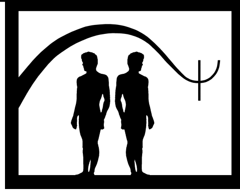

Self-Statement Modification

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I. Description of Treatment
II. Theoretical Bases
III. Empirical Studies
IV. Summary
Further Reading

GLOSSARY

cognitive contents The content of people's self-talk; what they think and the sentences they use. They are close to or just below the level of conscious awareness.

cognitive processes The cognitive distortions people use in interpreting sensory data, for example, overgeneralizing, personalization, and dichotomous thinking.

cognitive structures The network of tacit rules and assumptions people use in interpreting the world that are laid down at an early age. They consist of tacit cognitive contents organized around a theme. They are also called core cognitive schemas and consist of unrecognized assumptions about the self and the world, for example, "I'm unlovable."

covert behaviors (or coverants) Behavior (such as internal verbalization) that is observable only to the behaving and observing individual.

internal dialogue A series of automatic self-statements about a situation or behavior.

operant conditioning Consequential learning based on reinforecement, which increases subsequent behavior, or punishment, which decreases it.

self-instructional training (SIT) A training package that trains people how to assess what they are saying to themselves and then to modify what they say to themselves to overcome behavioral difficulties.

self-statement The self-verbalizations or self-talk in which people engage, either overtly (aloud) or silently (covertly).

I. DESCRIPTION OF TREATMENT

Self-statement modification is rarely attempted alone; rather it is generally presented as one component of a treatment package that includes other therapeutic ingredients such as modeling, role-playing, behavioral rehearsal, verbal reinforcement, problem-solving, or social skills training. There are two parts of self-statement modification, the assessment of maladaptive self-statements and the learning and production of new, more adaptive self-statements.

There are several methods for assessing self-statements, which were described (in another context) by Dowd in 1995. Interview-based methods include "think-aloud methods" (in which clients are instructed for a period of time to verbalize whatever comes to mind), "thought-listing" (in which clients list for a period of time whatever thoughts they might have had about a specific situation), "prompted recall" (in which clients view a video or audiotape of them in a problematic situation and indicate what their thoughts were at certain times), and "imagery assessment" (in which clients are asked about images they had during problematic situations). Questionnaire methods include such instruments as the Assertive Self-Statement Test (ASST), the Social Interaction Self-Statement Test (SISST), the Automatic Thoughts

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Questionnaire (ATQ), the Dysfunctional Styles Questionnaire (ASQ), and the Irrational Beliefs Test (IBT). Some of these assess attitudes at least as much as self-statements but there is no clear demarcation between the two.

Once the maladaptive self-statements have been identified, clients are then taught to emit adaptive or coping self-statements in place of the maladaptive ones. Following the developmental theory of Luria and Vygotsky, Meichenbaum and Goodman in 1971 developed the prototype of the modification of self-statements:

> First, E *(experimenter, therapist)* performed a task talking aloud while S *(subject, client)* observed (E acted as a model); then S performed the same task while E instructed S aloud; then S was asked to perform the task again while instructing himself aloud; then S performed the task while whispering to himself (lip movements); and finally S performed the task covertly (without lip movements). (p. 117, italics added)

Thus, the therapist gradually takes clients from overt verbalization of the new self-statements to covert verbalization, recapitulating the development of private speech or self-statements in children.

Examples of maladaptive self-statements might be, "I'll never be able to do this task!", "I just don't have what it takes!", "I'm not as smart as other people." Examples of coping or adaptive self-statements might be, "I can develop a plan to handle this," "I can do it if I slow down and take it one step at a time," "Just relax and let the fear subside," or "It worked! I did it — not perfectly but pretty good!"

As with other therapeutic procedures, repetition is very important in self-statement modification. People do not easily or quickly change long-entrenched and automatic ways of responding, including self-statements. Often they are not even aware of their self-talk until after it has occurred and sometimes not even then, even with therapist prompting. Practice outside of therapy as well as during the sessions is important for sustained progress.

II. THEORETICAL BASES

Self-statements are a universal aspect of human cognitive function and their modification is an important part of cognitive behavior therapy procedures. Indeed they are found in all of the important Cognitive-behavior therapy (CBT) interventions, although often by different names. Self-statements are the statements that people say to themselves in a variety of situations and they can be either positive or negative. Sometimes they are within the area of conscious recollection although often they are not; that is, we sometimes recognize that we are making these statements while much of the time we do not.

Self-statements are similar in many ways to the automatic thoughts of Aaron T. Beck's cognitive therapy, to the irrational thoughts of Albert Ellis's rational-emotive-behavior therapy, to Marvin Goldfried's cognitive (or rational) restructuring, and to Daniel Araoz's negative self-hypnosis. What they all have in common is an assessment and modification of the covert self-talk that lies at and just below the level of conscious awareness. They are what Meichenbaum and Gilmore refer to as "cognitive contents," or the actual content of our cognitive processes. Perhaps because self-statement modification is functionally similar to or part of other CBT procedures, some writers have not clearly distinguished it from other CBT procedures, such as self-instructional training, cognitive restructuring, rational disputing, and imagery work. It has therefore appeared on occasion that the differences among them are insignificant. Nevertheless, there are distinctions. The automatic thoughts in Beck's cognitive therapy are more idiosyncratic in nature than the more standard irrational thoughts of Ellis. Cognitive restructuring is a more generic term for a set of techniques. Hypnosis and imagery work represent a class of more nonverbal techniques.

Perhaps the best theoretical development of self-statement modification can be found in the self-instructional training (SIT) of Donald Meichenbaum. Meichenbaum based his work on both behavioral and developmental theories, out of which he derived his own cognitive theory of change. His early work in cognitive behavior modification was based primarily on self-statement modification with impulsive children in order to reduce their level of impulsivity. Behaviorally, he considered self-statements to be examples of covert behaviors, subject to the same laws of learning and modification as other behaviors. Generally, the theoretical basis for these laws was operant conditioning. In this, he followed Lloyd Homme's notion of coverants (or covert operants/behaviors) as obeying the same laws as overt behaviors. Covert behavior was reinforced or punished according to the same principles as overt behavior. Developmentally, he referred to the work of the Soviet psychologists Alexander Luria and Lev Vygotsky, who viewed the internalization of self-statements as fundamental to the human development of self-control and regulation of behavior. Luria and Vygotsky argued that self-statements in young children are first overt in nature and mimic the overt talk of significant adults. Later, the child's self-statements become covertly subvocalized and then entirely automatic and nonconscious in nature. It is these automatic thoughts or self-statements

that result in adult behavioral regulation. Children who do not internalize these self-statements have difficulty with self-regulation (most obviously in impulsivity) but internalization of maladaptive self-statements can result in later psychological problems.

Meichenbaum's cognitive theory of change has three phases. The first phase is self-observation, in which clients first become aware of their own behavior. They begin to monitor, with increasing accuracy, their own thoughts, feelings, physiological reactions, and interpersonal behavior. They gradually become aware that their self-statements (internal dialogue) are negative, repetitive, and unproductive and come to reconceptualize or redefine their problems, in part according to the theoretical orientation of the therapist. Thus, the client of a psychoanalyst may come to see his problems as stemming from his early relations with his father while the client of a behavior therapist may come to see her problems as arising from inadequate reinforcement for exploratory behavior as a child. In the process, both gain understanding (and therefore control and hope) of their feelings, behaviors, and thoughts. They begin the process of thinking differently about their problems.

The second phase is incompatible thoughts and observations. Here, as a result of the observations in Phase One, clients begin a translation process from the maladaptive internal dialogue to a more adaptive internal dialogue. They begin to reconceptualize their problems differently. The new internal dialogue affects their attention, their appraisals, their physiological responses, and even instigates new behavior. The increased attention in Phase One helps change the internal dialogue in Phase Two, which in turn guides new behavior.

The third phase is the development of new cognitions about change. In this phase, clients begin a new internal dialogue about the changes they have been undergoing and the new behaviors they have been producing. These changes provide evidence for a change in self-statements that make up the internal dialogue. If their interactions with other people change, they will then reflect on this in their changed internal dialogue. The modified internal dialogue is similar to what in other systems might be referred to as "insight." In other words, behavior change precedes insight, rather than following it, a point made in 1962 by Nicholas Hobbs.

The implication of this theory of change is that therapeutic interventions might profitably focus first on instigating behavior change and then fostering cognitive change as clients reflect on their behavioral change and its implications. But cognitive therapists in general have often focused first on changing cognitive contents (self-statements) or cognitive processes (cognitive distortions). Indeed, Jeffery Young, in his schema-focused therapy, focuses on cognitive structures, or the network of rules and assumptions that determine how we interpret the world.

III. EMPIRICAL STUDIES

There has been considerable research conducted on self-statement modification, even within relatively recent years. Two meta-analyses of the effects of self-statement modification were published by Dush, Hirt, and Schroeder, in 1983 and 1989, one on adults and the other on children. In the adult meta-analysis, the results for self-statement modification were impressive. Self-statement modification produced a greater effect size than alternative therapies when compared both to no-treatment controls and to placebo controls. However, the effect sizes were smaller when compared to placebo controls than to no-treatment controls. The efficacy of self-statement modification was found to be greater when combined with other cognitive-behavioral procedures. Similar results were obtained in the children's meta-analysis. Self-statement modification produced greater effect sizes than either no-treatment controls or placebo controls, although there was no significant difference between the two types of comparisons, indicating that placebo treatment with children may not be more effective than no treatment. Comparing the two meta-analyses, the effect of self-statement modification appeared to be less for children than for adults, especially when compared to no treatment.

