONAL LIFE-EVENTS:

Research has shown that the key risk periods for drug abuse are during major transitions in children's lives. The first big transition for children is when they leave the security of the family and enter school. Later, when they advance from elementary school to middle school, they often experience new academic and social situations, such as learning to get along with a wider group of peers. It is at this stage—early adolescence—that children are likely to encounter drugs for the first time. When young adults leave home for college or work and are on their own for the first time, their risk for drug and alcohol abuse is very high. Consequently, young adult interventions are needed as well.

8.1.12 Misinformation:

Perhaps the most avoidable cause of substance abuse is inaccurate information about drugs and alcohol. Nearly every teenager has friends who claim to be experts on various recreational substances, and they're happy to assure her that the risks are minimal.

8.2 PREVENTION

Preventive interventions can provide skills and support to high-risk youth to enhance levels of protective factors and prevent escalation to drug abuse. There are

numerous community-based prevention programs that have been thought to be helpful in educating children and families about the harms of substance abuse. There are mediating factors of classroom-based substance abuse that have been analyzed through research. There are specific conclusions that have been generated about effective programs.

First, programs that allow the students to be interactive and learn skills such as how to refuse drugs are more effective than strictly educational or non-interactive ones. When direct influences (e.g., peers) and indirect influences (e.g., media influence) are addressed the program is better able to cover broad social influences that most programs do not consider. Programs that encourage a social commitment to abstaining from drugs show lower rates of drug use. Getting the community outside of the school to participate and also using peer leaders to facilitate the interactions tend to be an effective facet of these programs. Lastly, teaching youth and adolescents skills that increase resistance skills in social situations may increase protective factors in that population.

Parents can use information on risk and protection to help them develop positive preventive actions (e.g., talking about family rules) before problems occur. Families can provide protection from later drug abuse when there is: a strong bond between children and parents; parental involvement in the child's life; and clear limits and consistent enforcement of discipline. Prevention programs can strengthen protective factors among young children by teaching parents better family communication skills, appropriate discipline styles, firm and consistent rule enforcement, and other family management approaches. Research confirms the benefits of parents providing consistent rules and discipline, talking to children about drugs, monitoring their activities, getting to know their friends, understanding their problems and concerns, and being involved in their learning. The importance of the parent-child relationship continues through adolescence and beyond.

Educators can strengthen learning and bonding to school by addressing aggressive behaviors and poor concentration—risks associated with later onset of drug abuse and related problems. Prevention programs in schools focus on children's social and academic skills, including enhancing peer relationships, self-control, coping, and drug-refusal skills. If possible, school-based prevention

programs should be integrated into the school's academic program, because school failure is strongly associated with drug abuse. Integrated programs strengthen students' bonding to school and reduce their likelihood of dropping out. Most school prevention materials include information about correcting the misperception that many students are abusing drugs. Other types of interventions include school-wide programs that affect the school environment as a whole. All of these activities can serve to strengthen protective factors against drug abuse. Recent research suggests caution when grouping high-risk teens in peer group preventive interventions. Such groupings have been shown to produce negative outcomes, as participants appear to reinforce each other's drug abuse behaviors.

Research also shows that combining two or more effective programs, such as family and school programs, can be even more effective than a single program alone. These are called multi-component programs.

Community Leaders can assess community risk and protective factors associated with drug problems to best target prevention services. The first step in planning a drug abuse prevention program is to assess the type of drug problem within the community and determine the level of risk factors affecting the problem. The results of this assessment can be used to raise awareness of the nature and seriousness of the community's problem and guide selection of the best prevention programs to address the problem. Next, assessing the community's readiness for prevention can help determine additional steps needed to educate the community before launching the prevention effort. Then, a review of current programs is needed to determine existing resources and gaps in addressing community needs and to identify additional resources. Finally, planning can benefit from the expertise of community organizations that provide youth services. Convening a meeting with leaders of these service organizations can set the stage for capturing ideas and resources to help implement and sustain research-based programs. Research has shown that the media can raise public awareness about a community's drug problem and prevent drug abuse among specific populations.

Another evaluation approach is to track data over time on drug abuse among students in school, rates of truancy, school suspensions, drug abuse arrests, and drug-related emergency room admissions. Data from community drug abuse assessments can serve as a baseline for measuring change. Because drug

abuse problems change with time, periodic assessments can ensure that programs are meeting current community needs.

Prevention programs can also be described by the audience for which they are designed:

- Universal programs are designed for the general population, such as all students in a school.
- Selective programs target groups at risk or subsets of the general population, such as poor school achievers or children of drug abusers.
- Indicated programs are designed for people already experimenting with drugs.

8.3 Examples of Research-Based Drug Abuse Prevention Programs

8.3.1 Life Skills Training (LST) was developed by Gilbert J. Botvin in 1996 and revised in 2000. LST is significant in giving adolescents with skills and information that are needed to resist social influences to substances, including alcohol, cigarettes, and other illicit drugs. The goal of this program is to increase personal and social competence, confidence and self-efficacy to reduce motivations to use drugs and be involved in harmful social environments. LST was structured to provide adolescents knowledge for fifteen 45-minute class periods during school for the first year. Ten booster sessions are given in the second year and then five booster class periods in the third year. A significant reduction in drug and polydrug use was found within this population with long-term effects even after three years.

8.3.2 Caring School Community Program (Formerly, Child Development Project). This is a universal family-plus-school program to reduce risk and strengthen protective factors among elementary school children. The program focuses on strengthening students' "sense of community," or connection, to school. Research has shown that this sense of community has been key to reducing drug use, violence, and mental health problems, while promoting academic motivation and achievement.

8.3.3 Classroom-Centered (CC) and Family-School Partnership (FSP) Intervention. The CC and FSP interventions are universal first-grade interventions to reduce later onset of violence and aggressive behavior and to improve academic performance. Program strategies include classroom management and

organizational strategies, reading and mathematics curricula, parent-teacher communication, and children's behavior management in the home.

8.3.4 Guiding Good Choices (GGC) (Formerly, Preparing for the Drug-Free Years). This curriculum was designed to educate parents on how to reduce risk factors and strengthen bonding in their families. In five 2-hour sessions, parents are taught skills on family involvement and interaction; setting clear expectations, monitoring behavior, and maintaining discipline; and other family management and bonding approaches.

8.3.5 Lions-Quest Skills for Adolescence (SFA). SFA is a commercially available, universal, life skills education program for middle school students in use in schools nationwide. The focus is on teaching skills for building self-esteem and personal responsibility, communication, decision-making, resisting social influences and asserting rights, and increasing drug use knowledge and consequences.

8.3.6 Project ALERT. Project ALERT is a 2-year, universal program for middle school students, designed to reduce the onset and regular use of drugs among youth. It focuses on preventing the use of alcohol, tobacco, marijuana, and inhalants. Project ALERT Plus, an enhanced version, has added a high school component, which is being tested in 45 rural communities.

8.3.7 Project STAR. Project STAR is a comprehensive drug abuse prevention community program to be used by schools, parents, community organizations, the media, and health policymakers. The middle school portion focuses on social influence and is included in classroom instruction by trained teachers over a 2-year timetable. The parent program helps parents work with children on homework, learn family communication skills, and get involved in community action.

8.3.8 Promoting Alternative Thinking Strategies (PATHS).

PATHS is a comprehensive program for promoting emotional health and social skills. The program also focuses on reducing aggression and behavior problems in elementary school children, while enhancing the educational process in the classroom.

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LESSON NO. 2.3 **AUTHOR : DR. AGYAJIT SINGH**

PSYCHOTHERAPY

LESSON STRUCTURE

9.0 OBJECTIVE

This lesson highlights the utility of psychotherapy in the treatment of various psychological disorders. After reading this lesson the students will be able to answer the following:

- Goals and objectives of psychotherapy.
- Psychodynamic therapy and its application for the treatment of various disorders.