A related meta-analysis examining the treatment of impulsivity in children by Baer and Nietzel found comparable results. The interventions were associated with improvements ranging from one-third to three-fourths of a standard deviation when compared to untreated controls. Self-statement modification in these studies was combined with other cognitive-behavioral interventions.

Other studies have found self-statement modification to be effective in preparing patients for various stressful medical procedures such as coping with office routines and illness management, particularly for children. It has also been found to be effective as part of a treatment program for anger management and in treating such problems as heterosexual effectiveness, assertive training, and dating-skills training. Because it has sometimes been evaluated in combination with other CBT techniques, it is not always clear what unique contribution it makes. However, it has been shown to be at least as, if not more, efficacious than alternative treatments.

IV. SUMMARY

Self-statements, positive and negative, appear to be a ubiquitous aspect of human cognitive and developmental functioning and are heavily implicated in self control. Self-statement modification is found in many of the cognitive-behavioral theories, including those of Aaron Beck, Albert Ellis, Marvin Goldfried, and Donald Meichenbaum, and is designed to replace negative self-statements with positive ones. However, it often goes by different names in different theories. Perhaps the fullest and most complete expression of the technique is found in Meichenbaum's self-instructional training. Self-statement modification consists of assessing the self-talk that clients use about a problematic situation and then training them to emit different, more adaptive, self-statements instead. Research has shown that it is a very effective and versatile technique, although it is often used in combination with other techniques.

See Also the Following Articles

Behavior Rehearsal ■ Coverant Control ■ Modeling ■ Objective Assessment ■ Role-Playing ■ Self-Control Desensitization ■ Self Psychology ■ Vicarious Extinction

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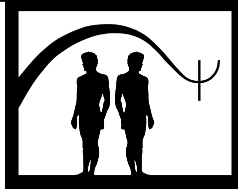

Setting Events

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I. Description of Treatment
II. Theoretical Basis
III. Empirical Studies
IV. Summary
Further Reading

GLOSSARY

consequence Any object or event that immediately follows the emission of a response.

discriminative stimulus A stimulus in the presence of which a response is reliably reinforced.

establishing operation A current environmental event, operation, or condition of the organism that alters the relative strength of the discriminative stimulus to control responding.

functional analysis An assessment technique whereby the experimenter directly manipulates potential controlling variables to directly assess their effects on the targeted behavior of interest.

punishment A contingent relationship between a behavior and a behavioral consequence, in which that consequence causes the behavior to decrease in frequency.

reinforcement A contingent relationship between a behavior and a behavioral consequence, in which that consequence causes the behavior to increase in frequency.

I. DESCRIPTION OF TREATMENT

A setting event is a distinct stimulus event or a specific level of a dynamic state of an organism that precedes and interacts with a particular stimulus and response function. Setting events may momentarily alter the relative control of a discriminative stimulus, resulting in a potentially different response than usually occasioned by that same discriminative stimulus. If a treatment was designed whereby a participant has been trained to emit a vocal response in the presence of a teacher's vocal prompt and subsequently reinforced with praise, the setting event of another person, say the participant's friend, may result in an altered probability of that same vocal response being emitted. In this case the setting event of the friend may result in a higher or lower probability of response emission by the participant. The relative change in response probability is a function of the participant's past history of reinforcement or punishment for similar responses in the context of that setting event. Assuming that the participant has been reliably reinforced for emitting a vocal response following a vocal prompt of the teacher, if now exposed to a similar situation where the friend is present he fails to emit the correct response. The occasioning ability of the teacher's prompt and the reinforcing function of the teacher's praise has been momentarily weakened in the presence of the participant's friend. Figure 1 provides a visual illustration of this example.

In order to establish new behaviors most effectively, one should be aware of the potential influence of setting events on a given treatment approach. Several variables will enhance the likelihood that the resulting treatment will be successful. First, attempts should be made to incorporate into treatment those setting

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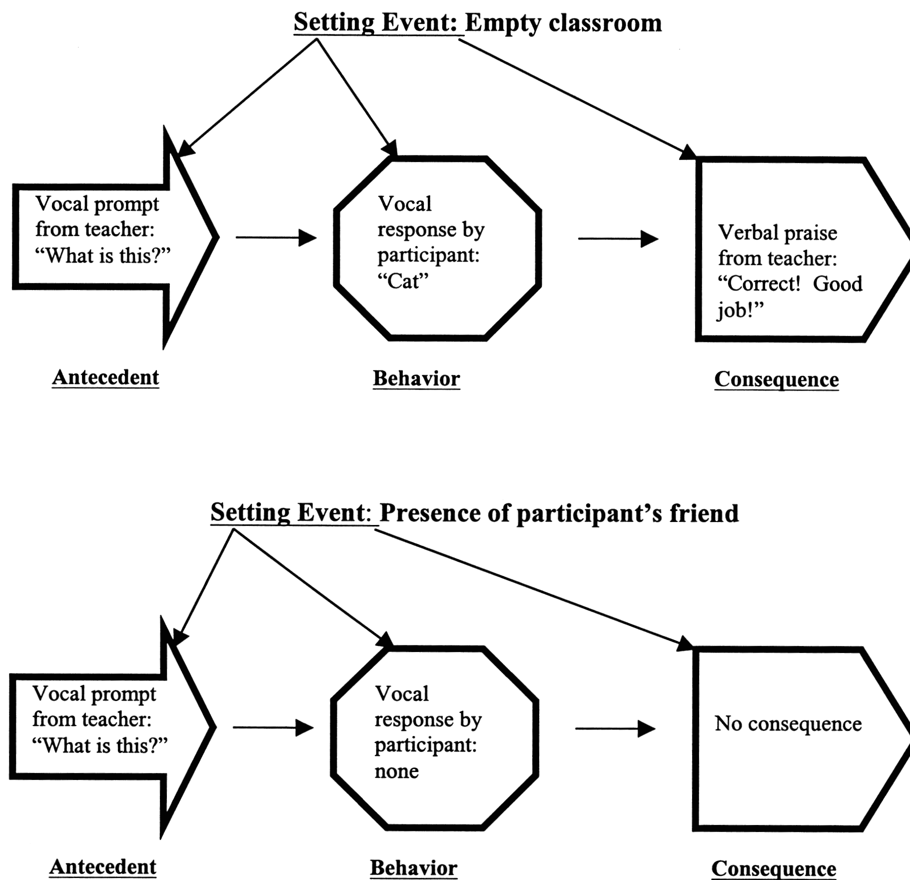

FIGURE 1 Conceptual illustration of the potential influence of a given setting event.

events that have been associated with increased emission of the desired response and eliminate those setting events that have been associated with decreased response emission. Proper identification of the relevant characteristics of the participant's environment that may be functioning as such setting events might be accomplished via an interview with relevant persons, direct observation, or a functional analysis. Second, it should not be assumed that a particular setting event will be directly observable or in temporal proximity to the stimulus–response function question. Setting events such as food deprivation, a fight with a spouse, and stomach pains may either be unobservable or currently absent from the immediate setting. In such cases, proper identification is still possible, yet may require additional exploration. Third, when the elimination of setting events that reduce the probability of treatment success are not possible, one should attempt to minimize their effect. This might be done by withholding the discriminative stimulus, which will now not occasion the appropriate response, providing additional discriminative stimuli for the appropriate response, or altering the magnitude, density, or salience of the reinforcement to be delivered contingent for the appropriate response. In the earlier example this might consist of the teacher not prompting the participant for a vocal response until his friend leaves the training environment, the teacher providing additional prompts such as "Show your friend how much you know" before presenting the original discriminative stimulus prompt, or the teacher providing a piece of candy coupled with praise as the consequence for a correct vocal response.

II. THEORETICAL BASIS

The concept of setting event was theoretically discussed as early as 1959 by J. R. Kantor, under the name "setting factors." He conceptualized the setting factor as

a general circumstance surrounding the interaction between the stimulus and the response. According to Kantor, the setting may have an effect on the stimulus object, the reacting individual, or the interaction between the two. The role of the setting factor was to facilitate or hinder the occurrence of the particular stimulus–response function. Although the original name has changed in contemporary discourse from "factors" to "event," the theoretical role it plays on subsequent behavior has not.

The notion of setting event is often added to theoretical conceptualizations of the traditional three-term contingency of (1) discriminative stimulus, (2) response, and (3) consequence, to aid in accounting for the periodic variability in otherwise assumed predictable responding. Setting events differ from other conceptualizations of an additional influence on the three-term contingency in terms of their scope. Setting events can be present in the current environmental context such as the case with food deprivation prior to meal time, yet they can also be somewhat removed in time such as the case with engagement in strenuous exercise the day before coming to therapy, or getting a traffic ticket on the way to work. The former example of food deprivation might be theoretically equivalent to the notion of an establishing operation, although the latter examples would not. Yet all three might exert some change in control over responding. In general the conceptualization of a setting event is broad and not limited by space–time proximity to a current emission of a participant's behavior.

Additionally setting events may take the form of complete stimulus–response interactions that also affect other stimulus–response interactions that follow it. In other words, the setting event may be both an environmental event and the participant's response to that event. For example, assume a college student whose studying behavior in her room is typically followed the next day by exceptional test performance, is now interrupted from studying in her room throughout the night by her brother's playing of the drums downstairs. The no studying–being in her room interaction serves as a setting event for bad test performance the next day. Here it is the case that the previous night's stimulus–response interaction has a latter effect on observed behavior the next day.