9.1 INTRODUCTION

The approaches towards the treatment of behavioural problems may be referred to as psycho-therapy. Jerome Frank defines psychotherapy as an attempt to enhance a person's feelings of well –being, are usually labelled treatment and every society

trains some of its members to apply this form of influence. Treatment always involves a personal relationship between the healer and the sufferer. Certain types of therapy rely primarily on the healer's ability to mobilize healing forces in the sufferer by psychological means. These forms of treatment may be generically termed as psycho-therapy.

Psychotherapy is also defined by its goals; as it is a treatment method intended to alleviate psychological disorder. Sometimes, psychotherapy is defined by its procedures. It is defined in terms of its use of psychological measures to modify personality maladjustment. According to Noyes & Kolb, "Psychotherapy may be defined as the treatment of emotional and personality problems and disorders by psychological means".

Psychotherapy is also defined by its practitioners. As Frank says, "psychotherapy is a form of help-giving in which, trained socially sanctioned healer tries to relieve a sufferers distress by facilitating certain change in his feelings ,attitudes and behavior." Psychotherapy can also be defined by the relationship. Psychotherapy is defined in terms of special kind of inter-personal relationship in which unique types of social learning, emotion-arousing interactions and growth experiences take place. Stein defines psychotherapy as "a process in which changes in an individual's behaviour are achieved as a result of expression in a relationship with a person in understanding behaviour." But according to Reisman, "psychotherapy can be defined as the communication of person related understanding, respect and a wish to be helped"

9.2 GOALS OF PSYCHOTHERAPY:

Any psychotherapy "is a situation in which one human being(therapist)tries to act in such a way as to enable another human being to act and feel differently. The basic assumption is that particular kind of verbal and nonverbal exchanges in a trusting relationship can achieve goals such as reducing anxiety and eliminating self-defeating or dangerous behaviour." In psychotherapy :

(i) There is a trained socially sanctioned healer (therapist).

(ii) A sufferer who seeks relief from the healer (patient).

(iii) More or less structured series of contacts tries to produce certain changes in the sufferer's emotional state, attitudes and behaviour.

People have many types of mental problems. Through psychotherapy, they wish to get a solution to their problems. The goals of psychotherapy depend upon the goals of treatment as follows:

(i) To relieve emotional distress.

(ii) To promote solution of problems in living.

(iii) To minimize conflicts and concerns that limit a person's realization of his potential for productive work and rewarding interpersonal relationships.

The goals of treatment are concerned with the creation of an insight which consists of the development of an ability in the client of understanding his thoughts,feelings and actions. Moreover, effective communication by the therapist would increase an understanding of himself in the patient.It should lead further towards bringing the behavioural changes in him. Of course, from psychotherapy, complete curve or perfect resolutions can not be expected. It is a helping procedure and not a creative one. It should be considered as a means of facilitating progress towards desired behavioural change, rather than as a route to total and permanent change.

9.3TYPES OF PSYCHOTHERAPY :

There are basiscally two types of psychotherapy, i.e.,

1. Insight therapy; and
2. Supportive therapy.

9.3.1 INSIGHT THERAPY :

In the insight therapy falls another two types of therapies:

(i) Re-educative therapy; and

(ii) Reconstructive therapy.

9.3.1.1 Re-educative psychotherapy :

This therapy is concerned with the nature of the problems with which the patient is suffering and how it has come to affect him. It promotes behavioural change by examining a person's psychological difficulties and helping him focus on his existing personality characteristics as a means of resolving these problems.

The objectives of insight therapy with re-educated goals are the insight into the more conscious conflicts, with deliberate efforts at readjustment, goal modification and devlopment of existing creative potentialities. The approaches applied are : relational therapy, therapeutic counselling, interview psychotherapy, psychological therapy, reconditioning, re-educative group therapy.

9.3.1.2 The Reconstructive Psychotherapy : This therapy concentrates on promoting behavioural change by examining the origins of an individual's personality style and helping him modify personality characteristics that are contributing to his psychological difficulties.

The objective of insight therapy with reconstructive goals are: "insight into unconscious conflicts with efforts to achieve extensive alternation of character structure; expansion of personality growth with development of new adaptive potentialities. The approaches are : psycho analytically oriented psychotherapy.

9.3.2 SUPPORTIVE THERAPY :

The objective of supportive therapy are strengthening of existing defences, elaboration of new and better mechanisms to maintain control and restoration to an adaptive equilibrium. The approaches which are employed are : guidance, environmental manipulation, externalization of interest, reassurance, pressure and coercion, persuasion, emotional catharsis and desensitization, prestige, suggestion, suggestive hypnosis, muscular relaxatives, hypotherapy, drug therapy, inspirational group therapy.

The uncovering psychotherapy seeks to help the patient to understand why he became the kind of person he is, whereas supportive psychotherapy focuses on helping him understand, how being the kind of person he is, contributed to the difficulties that brought in to treatment. Psychotherapy is concerned with bringing existing personality characteristics more effectively to bear on current problems and always denote attention to understand the origin of these personality characteristics.

9.4 OBJECTIVES OF PSYCHOTHERAPY :

According to Sundberg and Tyler, the following are the objectives of psychotherapy

1 Strengthening the patient's motivation to do the right things with persuasion and social pressure.
2. Reducing emotional pressure by facilitating the expression of intense feeling through catharsis i.e. release of pent up energy.
3. Releasing the patient's potential for growth by removing the psychological blocks.
4. Changing the habits of the patient.
5. Modifying the cognitive structure of the patient.
6. Increasing the patient's knowledge and his capacity for effective life decision through counselling.
7. Increasing the patient's self-knowledge and insight.
8. Improving interpersonal relationship.
9. Effective changes in the patient's social environment.
9. Altering somatic processes in order to reduce painful feelings and/or increasing body awareness.
10. Altering states of consciousness inorder to extend self - awareness, control and creativity.
11. Helping the mental patient to recognise his strengths and develop them to the utmost possible extent .
12. Making necessary reform in the patient's attitude towards people in the society.

14. Finding the nature of the unconscious of the mental patients inorder that the repressed conflict may be removed.

9.5 PSYCHODYNAMIC THERAPY

Psychodynamic therapy was developed by Freud and his associates.It is an intensive, long term procedure for uncovering repressed memories, thoughts, fears and conflicts presumably arising from problems in early psycho sexual development and helping individuals to solve their problems. It is considered that gaining insight into such repressed material frees the individual from the need to keep wasting their energies on repression and other defence mechanisms. Instead, they can bring their personality resources to bear on consciously resolving the anxieties that promoted the repression in the first place. In this way, they can turn their energies to better personal integration and more effective living.

This type of psychological treatments approach is termed as psychodynamic therapy which focuses on individual's personality dynamics from a psychoanalytic perspective. Here, Freudian theory based on psychoanalytic concepts will be examined due to its great significance. First of all we will describe four basic techniques of this form of therapy: free association, analysis of dream, analysis of resistance and analysis of transference.

9.5.1 FREE ASSOCIATION :

Free association is one of the techniques in which psychoanalysts used to help the patient recover conflicts that have been repressed. It is perhaps the best known and the most important which Freud used when he asked the patient to relax on couch, was encouraged to give free rein to thoughts and feelings and to verbalize whatever comes to mind. The assumption was that with enough practice, free association will facilitate the uncovering of unconscious material.

Freud used hypnosis in his early work to free repressed thoughts from his client's unconscious. Later, he stopped using it and used free association which is a direct method of gaining access to an individual's hidden thoughts and fears. The basic principle of free association is that an individual must say whatever comes into his/her mind, regardless of how personal, painful or irrelevant it may be. Usually, a client sits comfortably in a chair or lies in a relaxed position on a couch and gives an account of all the thoughts, feelings and desires that comes to his mind as one idea leads to another. The therapist usually takes a position behind the client so as not to, in any way, distract or disrupt the free flow of associations.

Freud believed that associations are determined like other events and that the conscious represents a relatively small part of the mind, while the pre-conscious and unconscious are the much larger portions. The purpose of free association is to explore thoroughly the contents of the preconscious which contain derivatives of repressed unconscious material, which if properly interpreted, can lead for an

uncovering of the latter. Analytical interpretation involves a therapist's typing together a client's often disconnected ideas, beliefs, actions and so forth in to a meaningful explanation to help the client gain insight in the relationship between his or her maladaptive behaviour and the repressed, i.e, unconscious events and fantasies that drive it.

9.5.2 ANALYSIS OF DREAMS :

Another important procedure for uncovering unconscious material is dream analysis. When a person is asleep, repressive defences are lowered, and forbidden desires and feelings may find an outlet in dreams. For this reason, dreams have been referred to as the "royal road to the unconscious." Some motives, however, are so unacceptable to an individual that even in dreams, they are not revealed openly but are expressed in disguised or symbolic form. Thus, a dream has two kinds of content - **manifest content,** which is the dream as it appears to the dreamer and **latent content,** composed of the actual motives that are seeking expression but are so painful or unacceptable that they are disguised. It is therapist's task to uncover these disguised meanings by studying the images that appear in the manifest content of a client's dream and his/her preconscious associations to them. For example, the cutting down of a tall tree (manifest content) might symbolise the patient's anger towards his father (latent content). The content of dreams then, is distorted by unconscious defensive structures, which never completely abandoned, even in sleep, continue to protect the ego from repressed impulses. Secondly, a client's dream of being engulfed in a tidal wave may be interpreted by a therapist as indicating that the client feels being overwhelmed by inadequately repressed fears and hostilities.

Interpretation and Denial :

After the unconscious material begin to appear, interpretations of the dream comes into play. This stage helps the person to face the repressed and emotionally loaded conflict. Here, the analyst begins to point out to the patient the underlying meaning of his dreams. Effective interpretation that reflects insights that a patient attributes to himself will be more readily accepted and thus, have a stronger therapeutic effect. It is only possible when the analyst suggests what the manifest content of dreams truly means, when he points out how certain verbalizations of patient relate to repressed unconscious material. Interpretations are held to be particularly helpful in establishing the meaning of the resistances that disturb the patient' s free association. For e.g. the therapist may point out how the patient manages to avoid a topic and it is common for the client to deny the interpretation. But this denial is sometimes interpreted as sign that the therapist's interpretation is correct rather than incorrect.

9.5.3 ANALYSIS OF RESISTANCE :

During the process of free association or associating to dreams, an individual may evidence resistance i.e., an unwillingness or inability to talk about certain thoughts, motives or experiences. For example, a client may be talking about an important childhood experiences and then suddenly switch topics. Resistance may also be evidenced by client's coming late to an appointment or even forgetting an appointment altogether. Because resistance prevents painful and threatening material from entering awareness, its sources must be sought if an individual is to face the problem and learn to deal with it in a realistic manner.

During this phase, the patients may try any tactic to interrupt the session, remaining silent, getting up from the couch, looking into the window, making jokes and personal remarks to the analyst. Patients may even come late or forget sessions altogether. Freud noted that such interferences led to repression and can be traced to unconscious control over some sensitive areas. In some respects, these resistances provide the analyst with the most information about the patient and the psycho-analytic therapists most thoroughly probe these areas.

9.5.4 ANALYSIS OF TRANSFERENCE :

At the end of this therapy, while the client and the therapist interact, the relationship between them may become very complex and emotionally involved. He develops a relationship with the therapist like a parent or any other person close to him in the past, a process known as *transference*. Thus, many clients react to their analyst as they did to some person before, and feel the same hostility and rejection that they felt long ago.

After the transference relationship has been established, a therapist may provide an individual with insight regarding his reactions to the problem and he may also introduce a corrective emotional experience. In this way, it may be possible for the individual to work through the conflict in feelings or to overcome feelings of hostility and self-devaluation that originate from the earlier parental rejection. In fact, the pathogenic effects of an undesirable early relationship are counteracted by working through a similar emotional conflict in the therapeutic setting. This experience is often referred to as *transference.*

The case of psychoanalytic therapy is the transference neurosis. Freud noted that his patients sometimes acted toward him in an emotion-charged and unrealistic way, eg. a much older patient would behave in a childish manner during a therapy session. These reactions may be negative and hostile. Freud utilized this transference of attitudes, which he came to consider as inevitable aspect of psycho analysis, as a means of explaining to patients, the childhood origin of many of their concerns and fears. This explanation tended to help lift repression and allowed the confrontation of buried impulses. In psycho analysis, transference is regarded as

essential to complete cure. Analysts encourage the development of transference by intentionally remaining shadowly figures, generally sitting behind the patients in doing free associations, and serving as relatively blank screens on which the important persons in the neurotic conflict can be projected. Because the therapy setting is so different from the childhood situation, analysis can readily point out to the patient the irrational nature of their fears.

9.6 EVALUATION OF PSYCHODYNAMIC THERAPY

Psychodynamic therapy has been criticized for being relatively time consuming and expensive. It has almost neglected a client's immediate problems insearch for unconscious conflicts in the past. It has failed to provide adequate evidence of its effectiveness, as the analysts have been less enthusiastic to subject their treatment outcomes to rigorous scrutiny and when the results have not been especially impressive. Because it expects an individual to achieve insight and major personality change, psycho analysis is also limited in its applicability. It has been proved that it is best suited for people who are average or above average in intelligence and economically well-off, and who do not suffer from severe psychopathology. Nevertheless, many individuals feel that they have profited from this therapy-particularly in terms of greater self-understanding, relief from inner conflict and anxiety, and improved interpersonal relationships. Psycho analytically oriented psycho therapy remains the treatment of choice for many individuals who are seeking extensive self-evaluation or insight into themselves. Even many behaviour therapists, when they seek treatment for themselves, select this approach over behavioural method, which surely give something about the value they place on it.

This therapy has been criticized for an account of the effectiveness of psychoanalysis in all its various forms;as it is very difficult to evaluate scientifically. The main aspect is the lifting of repression and making the unconscious and how that is to be demonstrated. Attempts to assess have sometimes relied on projective test like the Rorschach which rely on the concept of the unconscious. Moreover, the central concept of insight has also been questioned. Rather than accept insight as the recognition by the client of some importance, many experts propose that the development of insight is better understood as a social conversion process, whereby the patient comes to accept the belief system of his therapist. Of course, the behavioural therapists believe that an insight may help the client to change an outlook, whether or not the insight is true. Because of the immense complexity of human lives, it is impossible to know with any degree of certainty whether an event really happened, and if it did whether it caused the current problem.

9.7 SUMMARY :

Psychotherapy is the therapeutic treatment of behavioural and emotional problem of individuals. A clinical therapist tries to apply the psychological techniques to bring personality and behavioural changes in the patient. Psychotherapy may be defined as the treatment of emotional and personality problems and disorders by psychological means (Nayers & Koble). Any psycho therapy is a situation in which therapist tries to act in such a way as to enable the client to act and feel differently. Hence, there, is a trained person who is a therapist and a sufferer who wants relief - is a patient. The former tries to produce certain changes in the latter's emotional state, attitudes and behaviour. The goals of the psychotherapy are :

(i) to relieve emotional distress,
(ii) to promote solutions to various mental problems;
(iii) to minimize conflicts for productive work and rewarding interpersonal relationships.

There are basically two types of psychotherapies, i.e.

(a) re-educative therapy and
(b) reconstructive therapy.