Setting events influencing control over behavior can be identified in ways theoretically similar to those of discriminative stimuli and/or reinforcing consequences. One form of potential identification is through an interview or a rating scale. Caregivers or those known to the participant might be surveyed for potential awareness of the presence of a given setting event. These might include questions regarding the participant's daily sleep or eating patterns, medication changes, experience of recent traumatic life events, and the presence or absence of particular persons in a given setting. The interview or rating scale is a cost- and time-effective method for potential setting event identification. This method is also prone to potential problems. First, the skill of the interviewer must be such that appropriate questions are answered. Second, accuracy of responses is subject to the interviewee's ability to remember specific events. Third, the responses will provide correlated and anecdotal information at best. Current control by a specific setting event may or may not be identical to what has been post hoc reported.

Another form of identification is through observation. The clinician or the participant directly observes the behavior of interest and records current features of the present context that may be in part functioning as a setting event. In the case of the clinician, he or she might have a checklist or scorecard whereby a checkmark or tally is made when the observed behavior is emitted (or not emitted) by the participant in the presence of certain conditions. Self-monitoring might also be conducted whereby the participant attempts to observe and record data on their own behavior and its relation to potential setting events. Self-monitoring is useful when direct observation by another party is limited or not possible. One should keep in mind that accuracy is questionable with self-monitoring Without contingencies in place to ensure reliability of data collection, there may be incentives for the participant to inaccurately report the presence of a specific setting event. An example here might be a participant who just experienced a toileting accident and fails to record it on her daily tracking sheet of self-initiated activities outside of the house because she is embarrassed.

Like interviews and rating scales, the direct observation of setting events has potential problems. First, observers might not properly identify all relevant setting events. This is especially true when setting events are not in close temporal or spatial proximity to the behavior of interest or when they are covert events such as headaches, feelings of depression, or food deprivation. Second, direct observation is very time consuming to effectively train observers. Third, direct observation will only provide correlational data on the potential effects of a particular setting event. Causal inferences are not possible.

A last form of identification is through experimental manipulation. This technique is often termed functional analysis. A functional analysis assessment would

require the clinician manipulate directly the presence or absence of a particular setting event and then assess subsequent performance. From experimental manipulation, causal inferences can be made about the relative contribution of an assumed setting event on a targeted behavior. For example, if it is assumed that the administration of a given drug to a participant is responsible for that participant's aggressive behavior at the workplace when prompted to complete tasks, the clinician might withhold drug administration on certain days to determine if drug-free days differ from drug-induced days' levels of aggressive behavior.

As with the previously mentioned methods, there also are potential problems in the functional assessment strategy for identification of setting events. Problems include the extensive time and cost for training of clinicians to identify and subsequently manipulate variables, as well as the increased ethical concerns regarding intensifying or postponing treatment for a problematic behavior. In summary, the clinician should use the assessment method for identifying potential setting events that is best suited for the individual circumstances, and be aware of and attempt to control for potential problems with its implementation.

Through the adoption of a theoretical perspective whereby setting events might influence stimulus–response relationships, and upon the utilization of appropriate identification techniques for such setting events, clinicians might eventually accomplish more effective treatments for the participants they serve.

III. EMPIRICAL STUDIES

The following empirical studies demonstrate that through proper identification and manipulation of a particular setting event(s), one can alter the strength of a stimulus–response relationship. Proper techniques should enhance treatment success.

For example, in 1993 Craig Kennedy and Tina Itkonen examined the effects of setting events on the problem behavior of students with severe disabilities. In a series of two studies they examined the relative frequency of problematic behavior occurrences in the presence and in the absence of hypothesized setting events. One of their studies involved a girl who exhibited both aggressive acts during daily transitions and frequent running away or inappropriate grabbing of objects in the presence of dogs, jewelry, or men. The authors assessed possible setting events for these classes of behaviors via a review of the girl's records, a structured interview, and direct observation of her behavior. Once it was deduced that the potential setting event influencing the occurrence of her inappropriate behaviors was "awakening late in the morning," a reversal design coupled with a setting event elimination strategy was introduced. The setting event intervention consisted of providing additional incentives for the girl to awake within a set period of time, along with requiring her to shut off her own alarm clock. Resulting frequencies of her problem behavior reduced dramatically upon the removal of the setting event. Similar results were obtained in the authors' second study that involved a girl whose problem behaviors were eliminated upon the removal of the setting event of being transported to school via the city streets. Here the intervention was simply to transport the girl to school via the highway.

A study conducted in 1997 by Mark O'Reilly demonstrated the correlation between the setting event of otitis media (a recurrent or persistent inflammation or infection of the middle ear) and episodic self-injury in a 26-month-old girl with developmental disabilities. In this study, the participant frequently engaged in back banging and ear poking. Upon completion of assessment interviews with the mother and doctor, it was deduced that her problem behavior occurred around 3 to 10 days a month and was thought to correlate with the presence of ear infections. To further investigate these correlations, a comparison across the naturally occurring conditions of ear infected and ear uninfected was conducted. This comparison yielded high rates of problem behavior during most conditions when the girl had an ear infection, and no rates of the problem behavior when her ears were infection-free. These results led the author to further explore the possibility that the setting event of otitis media might have been enhancing the sensory escape function from noise of the self-abusive behavior. Further functional assessment conditions showed this to be the case.

It is often the case that one particular setting event alters the probability of a given response, as in the above studies. Yet, it may also be possible that a combination of two or more setting events will have a collective effect on behavior. For example, in 1992, Lynette Chandler, Susan Fowler, and Roger Lubeck examined the effects of multiple setting events on the social behavior of preschool children with special needs. In their two studies, they attempted to identify the most optimal combination of setting events to produce the greatest number of social interactions of seven preschoolers. After implementing a series of systematic combinations, they concluded that the ideal combination of setting events to

facilitate peer interactions was (1) the removal of the teacher from the activity location, (2) the inclusion of only a limited number of play materials, and (3) a pairing of the child with a socially skilled playmate.

IV. SUMMARY

Setting events are contextual stimuli that momentarily alter the strength of the relationship between a stimulus and a response. Appropriate identification of setting events can assist the clinician in explanation of potential variability in responding. They can also be useful for the development of more appropriate and effective training opportunities. Reinforcement is not a static process uninfluenced by anything other than a simple discriminative stimulus. Rather, the strength of the discriminative stimulus – response – reinforcement relationship is dynamic. That dynamic relationship is often a direct result of the impact of a given setting event on the current context.

See Also the Following Articles

Forward Chaining ■ Habit Reversal ■ Negative Reinforcement ■ Positive Reinforcement ■ Response Cost

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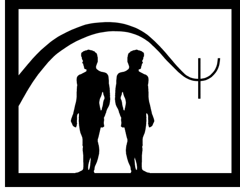

Sex Therapy

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I. The Evolution of Sex Therapy: Theoretical Underpinnings
II. Behavioral, Cognitive, and Systemic Treatment for Sexual Dysfunctions
III. Applications and Exclusions
IV. Empirical Research
Further Reading

GLOSSARY

etiology All of the causes of a disease or abnormal condition.
organic Of, relating to, or arising in a bodily organ; affecting the structure of the organism.
psychogenic Originating in the mind or in mental or emotional conflict.

I. THE EVOLUTION OF SEX THERAPY: THEORETICAL UNDERPINNINGS

A. Early Views of Sexual Dysfunction

Although difficulties with sexual functioning have undoubtedly existed throughout time, early theories of the development and treatment of sexual dysfunctions first began to appear in the late 19th and early 20th centuries. In 1902, Richard von Krafft-Ebing published *Psychopathia Sexualis,* a book that addressed the existence of dysfunctions and deviations alike. Krafft-Ebing theorized that many sexual disorders resulted from the improper use of sexual energy, creating a state of moral degeneracy. For men, this loss was conceptualized as a waste of semen on nonreproductive activities such as childhood masturbation and excessively frequent sexual activity in adulthood. Mental health professionals at that time advocated preventive treatment through the use of restraining devices that inhibited children's masturbation, such as metal mittens, and through the maintenance of a bland diet in adulthood to avoid overstimulation of the senses.

Sigmund Freud presented a different view of sexual dysfunction in 1905 with the introduction of the Oedipal and Electra complexes. Sexual disorders were thought to be the result of failing to resolve these complexes and becoming fixated at an immature stage of psychosexual development. Treatment did not involve direct attention to sexual functioning, but instead revolved around indirect psychoanalytic approaches, such as insight attainment and transference techniques.

B. Behavioral Sex Therapy

Despite the failure of Freudian therapy in the successful treatment of sexual dysfunction, it was nearly 50 years before Freud's views were challenged by early behaviorists. These early behavioral psychologists posited that anxiety functioned to inhibit normal sexual arousal, resulting in dysfunction. Treatment consisted of techniques to reduce anxiety such as progressive relaxation and systematic desensitization.

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In 1966 and 1970, William Masters and Virginia Johnson published their monumental works on the etiology and treatment of sexual dysfunctions. Masters and Johnson expanded on the theories of early behaviorists by stressing an informal social learning theory approach that emphasized the roles that negative messages about sexuality, lack of knowledge about sexuality, and traumatic first sexual experiences play in sexual functioning. In addition, they introduced the concept of sexual problems as self-maintaining cycles of dysfunctional sexual behaviors mediated by anxiety. They theorized that following a negative sexual experience, an individual might develop an anxious, self-evaluative spectator role that interferes with the normal sexual response cycle and results in the maintenance of sexual dysfunction. In addition to the anxiety reduction techniques utilized by early behaviorists, Masters and Johnson included the instruction of specific sexual stimulation techniques in their treatment protocol.