Psycho-analytical therapy is one of the psycho-therapies which was developed by Sigmund Freud and his co-workers. It is a technique for discovering repressed memories, thoughts, fears and conflict which usually originate from problems in early psycho sexual development, and also to help the individuals to solve their problems. This therapy consists of four basic techniques i.e.

(i) free association
(ii) analysis of dream;
(iii) analysis of resistance; and
(iv) analysis of transference.

The basic principle of free association is that an individual must say whatever comes into his mind so that the patient is helped to recover from the conflicts that have been repressed. Dreams analysis is meant for uncovering unconscious material. when a person is asleep, repressive defences, forbidden desires and feelings may find an outlet in dreams. But the motives are expressed in disguised or symbolic form. Hence, the dreams may have manifest or latent content. It is the therapist's task to uncover the disguised meaning by studying the images that appear in the manifest content of a client's dream. During the third phase, an individual may evidence resistance by trying any tactic to interrupt the session, remaining silent, coming late to the session, standing up from the couch, looking into the windows, etc. At the end of therapy, the relationship between client and therapist may become very complex and emotionally involved. Sometimes, the pathological effects of an undesirable relationship are opposed by working through

a similar emotional conflict in a therapeutic setting which is termed as transference neurosis.

Psycho-analysis therapy has been criticised for being relatively time-consuming and expensive. It has almost neglected a client's immediate problems in the search for unconscious conflicts in the past. But it has been proved that it is best suited for people who are average or above in intelligence and economically well off, and who do not suffer from severe psychopathology.

Exercise

Q:-1 Write short notes on

(a) Dream analysis

(b) Free association

(c) Reconstructive Psychotherapy.

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LESSON NO. 2.4 **AUTHOR : DR. AGYAJIT SINGH**

BEHAVIOUR THERAPY

LESSON STRUCTURE

10.0 OBJECTIVE

In the present lesson, we will study about the behavior therapy. Four different approaches of behaviour therapy will also be described. The main emphasis will be laid on systematic desensitization and aversion theory. Besides these, role of operant conditioning and modelling in the behaviour therapy will be explained. Biofeedback treatment will also be narrated here.

10.1 INTRODUCTION ;

Behaviour therapy originated in 1960 as one of the therapeutic procedures which was based on the principles of respondent and operant conditioning. In recent years, the therapeutic potentialities of behaviour therapy techniques have been strikingly demonstrated in dealing with a wide variety of maladaptive behaviour. In brief, behaviour therapy is an attempt to change abnormal behaviour, thoughts and feelings with the help of the methods and procedures adopted by behaviouristic psychologists.

A maladjusted person is different from another person because:

(i) he has failed to acquire competencies needed for coping with the problems of living:

(ii) has learned faulty reactions or coping patterns that are being maintained by some kind of reinforcement.

Thus, a behaviourist therapist tries to change the maladaptive behaviour in order to achieve the adaptive behaviour with the use of some specific learning principles or procedures. In fact, many psychological disorders arise from faulty learning i.e., some person have failed to acquire the skills and behaviour they need for coping with the problems of daily life or they have acquired maladaptive habits and reactions.

In this therapy, instead of exploring past traumatic events or inner conflicts to bring about personality change therapists attempt to modify behaviour directly by extinguishing of counter conditioning maladaptive reactions, such as anxiety or manipulating environmental contingencies i.e., by the use of reward, suspension of reward, or occasionally, punishment to shape overt actions. Behaviour therapy techniques are especially effective in altering maladaptive behaviour when a reinforcement is administered contingent with a desired response, and when a person knows what is expected and why the reinforcement is given. The ultimate goal, of course, is not only to achieve the desired responses but to bring them under the control and self-monitoring of the individual.

10.2 APPROACHES APPLIED IN BEHAVIOUR THERAPY

There are four theoretical approaches applied in behavior therapy, i.e.,

(i) Counter Conditioning ;
(ii) Operant Conditioning ;
(iii) Modeling; and
(iv) Cognitive Restructuring.

10.2.1.COUNTER CONDITIONING:

In this procedure, a response (R) given to stimulus (S) is eliminated by eliciting different behaviour (R_2) in the presence of that stimulus e.g., if a man is afraid (R_1) of enclosed spaces (S), the therapist helps him to have a calm reaction (R_2) suggests that unrealistic fears can be eliminated in this way. The assumption is that because learned behaviour patterns tend to weaken and disappear over time if they are not reinforced, hence the simplest way to eliminate a maladaptive pattern is to remove the reinforcement for it. This is especially true in situations where maladaptive behaviour has been reinforced unknowingly by others.

Two techniques that relay on the principles of counter conditionings or extinction are (i) implosive therapy and (ii) flooding. Both focus on extinguishing conditional avoidance of anxiety - arousing stimuli and can thus be used to treat anxiety disorders. These are primarily those therapies which focus on the modification of effect.

(A) IMPLOSIVE THERAPY :

In implosion, clients are asked to imagine and relieve aversive stress associated with their anxiety. However, instead of trying to release anxiety from the treatment sessions, a therapist deliberately attempts to elicit a massive implosion of anxiety. This approach often deals with post trauma and with an internal conceptualisation of anxiety, with repeated explosive sessions in a safe setting. Gradually the stimulus loses its power to elicit anxiety and the neurotic avoidance behaviour is extinguished. Hypnosis or drugs may be used to enhance suggestibility under implosive therapy.

(B) FLOODING :

It involves placing an individual in a real life situation as opposed to a therapeutic setting. It may be used with individuals who do not imagine stress realistically. For example, a client with a phobia of heights may be taken to the top of a tall building or bridge. This is another means of exposing the client to the anxiety-eliciting stimulus and demonstrating that the feared consequences do not occur. In the past few years, the flooding procedure has proved better than implosion.

Report on the effectiveness of implosive therapy and flooding have generally been favorable and they have been considered as good treatment for simple phobias. Moreover, the flooding procedure can be made relatively bearable without diminished effectiveness for even a severely fearful client by increasing therapist support and active guidance during exposure.

SYSTEMATIC DESENSITIZATION:

It is the process of extinction applied to that behaviour which is positively reinforced or negatively reinforced i.e., reinforced by the successful avoidance of a painful situation. It is a kind of aversive experience. An individual with negatively reinforced maladaptive behaviour becomes anxious and withdraws from the painful situation. This avoidance is anxiety reducing and hence, is itself reinforced.

The technique has proved useful in extinguishing negatively reinforced behaviour involving eliciting an antagonistic or competing response. The method of systematic desensitization is aimed at teaching an individual to relax or behave in some other way that is inconsistent with anxiety while in the presence of the anxiety-producing stimulus. The term systematic refers to the carefully graduated manner in which the person is exposed to the feared stimulus.

Wolpe (1958) elaborated on the procedure on the assumption that most anxiety-based patterns are fundamentally conditioned responses. He worked out a way to train a client to remain calm and relaxed in situations that produced anxiety. The procedure involves the following aspects :

(i) A client is first taught to induce a state of relaxation, typically by progressive concentration on the relaxing of various muscle groups.

(ii) An "anxiety hierarchy" is constructed consisting of imagined scenes graded as to their capacity to elicit anxiety.

(iii) Active therapy sessions consists of repeatedly imagining the scenes in the hierarchy under conditions of deep relaxation, beginning with the minimum anxiety item and gradually working towards those rated in the more extreme ranges.

(iv) A session is terminated any point where the client reports experiencing significant anxiety, the next session resuming at a lower point in the hierarchy.

(v) Treatment continues until all items in the hierarchy can be tolerated without discomfort when client has shown substantial improvement.

The usual duration of a desensitization session is about 30 minutes and the sessions are often given two to three times per week. The overall therapy programme may, of course take a number of weeks or even months. To sum up, it may be said that the truly essential element in the behavioural treatment of anxiety is repeated exposure of a client to the stimuli, even if only imaginary, that elicit the fear response regardless of the methods employed in achieving that end.