Later additions to the Masters and Johnson model for sex therapy have included elements of both cognitive and systemic theory. An emphasis was placed on a patient's thinking about sex, with various cognitive distortions becoming a major focus of treatment. Moreover, couple systemic considerations such as power struggles and difficulties with intimacy and trust have increasingly been included in both etiological considerations and treatment focus in a variety of sexual dysfunctions. In 1997, Joseph LoPiccolo termed this melding of theoretical approaches "post-modern sex therapy" and acknowledged that the procedures used by behavioral, cognitive-behavioral, and systemic therapists in treating sexual dysfunctions greatly overlap. As a result, the most comprehensive discussion of current treatment approaches to sexual dysfunctions must include an explanation of the theoretical underpinnings of postmodern sex therapy.

C. Post-modern Sex Therapy

Post-modern sex therapy is a therapeutic approach that uses behavioral, cognitive, and systemic methods to treat a variety of sexual disorders that affect both males and females. This approach is based on a theoretical foundation in which the etiology of sexual dysfunctions is considered to be multifaceted, with both psychological and physiological factors contributing to the onset of a particular disorder. As a result, both diagnosis and treatment of sexual dysfunctions must be considered in the context of a combination of behaviors, thoughts, and emotions.

Problems in sexual functioning are thought to have several potential causes that must be considered when designing the treatment approach. According to LoPiccolo, these include psychological factors, such as family of origin learning history, systemic relationship issues, cognitive distortions, and daily life stressors, as well as physiological or medical issues.

1. Family of Origin Learning History

Although Freudian theories of sexual dysfunction have largely been abandoned by modern mental health professionals, the idea that childhood can play a significant role in later sexual development has not. Most sex therapists today believe that childhood and adolescent experiences can play an important role in the development of both healthy and dysfunctional sexual relationships in adulthood. Issues in family of origin learning history often involve negative messages about sexual expression and a lack of sex education. In addition, many women and men who experience sexual dysfunctions have parents who have modeled unaffectionate and unhealthy sexual relationships.

The most common form of sex education for children who later develop sexual dysfunctions is the absence of sex education. Numerous adults who experience sexual difficulties report that they were not told about the positive aspects of sexuality by their families, and they often say that they did not receive any messages at all about sex. As noted by Susan Walen and Richard Perlmutter in 1988, the absence of communication about an issue does not indicate the absence of an underlying message, and often the topics that are never mentioned are the very topics that are seen as the most distasteful and inappropriate for discussion. By refusing to discuss sexuality, many parents set their children up for believing a multitude of myths about sex that they garner from peers, the media, and other unreliable outside sources of information. These can include misinformation about how one gets pregnant, the ways in which sexually transmitted diseases are transmitted, and the ways in which each partner must give and receive sexual pleasure.

Warren and Perlmutter outlined the "secrets of sex in families" that can contribute to the later development of difficulties in sexual functioning. One such secret is that sex is actually a pleasurable way to share feelings of love and affection with a partner, to express oneself as a healthy or happy person, or is a pleasurable form of recreation. Other deleterious family secrets include the secret that masturbation is a normal and healthy way to explore oneself and experience pleasure, the secret that

children can have appropriate sexual feelings, the secret that adolescence is a normal time to experience sexual impulses and urges, and the secret that parents are sexual. In many of these families, the parents hide their affection and sexuality from their children behind closed doors, and children quickly learn that sex is an activity that needs to be hidden from others. Finally, the most serious sexual secrets that families keep are those associated with incest, rape, and paraphilias. Incest, in particular, is a family secret that very commonly leads to adulthood sexual dysfunction.

This lack of sex education not only leads to negative feelings about sexuality, but it also leads to sexual behavioral deficits in adulthood. Because they are discouraged from communicating with others about sexual issues and from sexual self-exploration, many children grow into adults who are ignorant of their partner's and their own anatomy, as well as the sexual response cycle. Common deficits in education that illustrate the problems associated with several sexual dysfunctions include uncertainty about the location of the clitoris, the belief that women must experience an orgasm through vaginal penetration only, the inability to recognize an orgasm when it does occur, the belief that men must ejaculate every time they have intercourse, the belief that men should be able to quickly regain erections after ejaculation, and the belief that orgasm through intercourse is the only acceptable end to sexual activity. These erroneous beliefs often lead to sexual behaviors that are detrimental to a functional sexual relationship, such as by neglecting to properly stimulate the clitoris to orgasm. In addition, cultural myths about sexuality and aging contribute to these cognitive and behavioral causes of sexual dysfunction. For instance, it is frequently thought that men should be able to attain and sustain an erection with little or no direct stimulation even as they get older.

While a lack of sex education is a common denominator in adults who have developed a sexual dysfunction, many children receive direct, harmful messages about the undesirability of sex. Negative messages about sexuality are communicated to children and adolescents in myriad ways. Strict prohibitions against childhood and adolescent masturbation, and parental negativism toward dating and premarital sexual activities are somewhat common methods of providing youth with messages about the shamefulness of sexual arousal and orgasm. In addition, traumatic first sexual experiences in childhood and adolescence have been found to be a common causative factor in the development of adult sexual dysfunctions. Finally, direct negative messages about sex and its consequences are often reported by individuals who suffer from a sexual disorder. Children might be told that sex is wrong, immoral, it hurts, or that it is dirty. Many females are informed that women do not enjoy sex, and if they do, then they are "sluts" or "whores."

Direct negative messages about sex have been linked to female orgasmic disorder by many clinicians and researchers. A "typical" history for these women has been described as involving strong parental prohibitions against nudity, masturbation, and sex play; no preparation for the onset of menstruation; a lack of sex education; and severe restrictions on adolescent dating. However, this same history is also common in women who do not later develop a sexual dysfunction. In 1986, Julia Heiman and colleagues reported that women who are both sexually functional and sexually dysfunctional experience similar culturally bound negative messages about female sexuality. It is still not clear what mediating variables may play a role in causing sexual dysfunction in some women, but not in others.

2. Systemic Relationship Factors

In the history of sex therapy, it has often been thought that sexual dysfunctions were extremely distressing to both the diagnosed individual and his or her partner. Marital dissatisfaction and sexual dysfunction were often considered to be separate problems, and assessment and treatment in one arena was compartmentalized such that marital therapy did not deal with sexual issues, and vice versa. More recently, however, it has been noted that sexual dysfunctions can play an important role in the couple's relationship. Indeed, sexual dysfunctions can sometimes be seen to develop in order to fulfill a role or convey a message within the relationship. As a result, post-modern sex therapy recognizes the important psychological needs that a sexual dysfunction can be meeting for an individual. In these situations, the dysfunction can be seen to introduce or maintain a level of homeostasis in the relationship structure. Understanding the psychological and relationship needs that sexual dysfunctions can help to fulfill is an important component of post-modern sex therapy. In 1997, LoPiccolo noted that inattention to the individual or couple dynamic needs that are being met by the sexual dysfunction commonly results in client sabotage and resistance toward therapeutic progress.

In 1988, LoPiccolo and Jerry Friedman formulated a list of several commonly occurring systemic issues that may be both causes and effects of sexual disorders. These issues include a lack of attraction to the partner,

poor sexual skills of the partner, general dyadic unhappiness, fear of closeness or intimacy, a lack of basic trust, differences between the couple in the degree of personal space desired in the relationship, passive–aggressive solutions to a power imbalance, poor conflict resolution skills, and the inability to blend feelings of love and sexual desire. For example, some cases of low sexual desire disorder may reflect other relationship power disruptions. The diagnosed partner may use his or her lack of sexual desire to gain power in a relationship in which he or she feels very little control by becoming the sexual "gatekeeper." Alternately, the opposite could occur, where the nondiagnosed partner has a vested interest in the maintenance of the dysfunction because he or she gains some power in the relationship due to feelings of guilt in the diagnosed partner. In both instances, careful attention must be paid to the benefits that occur as a result of the dysfunction and treatment must address the underlying problems in the relationship.

3. Cognitive Distortions and Intrapsychic Factors

Cognitive contributions to the development and maintenance of sexual dysfunctions were first recognized by the early behaviorists who claimed that the major etiological factor associated with sexual dysfunction was anxiety. Masters and Johnson called this performance anxiety, a term referring to the excessive worrying about sexual performance that can in itself interfere with sexual arousal, resulting in sexual failure. Male erectile disorder is a sexual dysfunction that is often associated with performance anxiety, as men with this disorder tend to fear repeat occurrences of erectile failure, worry about it excessively, and spend much of their time during sexual encounters monitoring their arousal and strength of erection. As a result, they do fail to attain or sustain an erection, leading to even greater anxiety and the maintenance of a cycle of sexual dysfunction.