In systematic desensitization, a deeply relaxed person is asked to imagine a graded series of anxiety - provoking situations; the relaxation tends to inhibit any anxiety that might otherwise be elicited by the imagined senses. If relaxation gives way to anxiety, the client signals to the therapist and stops imagining the situation in mind, rests, re-establishes relaxation and then re-imagines the situation. If anxiety drives out relaxation again, the client goes back to an earlier situation; and later tries to handle the more difficult. Over successive session, a client is usually able to tolerate increasingly more difficult scenes as he climbs the hierarchy in imagination. It has been reported that the ability to tolerate stressful imagery is generally followed by a reduction of anxiety in related real-life situations.

AVERSION THERAPY :

Aversion therapy attempts to attach negative feelings to stimuli that are considered inappropriately attractive. The literature on classical aversive conditioning of animals, i.e., pairing a neutral or positive stimulus with an unpleasant unconditioned stimulus such as shock, led therapists to believe that negative reactions could be conditioned in human beings. The method of treatment is similar to desensitization but it has the opposite goal, since the new response of anxiety, or an aversion reaction is to be substituted for a positive response. Among the problems treated with aversion therapy are excessive drinking, drug addiction, gambling, smoking, exhibition and overeating. For example, an excessive drinker

who wishes to give up drinking, is asked to taste, see or smell alcohol and is then made uncomfortable while doing so. In addition to employing painful but not harmful shock to the hands as the unconditioned stimulus, some therapists have adopted use of enetics, drugs that make the client feel nausea when presented with the undesirable stimulus.

Aversion therapy involves modifying undesirable behaviour by the old method of punishment. Punishment may involve either the removal of desired reinforcer or the use of aversive stimuli, but the basic idea is to reduce the "temptation value" of stimuli that elicit undesirable behaviour. The most commonly used aversive stimulus is electric shock although drugs may also be used.

The first formal use of aversion therapy was made by Kantororich (1930) who administered electric shocks to alcoholics in association with the sight, smell and taste of alcohol. Since that time, aversion therapy has been used in the treatment of a wide range of maladaptive behaviors. But the use of electric shock as an aversive stimulus has generally diminished in recent years because of the ethical problems involved in its use. The method being used today is probably differential reinforcement of other responses, in which behaviours incompatible with the undesired behaviour are positively reinforced, e.g., for a child who indulges in antisocial disruptive behaviour, positive reinforcement might be used for every sign of constructive play. At the same time, any reinforcement that has been maintaining maladaptive behaviour is removed.

Aversion therapy is a very effective one for stopping maladaptive responses for a period of time. With this method, an opportunity exists for substituting new behaviour or for changing a life style by encouraging more adaptive alternative patterns that will prove reinforcing in themselves. Moreover, there is a little likelihood that a previously gratifying but maladaptive behaviour pattern will be permanently extinguished unless alternative forms of gratification are learned during the aversion therapy.

Aversion therapy has been controversial for ethical reasons. A great hue and cry was raised about inflicting pain and discomfort on people, even when they asked for it. Behaviour therapists who choose aversion procedures seldom use them alone. Instead, more positive techniques have been instituted to teach new behaviour to replace than elimination.

10.2.2 OPERANT CONDITIONING :

Skiner and his co-workers (1953) suggested that the therapist should try to shape overt behaviour through rewards and punishments. In this way, through operant conditioning, they could exercise some control over the complex puzzling, often, frantic behaviour of hospitalized patients. In addition to the use of praise, tokens and food as positive reinforcers, and of verbal punishment as negative

reinforcers, operant workers have developed other reinforcers. The "**Premack Principal"** holds that in a given situation, a more probable behaviour can serve as a reinforcer for a less probable behaviour, e.g., if you know that a boy would rather watch a football game than do the laundry work, you can make the former contingent on the latter, allowing him to watch football which can function as a positive reinforcer for washing the clothes. Most of us have applied this principle to our own behaviour many times, as when we resolve not to reward ourselves with going to a movie unless we first complete a task that holds less appeal for us.

Another operant tool is "**time out**" which refers to removing a person from an environment in which he can earn positive reinforcers, e.g., rather than just ignoring undesirable behaviour, one banishes the person for a stated period of time to a dreary room, where positive reinforcers are unavailable. Finally, **over-correction** is punisher that requires the person not only to restore an environment he has sabotaged but also to improve upon its original conditions. Thus if a destructive child tears the sheets off his bed, instead of making it, the therapist requires him to make not only his own bed but others as well as. Usually, operant treatments work best with client whose intellectual capacities are limited, and institutions in which considerable control can be exercised by the therapist.

Some of the best operant conditioning behaviour therapy has been done with children, perhaps because much of their behaviour is subject to the control of others. Children tend more than adults to be under continual suspension. At school, their behaviour is scrutinized by teachers, and when they come home, parents frequently observe their play and other social activities. In most instances, the behaviour therapist works with the parents and teachers in an effort to change the ways they reward and punish the children for whom they have responsibility. It is assumed that altering the reinforcement practices of the adults in a child's life will ultimately change the child's behaviour.

The range of childhood problems dealt with through operant conditioning is very broad, including bed-wetting, thumb sucking, aggression, tantrums, hyperactivity, disruptive classroom behaviour, poor school performance, language deficiency, extreme social withdrawal and asthmatic attacks. Self-mutilation has been effectively treated with punishment procedures, sometimes involving the response-contingent application of painful electric shocks to the hand or feet. Of course, such extreme measures are used only when less drastic interventions are ineffective and when the problem behaviours are health related or life-threatening.

10.2.3.MODELING :

Modeling is another theoretical approach employed by behaviour therapists. The importance of modeling and imitation in behaviour is self-evident, for, children

as well as adults are able to acquire complex responses and eliminate emotional inhibitions merely by watching how others handle themselves.

Modeling involves the learning of skills through imitating another person, such as a parent or therapist who perform the behaviour. A client may be exposed to behaviour or roles in peers or therapists and encouraged to imitate the desired new behaviours. For example, modeling may be used to promote the learning of simple skills, such as self-feeding in a profoundly mentally retarded child or more complex ones, such as being more effective in social situations for a shy and withdrawn adolescent.

Although reinforcement of modeled behaviour can influence whether an obsever-learner attends to a model's actions and strengthens the response, limited obsevational learning does not seem to require extrinsic reinforcement. According to Bandura, reinforcement functions as a facilitative conditon to learning. Anticipation of a reinforcement may also make an individual more likely to perform a behaviour.
As we have noted, modeling and imitation are used in various forms of behaviour therapy. Bandura (1964) found that live modeling of fearlessness, combined with instruction and guided participation, is the most effective desensitizing that resulted in the elimination of snake phobias in over 90% of the case treated. In fact, the effectiveness of modeling in clinical work was shown in an early study by Bandura and his co-workers in 1969.

In an attempt to expand the kinds of problems handled, some therapists and reasearchers have tried **covert modeling**. Here, the client imagines that he is watching a model, sometimes the client himself, coping with an object he fears or handling a situation requiring assertion. Research suggests that covert modeling can reduce fears and promote more assertive behaviour. Covert procedures, in which the patient does nothing overt and has no real life contact with what is feared or upsetting, are of-cource adopted when direct experience is not possible. Imagined substitutes are not expected to be as effective as actual exposure to threat and actual practice in confronting it.

Bandura (1986) has written extensively on the cognitive factors involved in modeling, which he defines as a process by which a person rather efficiently acquires rules for the generations of adaptive behaviour. This interest has led Bandura to formulate a "social cognitive" theory of behaviour in which the person's symbolic, cognitive processes play a key role. Other theories about memory storage and retrieval may shed light on how people acquire new and complex patterns of behaviour simply by watching others.

10.3 ASSERTIVE THERAPY :

This therapy has been used as an alternative to relaxation in the desensitization procedure and as a means of developing more effective coping

techniques. It appears particularly useful in helping individuals who have difficulties in interpersonal interactions because of anxiety responses that may prevent them from speaking up, claiming their rights or even from showing appropriate affection. Such inhibition may lead to continual inner turmoil, particularly if an individual feels strongly about a situation. Assertiveness therapy may also be indicated in cases where individuals consistently allow others to take advantage of them or put them into uncomfortable situations.

Assertiveness is viewed as the open and appropriate expression of thoughts and feelings, with due regard to the rights of others. Assertive training programs typically follow stages in which the desired assertive behaviours are first practised in a therapy setting. Then guided by the therapist, the individual is encouraged to practice the new and more appropriately assertive behaviours in real life situation. Often, the attention is focused in developing more effective interpersonal skills. Each act of intentional assertion is believed to inhibit the anxiety associated with the situation and therefore, to weaken the maladaptive anxiety response pattern. At the same time, it tends to foster more adaptive interpersonal behaviours.

Although assertiveness therapy is a highly useful procedure in certain types of situation, it does have certain limitations. For example, Wolpe (1969) has pointed out that it is largely irrelevant for phobias in solving non - personal stimuli. It may also be of little use in some types of interpersonal situations, e.g., if an individual has infact, been rejected by someone, assertive behaviour may tend to aggravate rather than resolve the problem. However, in interpersonal situation where maladaptive anxiety can be traced to lack of self-assertiveness, this type of therapy appears particularly effective.

10.4 BIO-FEEDBACK TREATMENT :

The importance of the autonomic nervous system in the development of abnormal behaviour has long been recognized. For example, autonomic arousal is an important factor in anxiety states. Thus, many researchers have applied techniques developed in the autonomic conditioning studies in an attempt to modify the internal environment of troubled individuals to bring about more adaptive behaviour - e.g., to modify heart rates in client with irregular heartbeats, to treat stuttering by feeding back information on the electric potential of muscles in the speech apparent, and to reduce lower back pains and chronic headaches.

This treatment approach - in which a person is taught to influence his or her own physiological processes is referred to as **biofeedback**. The following steps are important in the process of biofeedback treatment.

(i) Monitoring the physiological response that is to be modified such as blood pressure or skin temperature.

(ii) Converting the information to a visual or auditory signal.

(iii) Providing a means of prompt feedback - indicating to a subject as rapidly as possible when the designed change is taking place.

Given this feedback, the subject may thus, seek to reduce his emotionality, as by lowering the skin temperature. For the most part, biofeedback is oriented to reducing reactivity of some organ system innervated by the autonomic nervous system - specifically ,a physiological component of the anxiety response.

Biofeedback treatment is a popular treatment approach. Although there is general agreement that many physiological processes can be regulated to some extent by learning, the application of biofeedback procedures to alter abnormal behaviour has produced equivocal results. But biofeedback has not been shown to be any more effective than relaxation training.

10.5 EVALUATION OF BEHAVIOUR THERAPY

Behaviour therapy seems to have three distinct advantages :

(i) The treatment approach is precise, behaviour to be modified is specified; the methods to be used are clearly delineated, and the results can be readily evaluated;

(ii) The use of explicit learning principles is a sound basis for effective interventions in the economy of time, and cost is quite good. Behaviour therapy usually achieves results in a short period of time because it is generally directed to specific symptoms, leading to faster relief of an individual in distress and to lower financial costs. In addition, more people can be treated by a given therapist.

But its effectiveness is limited and it works better with certain kinds of problems than with others. In case of pervasive and vague problems of the clients, this therapy is less useful. In case of personality disorders, it is rarely employed especially when the specific symptoms are rare. On the other hand, for treating sexual dysfunctions, behavioural techniques are used. The meta-analysis of therapeutic outcomes confirms the expectation that behaviour therapy has a particular place in the treatment of neurotic disorders particularly where anxiety is a manifest feature. Although behaviour therapy is not a cure-all, it has earned, in a relatively brief period, a highly respected place among the available psychological treatment approaches.

10.6 SUMMARY ;

Behaviour therapy is one of the latest therapeutic procedure which is based on the principles of operant conditioning, where the attempt is made for modifying maladaptive behaviour. There are four basic approaches in this therapy, i.e,.,

(i) Counter Conditioning;

(ii) Operant Conditioning;

(iii) Modeling; and

(iv) Cognitive Restructuring.

In the counter - conditioning approach, a response to a given stimulus is eliminated by eliciting different behaviour in the presence of that stimulus by weakening the reinforcement. There are two aspects of counter - conditioning, i.e., implosive therapy and flooding. In implosion, patients are asked to imagine and relieve aversive scenes associated with their anxiety. Flooding involves placing an individual in a real-life situation as opposed to a therapeutic setting.

Systematic desensitization is the process of extinction applied to that behaviour which is positively reinforced or negatively reinforced, i.e., reinforced by the successful avoidance of a painful situation. Wolpe elaborated on this procedure on the assumption that most anxiety based patterns are fundamentally conditioned responses. In this technique, a deeply relaxed person is asked to imagine a graded negative feelings to stimuli that are considered inappropriately attractive. Problems like excessive drinking, drug dependency, smoking, gambling and overeating can-be treated with the help of this therapy. Sometimes, this therapy modifies undesirable behaviour by punishment through electric shock, etc. Behaviour therapy is based on the principles of operant conditioning suggested by Skinner that the overt behaviour can be shaped by rewards and punishments. This procedure has mostly been used in children as the childhood problems like bed-wetting, thumb-sucking, aggression, tantrums, disruptive classroom behaviour, poor school performance and language deficiency are dealt with through operant conditioning. Modeling is another approach of behavioral therapists, which involves the learning of skills through imitation of other persons who perform the behaviour.

Assertiveness therapy has also been used as an alternative to relaxation in the desensitization procedure as a means of developing more effective coping techniques. It is helpful to those individuals who have difficulties in inter personal interactions because of anxiety responses. Biofeedback treatment approach is also applied in which a person is taught to influence his own physiological processes.

Exercise

Write short notes on:-

(a) Implosive Therapy
(b) Systematic Desensitization
(c) Modeling
(d) Assertive Therapy

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COGNITIVE - BEHAVIOUR THERAPY

LESSON STUCTURE

11.0 OBJECTIVE

This lesson focuses on the applicability of cognitive behaviour therapy in the treatment of maladaptive behaviour. After going through this lesson the students shall be able to answer three different approaches of cognitive behaviour therapy and the effectiveness of the therapy.

The present lesson highlights the essence of humanistic and existential therapies. The main focus is on Carl Roger's client centered approach in dealing with the low self esteem and anxieties of an individual.

11.1 INTRODUCTION

Starting in the 1970's , a number of behaviour therapists began to give importance to "private events" - thoughts, perceptions, evaluations and self-statement seeing them as processes that mediate the effects of objective stimulus conditions and thus, help determine behaviour and emotions (Berkovec, 1985).

As the term suggests, cognitive-behaviour, therapy stems from both cognitive psychology (with its emphasis on the effects of thoughts on behaviour and on the study of the very nature of our cognitive processes) and behaviourism. At present, there is no single set of techniques that define cognitive-behaviour therapy. Two main themes have emerged :

(a) the conviction that cognitive processes influence-affect, motivation and behaviour; and

(b) use of cognitive and behaviour change techniques in a pragmatic (hypothesis-testing) manner.

That is, much of the content of the therapy sessions and home work assignments is analogous to experiments in which a therapist and a client apply learning principles to alter the client's cognitions, continuously evaluating the effects that the changes in cognitions have subsequent thoughts, feelings and overt behaviour.