Many cognitive distortions play a role in the development and maintenance of sexual dysfunctions. Individuals who have problems with sexual functioning often engage in dichotomous thinking, in which they take an all-or-nothing attitude toward sexual functioning. A man who experiences premature ejaculation, for instance, may feel that if he cannot control his time to ejaculation, then he is a total sexual failure. This type of belief may even occur despite his bringing his partner to orgasm through other methods of sexual stimulation. Catastrophizing is also common, and can be seen when individuals make negative predictions about their future sexual functioning and their ability to overcome dysfunction. Imperatives, in which the client makes "should" and "must" statements about their sexual functioning, are characteristic of many people with dysfunctions. For example, a woman who has never experienced an orgasm during intercourse with her partner may tell herself "I should be able to have an orgasm just from having his penis in my vagina. I shouldn't have to stimulate my clitoris." Finally, people who experience problems in sexual functioning often engage in mind reading when it comes to the reactions of their partners, which can lead to even more anxiety. A woman who has vaginismus might make attributions about what her partner thinks about her as a person or a sexual being, such as, "He's thinking I'm frigid and undesirable."

According to LoPiccolo and Friedman, other intrapsychic and cognitive factors that are important contributors to a variety of sexual dysfunctions include a fear of loss of control over sexual urges, fears of having children, underlying depression, religious orthodoxy, gender identity conflicts, homosexual orientation or conflict, masked sexual deviation, aging concerns, sexual phobias or aversions, anhedonic or obsessive–compulsive personality, unresolved feelings about the death of a spouse, and attempting sex in a context or situation that is not comfortable for the client.

4. Daily Life Stressors and Operant Issues

A fourth psychological factor in the development and maintenance of sexual dysfunctions are the daily life stresses that an individual experiences and the operant value that the dysfunction may have for either partner. An operant value can be defined as a reinforcing consequence for a sexual dysfunction that comes from the external world, such as through the admiration of friends for sticking by a dysfunctional partner, or devoting extra time to work because of the impaired sexual and marital relationship and experiencing financial rewards as a result. Friends and family may admire a woman who devotes extra time to her children and their activities because she has distanced herself from her low-desire husband. As a result, she may have reservations about making real therapeutic gains on the low sexual desire.

5. Physiological or Medical Factors

Sexual dysfunctions are best understood as existing in a multidimensional realm, with both psychological and physiological factors playing differing roles in the development and maintenance of problems. Although some individuals may experience a disorder caused solely by physiological or psychological factors, most

have a complex intermingling of etiologies that are unique to each individual. Many illnesses that affect the functioning of the neurological system, such as diabetes and multiple sclerosis, result in sexual disorders because they interfere with the very system that controls arousal and orgasm. Other illnesses and diseases that result in chronic pain or fatigue can also interfere with sexual arousal and enjoyment of a variety of sexual activities. Finally, many medications have side effects that interfere with functioning by inhibiting sexual responsiveness. These include a variety of psychotropics, particularly antidepressant and antianxiety medications, and drugs prescribed for various medical conditions, such as high blood pressure. Marijuana, alcohol, barbiturates, and other street drugs can also have a deleterious effect on sexual functioning.

These five categories not only serve a causative function in many instances of sexual dysfunction, but they can also work in a variety of combinations to maintain problems that are extremely disrupting to the lives of individuals with disorders. For instance, a man may experience his first erectile failure as a result of a medical problem, such as a reaction to an antidepressant. However, even when taken off of the antidepressant, he may continue to experience problems with attaining or sustaining an erection because he continues to make irrational and anxiety-provoking cognitive distortions. Similarly, a woman may originally experience anorgasmia due to the extremely negative messages she received about sex as a child and adolescent, but the problem may be maintained by her tremendously stressful life as a working mother who has little time to relax and resists adding a sexual role to the others for which she has already assumed responsibility. The combination of causative and maintaining factors that contribute to any individual case of sexual dysfunction must be thoroughly examined and treated within the context of fostering a healthy, mutually pleasurable sexual relationship for the dysfunctional couple.

II. BEHAVIORAL, COGNITIVE, AND SYSTEMIC TREATMENT FOR SEXUAL DYSFUNCTIONS

A. Treatment Overview

Post-modern sex therapy addresses the causal and maintaining factors of sexual dysfunction through a variety of behavioral, cognitive, and systemic treatment methods. In 1997, LoPiccolo outlined nine general principles of sex therapy through which couple change takes place. First, the sexual dysfunction is conceptualized as a disorder of the couple, with both partners bearing a mutual responsibility for treatment. It is important to take the blame out of sexual disorders and facilitate a team approach to treatment. Both partners should be engaged in the treatment process and willing to take on responsibility for the sexual dysfunction and its treatment. In cases where the nondysfunctional partner refuses to actively participate in therapy, the rates of treatment success can be seriously reduced.

Second, in many cases couples have limited knowledge of the basic anatomy and physiology of human sexual response. Consequently, it becomes necessary for the therapist to provide an informational and educational component to treatment. Clients often need to be educated about the process of sexual arousal in both males and females, as well as about human anatomy. For instance, many couples do not know where the clitoris is located, that vaginal lubrication is not automatic, or that men have a refractory period between the time they ejaculate and the time they can attain another erection. A sex therapist will assist their clients in learning about their bodies and the process of sexual arousal and orgasm.

The third principle of sex therapy is to foster an attitude change in clients who have negative attitudes toward the expression of their sexuality. As noted earlier, negative attitudes can come from a variety of sources, including the family of origin. The therapist must work to combat these negative attitudes and replace them with more positive, accepting attitudes toward sexuality.

A fourth mechanism of change in sex therapy is the elimination of performance anxiety. Many individuals who experience problems in sexual functioning possess negative self-fulfilling expectancies about their sexual abilities and how their sexual encounters will progress. There are many strategies used in sex therapy to help clients begin to enjoy the process of sex as opposed to focusing on sexual goals. Participants in therapy are taught that worrying about the outcome of sex guarantees that they will not attain their "goal," because it directly interferes with arousal. Instead, the emphasis is on enjoying the process of sex. This intervention is paradoxical: Often, as soon as clients are no longer worrying about maintaining an erection or attaining an orgasm, they are free to enjoy sex and experience normal sexual functioning.

A fifth goal of sex therapy is to increase communication skills in the couple. Dysfunctional couples often have many communication deficits that directly affect their ability to have satisfying sexual relationships. For instance, couples with sexual dysfunctions often have trouble communicating their likes and dislikes to one

another for a number of reasons. Some couples are embarrassed about such communication, or they may not feel that it is part of their proscribed sexual role. Others may lack the knowledge of how to convey their preferences in an effective manner, resulting in their partners feeling criticized or humiliated by the communication that does take place. Another common difficulty concerns the initiation and refusal of sexual activity, with many couples developing indirect and ineffective ways of telling their partner when they do and do not want to engage in sexual activity. Sex therapy addresses these common problems by teaching couples effective communication strategies for conveying sexual preferences and responses in a clear, open, and supportive manner, and for initiating and refusing sexual activity in a clear, nonhurtful, and nonthreatening manner.

Changing destructive sex roles and lifestyles is the sixth mechanism of change in post-modern sex therapy. Many people have developed life habits that indirectly interfere with sexual functioning in a number of ways. Problems with extended family, children, and careers can all interfere with the sexual lives of adults. In addition, the sex roles that people acquire can interfere with sexual expression in a relationship. For instance, a common problem experienced by two-income households is the idea that the female partner is still responsible for the majority of housework and child care in addition to her career. This expectation leads many women to feel highly stressed and overworked, which in turn interferes with feelings of sexiness and sexual desire. A destructive sex role for men might include the expectation that they always initiate sexual relations, leading to pressure to be the pursuer and to feelings of uncertainty about their own sexual desirability. Sex therapy addresses these destructive lifestyles and sex roles by helping the client to initiate the life changes that will facilitate healthy sexual relationships.

Seventh, sex therapists must often help couples to change disruptive marital systems and enhance the marital relationship. Commonly, sexual dysfunctions are present in unhappy marital relationships. As such, it is unrealistic to believe that a couple can leave behind their disagreements about parenting, finances, or other issues while working solely on sexual issues. Often, therapists must address these issues in conjunction with sexual dysfunction in order to foster a more satisfactory sexual relationship. Current sex therapy frequently involves direct restructuring of the marital relationship.

Physical and medical interventions are sometimes needed to restore healthy sexual functioning. Many medical diseases can interfere with sexual functioning, including diabetes, heart disease, and neurological conditions such as spinal cord injury, multiple sclerosis, and pituitary/hypothalamic tumors. In addition, many prescribed medications can interfere with the arousal process. Antihypertensive medications and psychotropic medications such as antianxiety, antidepressant, and antipsychotic agents have been shown to interfere with arousal and orgasm for both men and women. Similarly, recreational drugs such as alcohol, marijuana, heroin, and cocaine can negatively impact sex drive, sexual arousal, and orgasm. Finally, hormone levels in the body can also have major effects on sexual functioning. Disruptions in the levels of testosterone, estrogen, and prolactin can suppress sex drive and negatively impact sexual functioning for men and women. As a result, team approaches to sex therapy are often warranted, with the therapist and a medical practitioner working together to improve sexual functioning.

Perhaps the most distinctive element of sex therapy is the behavioral component: changing sexual behavior and teaching effective sexual techniques. Stanley Althof outlined several goals of behavioral techniques in sex therapy in 1989. These goals include overcoming performance anxiety, altering the previously destructive sexual system, confronting resistances in each partner, alleviating the couples' anxiety about physical intimacy, dispelling myths and educating clients regarding sexual function and anatomy, counteracting negative concerns with body image, and heightening sensuality. For each sexual dysfunction, the therapist prescribes a series of specific sexual behaviors for the clients to perform in their own homes. Clients are confronted with the behavioral challenge of both changing their actual sexual behaviors and understanding the problems they have in implementing this change. In 1995, Walter Vandereycken outlined several common behavioral interventions that are used in sex therapy. Vandereycken divided these procedures into two categories: "nondemand" procedures aimed at decreasing sexual anxiety, and "excitement-awareness" procedures to increase sexual arousal. The nondemand interventions include deemphasizing sexual intercourse by placing a temporary ban on coitus, desensitization techniques, relaxation training, sensate focus, and graded noncoital contact and stimulation. Common excitement-awareness procedures include the development of sexual fantasies and imagery, role-play of an exaggerated orgasm, body awareness and self-exploration, directed masturbation, and guided stimulation by the partner. Although some of these behaviors may be similar for different disorders, the treatment for each sexual dysfunction

includes unique behavioral prescriptions that will be described in detail later in this article.

It is important to note that these mechanisms of change are not a step-wise therapy, with each component being undertaken after the previous ones have been mastered. Instead, post-modern sex therapy is a conglomeration of these overriding principles, with the therapist using these techniques in conjunction with one another. Thus, throughout treatment, therapy is seen as a process for which both partners are mutually responsible, the therapist attempts to foster the development of more effective communication skills, and attention is paid to dyadic relationship satisfaction. All the while, specific behavioral modifications in sexual functioning are made.

B. General Strategies in Assessment and Treatment

Sex therapy usually begins with an evaluation and assessment of the particular sexual dysfunction and its impact on the marital relationship. This assessment has historically included taking an extensive sexual history of both partners, interviewed separately. Masters and Johnson advocated the use of a semistructured interview that typically lasted for several hours. However, as pointed out by LoPiccolo in 1995, the utility of this type of interview has not been empirically demonstrated and its application may not be the most efficient use of therapeutic time. Particularly in this time of insurance-placed restraints on the number of therapy sessions a given person is covered for, it is important for the therapist to be mindful of the benefits that a shortened sexual history assessment can provide for the therapeutic process.

Paper-and-pencil questionnaires are also commonly used to assess sexual history and current sexual functioning. The Sexual Arousal Inventory, developed by Peter Hoon, Emily Hoon, and John Wincze in 1976, and the Sexual Interaction Inventory, developed by LoPiccolo and Jeffrey Steger in 1974, are two questionnaires that can be particularly useful in the assessment and treatment outcome phases of sex therapy. These questionnaires can provide valuable information to the therapist by identifying arousal deficits and problem behaviors that can be the focus of treatment. They are also useful tools for identifying significant discrepancies in thoughts, feelings, and behaviors reported by the partners.

A physiological assessment by medical professionals is also indicated in the assessment of several sexual dysfunctions, including male erectile disorder and dyspareunia. Although vaginismus is not caused by organic factors, a medical assessment is still warranted to rule out the possibility that dyspareunia has not been incorrectly diagnosed as vaginismus. Premature ejaculation and female orgasmic disorder are not associated through empirical research with organic factors. Physiological assessments should include a pelvic examination by a specialist, such as a gynecologist or urologist, an assessment of current medications and their potential side effects, and tests for thyroid function, endocrine status, and glucose tolerance. In addition, vascular and neurological examinations are especially important in cases of male erectile disorder.

Following these initial assessment procedures, the therapist presents a comprehensive formulation of the etiology and maintenance of the dysfunction to the couple. Their sex histories, family-of-origin dynamics, cognitive styles, current relationship structure, external reinforcers, and any organic factors are used in this formulation, and the couple is informed about how these factors have interacted to create and maintain their sexual problems. This presentation is useful in initiating change procedures and sometimes has positive effects on the sexual problem itself.

After the completion of the assessment portion of therapy, some simple behavioral interventions are made that are common to all of the dysfunctions. First, the couple is asked to refrain from attempting sexual intercourse until it is prescribed by the therapist. Many sex therapists believe that this prohibition of coitus serves to alleviate performance anxiety, allowing the couple to rebuild their sexual relationship from the beginning. Next, the couple is typically asked to complete a series of sensate focus exercises. Sensate focus is a behavioral intervention that focuses the clients' attention on the sensuality of the body, without the pressure attendant upon sexual behaviors such as intercourse. These exercises include sensual touching of the clients' own bodies or their partners', and consist of caressing, hugging, kissing, and body massage. Participants in sex therapy are instructed to tune in to their sensual response to the touching. Sensate focus exercises serve to reduce anxiety in a number of ways, including providing a no-demand experience to the couple, eliminating the "spectator role," and increasing dyadic communication by giving feedback to the partner about what feels good. Breast and genital contact, intercourse, and orgasm are not allowed as part of these exercises. Vandereycken points out that the ban on intercourse and the inclusion of sensate focus exercises in the therapeutic process are of somewhat questionable value because

they have never been systematically studied. However, their use is indirectly supported through their inclusion in several treatment protocols for different sexual disorders that have been empirically validated.

The next step in post-modern sex therapy is dependent on the exact nature of the couple's sexual dysfunction. Following is a description of each of the major sexual dysfunctions listed in the *DSM-IV,* along with the more specific treatment procedures used for each disorder.

C. Gender-Specific Sexual Dysfunctions

Several sexual disorders are unique to males, whereas some are experienced exclusively by females. These gender-specific disorders occur during both the arousal and orgasm stages of the human sexual response cycle. The male sexual dysfunctions include erectile dysfunction, premature ejaculation, and male orgasmic disorder. Disorders that commonly affect women are female arousal disorder, female orgasmic disorder, and vaginismus.

1. Male Sexual Dsyfunctions

a. Male Erectile Disorder Male erectile disorder is characterized by an inability to attain or maintain an erection, resulting in an incapacity to complete sexual activities such as intercourse. The etiology of male erectile disorder can be extremely complex, with a primarily psychogenic cause, a primarily organic cause, or most often, an interaction of the two. Neurological diseases such as multiple sclerosis and diabetes, a failure of blood flow to the penis, medication side effects, and surgical damage are all potentially physiological causes of erectile dysfunction. As stated before, a physical evaluation is extremely important in the assessment of this particular disorder. However, as LoPiccolo noted in 1995, the presence of some degree of organic impairment does not always negate the need for behavioral treatment. Men who suffer from mild organic impairment are often more vulnerable to psychological factors of erectile failure. As a result, treating the psychological difficulties can frequently enable a man to experience a fully functional erection even with the mild physiological impairment. Psychological treatment of erectile dysfunction in men with organic causes serves to help the client function at his optimum physiological capacity.

Psychogenic causes of male erectile disorder can include performance anxiety and the spectator role, as well as a lack of adequate physical stimulation of the penis. Commonly, men who experience difficulty attaining or maintaining an erection enter each sexual encounter with negative expectancies about their ability to "perform" and consequently, they constantly self-monitor their own level of arousal. These men become anxious observers rather than aroused participants. This sort of mindset prevents arousal, and as a result, the dysfunction is cyclically maintained. Problems with erection can also result from poor sexual techniques, such as inadequate stimulation of the penis. Especially as men age, direct stimulation of the penis for some period of time is necessary for the attainment of an erection. However, many couples expect erections to be automatic and effortless, and therefore do not give the penis adequate stimulation. Consequently, the predominant themes in the psychological treatment of erectile dysfunction are the reduction of performance anxiety and the increase of sexual stimulation.

After engaging in general sensate focus techniques, the couple is instructed to add genital contact to their sessions. They are taught the "tease technique" in which the couple is instructed to cease genital contact if the male should attain an erection. The couple can resume penile contact only after the erection is lost. This exercise teaches clients that erections occur naturally in response to stimulation, as long as the couple does not focus on performance. The male is paradoxically instructed throughout sensate focus that, "The purpose of this exercise is for you to learn to enjoy sensual pleasures, without focusing on sexual goals. Therefore, you should try to not get an erection." This demand to not get an erection frees the male to enjoy sensual situations without the accompanying anxieties that have worked against attaining an erection in the past.

After the couple experiences this process several times, they move on to intercourse. Intercourse is also attempted in several steps. First, the male partner lies on his back while the female partner kneels astride him and uses her fingers to push his flaccid penis into her vagina. This procedure, known as the "stuffing technique," frees him from having to have a rigid penis to accomplish entry. Sometimes called "quiet vagina," the woman remains still while his penis is inside of her. Gradually, the couple can add movement by the female gently moving her hips. Finally, the male is instructed to thrust and the couple resumes full sexual activity, with no further restrictions. Throughout this process, the couple is instructed to achieve the woman's orgasm through manual or oral sex, resulting in the reduction of pressure on the male to perform as well as partner

compliance with treatment. In addition, Althof suggests that guided explicit fantasies can be used when the male is preoccupied with performance issues or when he is having difficulty becoming aroused.

This set of procedures seems to be effective in cases where there is no major organic impairment of erection. For men with more severe physiological problems underlying or complicating their erectile dysfunction, however, physical interventions may be warranted. One of several medical procedures may be useful for men who experience erectile failure as the result of a more severe organic impairment.

Penile injections of drugs that cause rigidity, such as prostaglandin E, phentolamine, and vasoactive intestinal polypeptide, can be an effective treatment for men with irreversible erectile dysfunction. These drugs are self-administered by the patient just before intercourse, and they work by dilating the penile arteries. Research indicates that most men who use penile injections experience erections as a result. In their discussion of organic treatment methods for male erectile disorder in 1989, Leonore Tiefer and Arnold Melman warn that this "quick fix" can often be tempting to men who have a more psychogenic basis for the disorder. However, they warn against using this method of treatment for these men, citing potential risks of scarring of the penis, and research results that indicate these types of men are often very dissatisfied with the treatment.