Aaron Beck (Beck and Weishaar, 1989) acknowledges that disordered cognitions are not a cause of abnormal behaviour or emotions but rather an intrinsic (yet alterable) element of such behaviour and emotions. According to this view, if the critical cognitive components can be changed, then the behaviour and maladaptive emotions will change.

Cognitive therapies, such as those devised by Kelly and Beck, were developed within traditional psychotherapeutic setting. Cognitive-behaviour therapy reflects the increasing interest of therapists in cognitive modification as means of influencing emotions and behaviour. This approach to therapy makes use of a variety of behavioural techniques, such as graded program of activities, home work and role playing, along with an effort to identify and modify unrealistic cognitions. In the recent years, cognitive therapists and behavior therapists have freely borrowed techniques from one another. For example, Beck now employees home work assignments in his therapeutic work. Cognitive-behaviour therapy builds on behaviour therapy.

11.2 Approaches

Because altering cognitions is central in these therapies, these are called Type C approaches. The main three approaches are :

I The rational-emotive therapy of Albert Ellis;

II The stress-inoculation training of Donald Meichenbaum; and

III The cognitive behavior therapies of Beck.

11.2.1 RATIONAL EMOTIVE THERAPY (RET)

(Albert Eills, 1958, 1973, 1975, 1989)

RET attempts to change a client's basic maladaptive thought processes on which maladaptive emotional responses and thus, behaviour are presumed to

depend. Now, it has become one of the most widely used therapeutic approaches (Ellis, 1989).

Ellis posited that a well-functioning individual behaves rationally and in tune with empirical reality. Thoughts do have causal primacy in behaviour, not emotional behaviour. Unfortunately, many of us have learned unrealistic beliefs and perfectionists values that cause us to expect too much of ourselves, leading us to behave irrationally and then feel unnecessarily that we are worthless failure. for example, a person may continually think, " I should be able to win everyone's love and approval" or " I should be thoroughly adequate and competent in everything I do". Such unrealistic assumptions and self-demands inevitably lead to ineffective and self-defeating behaviour in the real world, which reacts accordingly, and then to the recognition of failure and the emotional response of self-devaluation. This emotional response is thus, the necessary consequence not of "reality" but of an individual's faulty expectations, interpretations and self-demands.

Another specific example is : consider a man who has an intense emotional reaction of despair with deep feeling of worthlessness, inviolability and self-devaluation when he is deserted by his fiancée. With a stronger self-concept and a more realistic picture of both, himself and his fiancée, as well as of their actual relationship, his emotional reaction might have been one of relief. It is his interpretation of himself that lead to his intense emotional reaction.

Ellis (1970) believed that one or more of the following core irrational beliefs are at the root of most psychological maladjustment.

* One should be loved by everyone for everything one does.
* Certain acts are awful or wicked, and people who perform them should be severely punished.
* It is horrible when things are not the way we would like them to be.
* If something may be dangerous or fearsome, one should be terribly upset about it.
* It is better to avoid life problems if possible than to face them.
* One needs something stronger or more powerful than oneself to rely on.
* One must have certain and perfect self - control.
* We have virtually no control over our emotions and cannot be having certain feelings.

The task of RET is to restructure an individual's belief system and self-evaluation, especially with respect to the irrational "should", "oughts" and "musts" that are preventing a more positive sense of self-worth and creative, emotionally satisfying and fulfilling life. One method is dispute a person's false beliefs through rational confrontation. Here, the therapist would teach the client to identify and dispute the beliefs they were producing the negative emotional consequences.

A RET therapist also uses behaviorally oriented techniques usually to help clients practice living in accordance with their new belief and philosophy. This can be taught with the help of external reinforcer such as a food treat or self-reinforcement with the help of positive statements to self such as "you are doing a really good job". RET aims at increasing an individual's feelings of self-worth and clearing the way for self-actuatlization by removing the false beliefs that have been stumbling blocks to personal growth.

11.2.2 STRESS-INOCULATION THERAPY

A second cognitive-behavioural approach to treatment is stress inoculation therapy-a type of self-instructional training focused on altering self-statements an individual routinely makes in stress producing situations. Here, the approach is to restructure these statements so as to improve functioning under stressful conditions (Meichenbuan and Cameron,1982).Like other cognitive-behaviour therapies, stress-inoculation therapy assumes that a person's problems result from maladaptive beliefs that are leading to negative emotional states and maladaptive behaviour, familiar elements in the causal chain cognitive theorists have posited.

This therapy involves these stages. In the initial phase, cognitive preparation, client and therapist together explore the client's beliefs and attitudes about the problems situation and the self-statements to which they are leading. The focus is on how the person's self-talk can influence later performance and behaviour. Together, the therapist and the client agree on new self-statements that would be more adaptive.

Then, the second phase of the stress inoculation, skill acquisition and rehearsal is begun. In this phase, more adaptive self-statements are learned and practised. For example, a person undergoing stress-inoculation therapy for coping with the "feeling of being overwhelmed" would rehearse self-statements such as.

* When fear comes, just pause.
* Keep focus on the present; what is it you have to do.
* Label your fear from 0 to 9 and watch it change.
* Don't try to eliminate fear totally, just keep it manageable.
* You can reasons fear away.
* It's not the worst thing that can happen.
* Do something that will prevent you from thinking about fear.
* Describe what is around you. That way you won't think about worrying

(Meichenbaum, 1974)

The third phase of stress-inoculation therapy, application and practice involves applying the new coping strategies in actual situations. This practice is

graduated in such a way that the client attempts easier situations first and only gradually enters more stressful situations as he or she feels confident of mastering them.

11.2.3 BECK'S COGNITIVE - BEHAVIOUR THERAPIES

Aaron Beck's (1976) cognitive therapy is also directed toward the thoughts that underlie intense, persistent emotional reactions. Beck's technique involves frequent, gentle questioning the client about the basis for what he or she is saying. Beck speaks of "automatic thoughts" that seem to arise by themselves, without reasoning. These thoughts are accepted as valid even though they are not the products of rational consideration of alternatives. Children, who simply accept their parents value without questioning them, are engaging in automatic thought. Therapy should be aimed at terminating automatic thinking and replacing it with thoughts that result from rational consideration of alternatives.

This approach was originally developed for the treatment of depression and was later extended to anxiety disorders, eating disorders and obesity, conduct disorder in children, personality disorder and substance abuse (Beck 1985; Beck et al., 1990; Hollon and Beck, 1994).

In the initial phases, clients are taught the connection between their patterns of thinking and their emotional responses. By then, learning with the therapist's help about the logical errors in their thinking, they learn to challenge the validity of these automatic thoughts. Clients are not persuaded to change, their beliefs by debate and persuasion as in rational-emotive though unbiased experiments that allow them to disconfirm their false beliefs. Together, a therapist and a client identify the client's beliefs and expectations, and formulate them as hypotheses to be tested. They then design ways in which the client can check out these hypotheses in the real world, and are arranged according to difficulty, that the least difficult tasks will be accomplished successfully before the more difficult ones are attempted.

Besides planning the behavioural sessions, evaluating the results in subsequent sessions, in therapy sessions for depression include several other cognitive emphases. For example, the client is encouraged to discover underlying dysfunctional assumptions that may be leading to self-defeating tendencies. These generally become evident over the course of therapy, as the client and the therapist examine the themes of the client's automatic thoughts. Because these depressogenic schemes are seen as creating the person's vulnerability to depression, this phase of treatment is considered essential in ensuring resistance to replace when the client faces stressful life events in the future. That is, without changing the underlying cognitive vulnerability factors, the client may show short-term improvement but will still be subject to recurrent depression.