Another nonsurgical and noninvasive treatment method is the use of a vacuum constriction device. A hollow cylinder is placed over the penis, and a hand pump is used to pump the air out of the cylinder, leaving the penis in a partial vacuum. As a result, blood rushes into the penis. The cylinder is removed and a rubber constricting band is placed at the base of the penis to maintain the erection. This treatment method is most often used for men who have erectile dysfunction rooted in diabetes or neurological problems, and it does not have any known negative effects on the body. It can, however, be awkward and can interfere with the spontaneity of sex.

Artificial erections can also be manufactured in men with severe physical problems through the use of a penile prosthesis. This device consists of a semirigid pair of rods made of rubber and wire, and it is surgically implanted in the corpora. This device does not allow for growth of the penis in width or length during sexual activity. Instead, it can be bent up to an erect position when the man wants to have sex, and bent back down for normal wear. An alternative to this type of prosthesis is a hydraulic inflatable system that allows for tumescence. Inflatable hollow cylinders are surgically inserted into the penis, a reservoir of saline fluid is placed under the abdominal wall, and tubing connecting the cylinders to a pump is inserted in the scrotum. When he wishes to have sex, the man or his partner can squeeze the pump, forcing fluid from the reservoir to the penile cylinders, which expand and produce an erection. Tiefer and Melman caution that because of their invasiveness and annihilation of any capacity to produce an erection should they need to be removed at a later date, penile implants should be considered the last resort in the treatment of erectile disorder.

Finally, the recent proliferation of advertisements for Viagra speak to its popularity as a pharmacological treatment for erectile disorder. Viagra is an effective treatment, showing positive results in 70 to 80% of cases treated. The drug works by reducing venous outflow once blood has been pumped into the cavernous bodies, not by increasing arterial inflow. As such, men who use Viagra still need adequate sexual and emotional stimulation to achieve an erection. Some of the 20 to 30% of cases in which Viagra fails are not actually pharmacologic failures, but failures to provide adequate physical or emotional stimulation. Consequently, the use of Viagra is contraindicated in instances where couple systemic issues are the only etiological factor involved with erectile difficulties. In addition, Viagra is also contraindicated in instances where low desire is the cause of erectile failure, as the drug has not been shown to increase levels of desire.

b. Premature Ejaculation Premature ejaculation is defined as the persistent onset of orgasm and ejaculation with minimal stimulation, before or shortly after intromission occurs. An important determinant of premature ejaculation is that it causes marked distress in the male and/or his partner. Time criterion have had little use in the assessment of premature ejaculation, as differences in foreplay activity, age, and the use of distraction techniques can artificially increase or decrease the duration of intercourse. A more clinically useful conceptualization of premature ejaculation includes the couple's subjective opinions about the appropriateness of duration, and the pleasure and satisfaction that each partner gains from their sexual encounters. If both partners agree that their sexual encounters are negatively influenced by efforts to delay ejaculation, then premature ejaculation is considered a problem.

In 1970, Masters and Johnson reported that premature ejaculation can be treated with direct behavioral retraining procedures that are successful in nearly 100%

of cases. The standard treatment for premature ejaculation involves the "stop-start" or "pause" procedure, introduced by Semans in 1956. With this procedure, the penis is manually stimulated until the man is highly aroused and he feels that ejaculation is imminent. At this point, the couple stops stimulation until the arousal subsides, and they resume stimulation again when the male no longer feels that ejaculation is imminent. The "squeeze" technique can also be added to help the male delay ejaculation during manual stimulation. In this procedure, the female partner firmly squeezes the penis between her thumb and forefinger, at the place where the head of the penis joins the shaft. For some couples, this procedure can be an effective way to reduce arousal even further than that experienced with the stop-start technique. The stop-start and squeeze procedures are repeated many times so that the male can experience an immense amount of stimulation and arousal without the occurrence of ejaculation. Ultimately, the man should experience significantly more total time of stimulation than he has ever experienced before. These behavioral procedures lead to a higher threshold for ejaculation, with the male gradually gaining the capacity for participating in quite lengthy periods of penile stimulation without ejaculation.

After a few weeks of this training when the necessity of pausing diminishes, the focus of behavioral exercises shifts to include intercourse. The couple continues to practice a modified stop-start technique in which the penis is placed in the vagina without any thrusting movements. The most effective intercourse position during this period of treatment is the woman on top position. The "quiet vagina" exercise is utilized, and the male partner is encouraged to make no movement but to feel free to engage in erotic touching of his partner. If this stimulation produces high levels of arousal and a feeling of ejaculatory inevitability, the penis is withdrawn and the couple waits for arousal to drop off. When good tolerance for inactive containment of the penis is achieved, the training procedure is repeated during active thrusting exercises with a variety of sexual positions. After 2 to 3 months of practice, males who undergo treatment for premature ejaculation are generally able to enjoy significantly prolonged intercourse without the need to use pause and squeeze techniques.

In a 1989 publication of a treatment protocol for premature ejaculation, Barry McCarthy stressed the importance of the process of successive approximation in ejaculatory control exercises. The male is taught to become aware of his level of arousal and the point of ejaculatory control when he is still able to stop short of ejaculation. It is inevitable that the client will have at least one experience during treatment where he pushes the limits too far, and signals for his partner too late to stop the ejaculatory process. McCarthy emphasized that it is important for the therapist to confront the couple with this possibility early in therapy, and to encourage the couple to use it as a pleasurable learning experience about identifying ejaculatory inevitability rather than experience it as a failure in treatment. He also highlighted the importance of ensuring that the female partner's desires and preferences be given equal attention, with both manual and oral stimulation encouraged as a method to bring sexual satisfaction to the woman during the treatment period. The benefits of this are twofold. First, the female partner is more likely to remain invested in the treatment if the couple's sexual encounters are not always completely focused on the male partner's arousal. Second, the male can learn that women can be sexually satisfied in a number of ways that have little or nothing to do with the penis and intercourse, which in turn leads to the alleviation of performance anxieties. Finally, McCarthy suggested that cognitive restructuring procedures used in conjunction with behavioral interventions can have an important effect on the long-term success of therapy. Couples need to learn that sex is a collaborative process in which neither partner bears the responsibility for performing, in which both partners are integral to changing problematic sexual behaviors and maintaining those changes, and in which intimacy and sexuality are integrated to form a stronger sexual relationship for the couple.

c. Male Orgasmic Disorder Male orgasmic disorder is present when a man experiences a recurrent delay in, or absence of, orgasm following a normal phase of sexual excitement. Formerly known as inhibited ejaculation, male orgasmic disorder is a fairly rare sexual dysfunction, and the cause of the problem often remains unclear. Many psychological factors have been theorized as causes for male orgasmic disorder, such as an autosexual orientation and fear of intimacy with the partner, but there is little supporting empirical research. However, etiology has been established with several physiological factors, including multiple sclerosis, medication side effects, and damage to the hypothalamus.

Treatment of male orgasmic disorder is based on many of the standard strategies used with other sexual dysfunctions. Eliminating performance anxiety and ensuring adequate stimulation through paradoxical sensate focus exercises are the basis for treatment. The couple is instructed that during sex the penis is to be

caressed manually and/or orally until the man is aroused, but that stimulation is to stop whenever he feels he might be close to orgasm. This procedure takes the focus of sex off of orgasm, and paradoxically, allows the man to fully enjoy the pleasurable sensations of stimulation. Additionally, in 1977 LoPiccolo reported that the use of electric vibrators, behavioral maneuvers called "orgasm triggers" (discussed in the section on female orgasmic disorder), and having the client role-play an exaggerated orgasm all seem to have some success with the treatment of male orgasmic disorder.

Physiological interventions are indicated when the primary cause is organic in nature. Drugs that increase the arousal of the sympathetic nervous system have been found to be helpful in some cases, as has increased stimulation of the scrotal, perineal, and anal areas. In particular, direct stimulation of the anus through the use of a vibrator has been found to be an extremely effective orgasm trigger in men who suffer neurological damage.

2. Female Sexual Dysfunctions

a. Female Sexual Arousal Disorder and Female Orgasmic Disorder A persistent inability to attain or maintain sexual excitement through the completion of sexual activity describes female sexual arousal disorder; female orgasmic disorder occurs when sexual excitement is normal, but orgasm does not occur. Both disorders can be successfully treated with many of the same behavioral techniques, including education, self-exploration, body awareness, and directed masturbation. These procedures are particularly effective for women who have never had an orgasm through any form of stimulation.

Directed masturbation, a treatment protocol for female arousal and orgasm disorders, has broad empirical support in individual, couple, and group modalities. This program of therapy is described in *Becoming Orgasmic,* a self-help book and accompanying film written by Heiman and LoPiccolo, and published in 1988. The directed masturbation protocol involves nine steps. In the first step, the inorgasmic woman is instructed to use various diagrams and reading materials to learn about her body, her genitals, and the female sexual response. She is also encouraged to work on her attitudes and cognitions surrounding the acceptability of female sexuality, and to examine her own sexual history to identify negative influences that have carried into her current functioning. Step 2 involves the woman exploring her body and genitals through both sight and touch. Next, in Step 3 the woman furthers her body exploration by locating erogenous zones, with a focus on the clitoris, breasts, and other genital regions.