The general approach is similar for disorders other than depression. For example, in generalized anxiety disorder, the client is taught to correct the tendencies to overestimate the presence and likelihood of danger and to under estimate his or her ability to cope in a variety of situations (Beck and Emery, 1985) . In bulimia, the cognitive approach proposes that the person has overvalued ideas about body weight and shape which lead to low self-esteem and fears of being unattractive. The cognitive part of the treatment involves getting these clients to identify and change their maladaptive beliefs regarding weight and body image as well as about foods that are "safe" and 'dangerous" (Agras, 1993).

11.3 How Effective Is Cognitive-Behaviour Therapy?

Cognitive-behavioural interventions aim to correct people's misconceptions, strengthen their coping skills and feeling of control over their own lives and facilitates constructive self-talk, or the things people typically say to themselves as they confront different types of situations. For instance, rather than saying "I will never be able to do all that", they might tell themselves, "I'll just take it one step at a time".

There is growing evidence that cognitive behavioural training can be quite effective in helping people, overcome fears and inhibitions, and increase their coping skills (Barlow, 1994). An important factors seems to be the client's sense of self-efficacy, that is, the client's belief that he or she is effective at carrying all tasks. Feelings of self-efficacy increase when individuals acquire new skills, which in turn, encourages them to strengthen their skills even further.

Cognitive-behavioural interventions seem to be particularly effective in treating disorders in which anxiety plays a prominent role (Hollon and Beck, 1994) and is the best predictor of longterm outcomes. For depression and panic disorder cognitive change is vital as restructuring of the thought process helps the individual to overcome existing negative & self defeating thought process.

11.4 INTRODUCTION TO HUMANISTIC – EXISTENTIAL THERAPIES

These therapies emerged as significant treatment approaches during the post-World War II era. To a large extent, they developed in reaction to the psychodynamic and behavioral perspectives, which many feel do not actually take into account either the existential problems or the full potentialities of human beings. They are based on the assumption that we have both the freedom and responsibility to control our own behavior, that we can reflect on our problems, make choices and take positive action.

In a society dominated by self interest, mechanization, computerization, mass-deception and mindless bureaucracy, proponents of the humanistic experiential therapies see psychopathology as stemming in many cases from

problems of alienation, depersonalization and a failure to find meaning & genuine fulfilment.

The humanistic-existential therapists feel that a client must take most of the responsibility for the direction and success of therapy, with a therapist merely serving as a counsellor, guide and facilitator. These therapies may be carried out with individual clients of humanistic existential therapies is always that of expanding a client's "awareness", accordingly, we consider them Type C (cognition-oriented) approaches.

11.5 CLIENT-CENTERED THERAPY :-

In client centered therapies, a non- fundamental therapist facilitates the process of self-understanding by serving as a mirror for the client.

Carl Rogers (1951, 1961, 1966) saw psychotherapy as a growth progress and encouraged objective study of the events that occur as therapy progresses. He recognized that people's ideas and ways of looking at the world' influence their emotional lives. The client-centered therapist believes that perceptions and cognitions determine whether an individual has unpleasant emotions. As the client restructures his or her view of the self, some constraints grow out of unrealistic demands that people tend to place on themselves when they believe, as a condition of self-worth, that they should not have certain kind of feelings, such as hostility. As they lose touch with their own genuine experience, the result is lowered integration, impaired personal relationship and various forms of maladjustment.

The primary objective of Rogerian therapy is to help clients become able to accept and be themselves. The therapist establishes a psychological climate in which clients can feel unconditionally accepted, understood and valued as people. In this climate, they can begin to feel free, for perhaps the first time, to explore their real feelings and thoughts. As their self-concept becomes more congruent with their actual experiences, they become more self-accepting and more open to new experience and perspectives to become better integrated people.

Client centered therapy is also called non-directive therapy. It is not the therapist's task to direct the course of therapy. He or she simply listens attentively and accordingly to what the client wants to talk about, interrupting only to restate in other words what the client is saying. Such restatements, without any judgement or interpretation by the therapist, help the client clarify further the feelings and ideas that he or she is exploring-really to look at them and acknowledge them. Roger made an objective analysis of what was said, of the client-counselor relationships and of the ongoing precessions of these therapy sessions. He compared client's behavior and attitudes at different stages of therapy. Eventually, positive feelings, a reaching out toward others, greater self-confidence and interest in future plans appeared. This characteristic sequence gave support to Roger's

hypothesis that once freed to do so, individuals have the capacity to lead themselves to psychological health.

Pure client-centered psychotherapy, as originally practiced, is rarely used today. However it opened the way for a variety of humanistically oriented therapies in which the focus is on the client's present conscious problems and in which it is assumed that the client's present conscious problems and in which it is assumed that the client is the primary actor in the curative process, with the therapist essentially being a facilitator. The newer humanistic therapies thus, accept Roger's concept of an active self, capable of sound value choices; they also emphasize the importance of a high degree of empathy, warmth and unconditional positive regard that are however, seen as central in therapy.

11.6 EXISTENTIAL THERAPY :-

These therapies also emphasize the present and the need to recognize the uniqueness of each client. These therapists work as partners with their clients. Many combine humanistics and psychodynamic approaches in dealing with anxiety, its causes, and the defences that the client erects to cope with it. In this sense, the existential approach is a therapeutic hybrid.

The emphasis of existential therapy is on helping clients come to terms with basic issues concerning the meaning and direction of their lives and the choices by which they shape their own destiny. Most therapists work with people who are troubled by anxiety and depression. Their primary role is in helping lonely people make constructive choices and become confident enough to fulfil their unique selves rather than repressing or distorting experiences. Therapists believe that the task of creating and revising one's life design is lifelong. It is not something that, once accomplished, need never by re-examined or revised. One's own growth and maturing; the contingencies of living with others, each having a somewhat different life design, and the unpredictability of life generally combine to demand repeated attention to one's personal life view.

The following case illustrates the type of problem situation that would lend itself to treatment in existential framework.

A 42-year-old business executive seeks therapy because he feels that life has lost its meaning-he no longer feels that family matters are important to him (his wife is busy starting her career and his only child recently got married and moved to Alaska). Additionally, his work, at which he has had extra ordinary success-earning him both financial security and respect no longer holds meanings for him. He views his days as "wasted and worthless" - he feels both "bored and panicked" - and he goes through the motions of the business day feeling "numb", as though he isn't even there. At times, he feels fearful and overwhelmed with a sense of dread that this is all the life has left for him.

For existential therapists, life always required that people create, and revise as needed, framework within which is to discover the meaning of living (Bugental and McBeath, 1995). The existential treatment approach is believed to work best with individuals who have anxiety based disorders or personality disorders.

11.7 SUMMARY

Cognitive-behaviour, therapy stems from both cognitive psychology (with its emphasis on the effects of thoughts on behaviour and on the study of the very nature of our cognitive processes) and behaviourism. Cognitive-behaviour therapy reflects the increasing interest of therapists in cognitive modification as means of influencing emotions and behaviour. This approach to therapy makes use of a variety of behavioural techniques, such as graded program of activities, home work and role playing, along with an effort to identify and modify unrealistic cognitions. In the recent years, cognitive therapists and behavior therapists have freely borrowed techniques from one another. Three approaches of cognitive behaviour therapy have been explained in this lesson ie;

I The rational-emotive therapy of Albert Ellis;

II The stress-inoculation training of Donald Meichenbaum; and

III The cognitive behavior therapies of Beck.

The humanistic-existential therapists feel that a client must take most of the responsibility for the direction and success of therapy, with a therapist merely serving as a counsellor, guide and facilitator. These therapies may be carried out with individual clients with the aim of expanding a client's "awareness", about his feelings, motives and situation respectively.

Exercise

Q1 Write a detailed note on the application of cognitive behaviour therapy in the treatment of various maladaptive disorders.

Q2 Explain Becks approach in dealing with negative thoughts.

Q3 Explain the concept of humanistic approach in dealing with maladjusted individuals.

Q4 Explain Carl Rogers "Client Centered" theory.

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