The woman is directly instructed in techniques of masturbation in Step 4. She is encouraged to target the erotically sensitive areas that she has identified in previous sessions and increase the intensity and duration of stimulation. Step 5 is erotic masturbation, in which an attempt is made to make masturbation more erotic and sexual. The woman is encouraged to develop sexual fantasies, read erotic stories, or view sexually arousing pictures to increase her feelings of arousal.

The sixth step has three elements. If the woman has not yet reached orgasm, she will begin to use an electric vibrator to increase the intensity of stimulation. Women who experience their first orgasm through the use of a vibrator usually go on to have orgasms through other methods of stimulation, but the vibrator can be invaluable to the attainment of the first orgasm. Second, she will be instructed to act out or role-play an exaggerated orgasm. This procedure helps the woman overcome any fears about looking silly or losing control when she has a real orgasm. In the final element of the sixth step, "orgasm triggers," such as holding the breath, contracting the pelvic muscles, tensing the leg muscles, and thrusting the pelvis are used by the woman.

The final three steps of the directed masturbation protocol integrate the partner into treatment. In Step 7, the woman shows her partner how she likes to be touched and how she can have an orgasm. During this step, the partner also shares his or her own masturbation preferences with the woman so that she can feel less inhibited, and to ensure that the learning process is reciprocal. In the next step, her partner brings her to orgasm with manual, oral, or vibrator stimulation, using the woman's instruction and guidance to increase arousal and sexual satisfaction. Finally, in Step 9, the heterosexual couple resumes penile-vaginal intercourse in positions that permit one of them to continue clitoral stimulation.

During this final stage, it is essential to educate the couple that continued stimulation of the clitoris during intercourse is both normal and often necessary for many women to experience orgasm through this sexual behavior. Many women and their partners are wed to the myth that women should be able to experience orgasm through penile stimulation only. Educating them about the myth of vaginal versus clitoral orgasms is often necessary. In addition, it should be noted that the couple's goals can be vastly different—some couples are

not as concerned with an ultimate goal of orgasm through coitus, and these individuals should be encouraged to see their treatment as successful if they learn to experience an orgasm through any method of stimulation that they find acceptable.

Not all women who seek treatment for arousal and orgasm disorders have difficulty becoming aroused or reaching orgasm in all situations. Such types of situational orgasmic dysfunction include only being able to reach orgasm in solitary masturbation, without a partner present, or through a circumscribed sexual activity, such as oral stimulation. It is important to note that sex therapists do not consider lack of orgasm during intercourse to be an indication for treatment, provided that the woman can have orgasm in some way with her partner, and that she enjoys intercourse. However, some women are distressed by their limited orgasmic experiences, and there are treatment techniques that can be utilized in these situations.

Treatment for situational lack of orgasm includes a gradual stimulus generalization approach developed by Antionette Zeiss, Raymond Rosen, and Robert Zeiss in 1977. This procedure helps the woman to expand the ways in which she reaches orgasm through a sequential series of changes in stimulation. For example, a woman who can masturbate to orgasm wants to experience orgasm during intercourse. The therapist will help her to identify a number of small, intermediate steps between the way she has orgasm now and the wished-for orgasm during intercourse with her partner. As a first step, the woman might be instructed to masturbate as usual, with the addition of having her finger passively inserted into her vagina from the beginning of stimulation. This procedure will enable her to learn to experience orgasm with something contained in the vagina. Other intermediate steps in this example might include thrusting the inserted finger, having the partner present while she masturbates, having the partner manually stimulate the clitoris with first her and then his finger inserted, passive containment of the penis in the vagina while the woman masturbates, and passive containment of the penis while the man manually stimulates the woman. Once the woman has been able to reach orgasm through each of these phases, the couple can attempt active intercourse with concurrent direct manual stimulation of the clitoris. By breaking down the differences between masturbation and intercourse into a series of very small and discrete changes, there is a much greater success in broadening the woman's range of orgasmic responsivity.

b. Vaginismus Vaginismus is characterized by the involuntary contraction of the muscles surrounding the outer third of the vagina. These contractions have a spasmodic quality, and they prevent the insertion of a penis or other objects into the vagina. Women who experience vaginismus are often capable of becoming sexually aroused and experiencing orgasms—it is the possibility of penetration that triggers the muscle contractions. However, they may also present with a variety of other disorders, including an aversion to sex, female arousal disorder, or female orgasmic disorder.

Relaxation training, Kegel exercises, and use of progressive dilators inserted in the vagina are the procedures used to treat vaginismus. The woman is taught deep muscle relaxation and diaphramatic breathing techniques in order to decrease her overall feelings of anxiety and to help her gain volitional control of her vaginal muscles. Voluntary control of the vaginal muscles is acquired through Kegel exercises, in which the woman practices contracting and relaxing the pubococcygeal muscle. Next, the woman is helped to overcome her fear of penetration by using a set of gradually larger dilators that she inserts into her vagina at home and at her own pace. Once the woman has been able to comfortably insert the largest dilator, she can begin to guide her partner as her or she slowly and gently inserts the dilators. It should be stressed to women in treatment for vaginismus that they go slowly and become comfortable with each step and each size dilator before moving on to the next. If a woman or her partner pushes treatment forward at too quick of a pace, the result is often increased anxiety about penetration and a rapid return to experiencing the spastic contractions. In addition, both partners should be educated about the need for effective stimulation of the woman's erogenous zones, so that the woman can learn to associate penetration with vaginal lubrication, pleasure, and arousal. The use of fantasies and erotic materials can also aid in this process.

After the woman and her partner have been able to successfully insert the graduated dilators, heterosexual couples can begin to attempt penile penetration. First, the partner lies passively on his back while the woman kneels above him and gradually inserts his erect penis into her vagina. Again, the couple is encouraged to go slowly, at the woman's pace. When the woman is able to contain her partner's penis in her vagina comfortably, she can begin to move. Once she is comfortable, the partner can begin to thrust and the couple can explore a variety of intercourse positions that are enjoyable to both of them.

D. Nongender-Specific Sexual Dysfunctions

1. Dyspareunia

The *DSM-IV* defines dyspareunia as persistent genital pain associated with sexual intercourse in either a male or a female. Although dyspareunia can occur in males or females, clinically, pain is much more frequently seen in female clients.

Most cases of dyspareunia involve an organic etiology, such as vaginitis, endometriosis, Peyronie's disease, unrepaired damage following childbirth in woman, and prostate conditions in men. However, this dysfunction must also have some element of psychogenic etiology in order to be diagnosed as a true case of dyspareunia. A complete medical examination is necessary to differentially diagnose dyspareunia from other, similar disorders such as vaginismus or simple medical conditions. In males, painful intercourse is almost always related to an underlying medical condition.

Because psychogenic dyspareunia is often attributed to a lack of arousal, the general sex therapy procedures and the specific techniques for enhancing female arousal and orgasm are commonly used. In addition, because dyspareunia is commonly linked with vaginismus and may in fact be an earlier stage of that disorder in some women, the treatment protocol for vaginismus is often used. Artificial genital lubricants and relaxation training can also be effective additions to therapy.

2. Hypoactive Sexual Desire Disorder and Sexual Aversion Disorder

Hypoactive sexual desire disorder, often called low sexual desire disorder, is characterized by the persistent absence of desire for sexual activity. A person with this disorder feels little or no interest in sex, but they do not have negative emotions associated with the sex itself. Sexual aversion, on the other hand, is defined as an aversion to and actual avoidance of sexual contact by a partner and is based on strong negative emotional reactions to sex that include fear, revulsion, and disgust. Differential diagnosis between these two disorders is imperative for good treatment results.

Low desire used to be thought to be more prevalent in women; however, more recent data suggest that it affects males and females at a relatively equal rate. According to a treatment guide authored by Cathryn Pridal and LoPiccolo in 2000, low desire is characterized by a very low level, or absence of, spontaneously occurring sexual interest. A distinction is made between receptive and proceptive sexual behaviors, with a lack of proceptive behavior most indicative of true low sexual desire. Just as differential diagnosis is important, so is an assessment of comorbid sexual disorders. Often, individuals with low desire also experience another dysfunction, such as lack of erection or orgasm. In these cases, it is difficult to determine if low desire is the cause or effect of other disorders. Careful assessment must be made to determine which disorder should be treated first. For instance, a woman suffering from posttraumatic stress disorder (PTSD) after a traumatic sexual history as a child should not be treated for low desire or sexual aversion until her abuse has been adequately dealt with.

In 1988, LoPiccolo and Friedman described a four-element sequential model for hypoactive desire and aversion that has been widely adopted. The first component of the treatment program, called affectual awareness, focuses on helping the client to become more familiar with his or her negative attitudes, beliefs, and cognitions about sex. Feelings of anxiety, fear, resentment, and vulnerability are uncovered as the client is encouraged to closely examine his or her attitudes about sex. Many clients begin therapy insisting that they do not have negative feelings about sex, but instead, are merely indifferent to it. Pridal and LoPiccolo recommended that therapists dispute this claim by using an "umbrella metaphor." In the umbrella metaphor, the therapist explains that all humans have an innate sexual drive. Their indifference to sex is an umbrella that blocks their awareness of the negative emotions that are working to block this innate sexual drive. During this stage, both partners are encouraged to make lists about the benefits of gaining a sexual drive, but also about the possible risks to each individual if sex drive increases, and the potential risks to the relationship. These lists help the low-drive partner gain some motivation for therapy, as well as point out any potential issues that would result in resistance to therapy. In addition, clients are encouraged to visualize sexual scenes and talk about sex in a more graphic way so that they can more accurately recognize negative emotions that they were not previously aware that they had. Finally, role-plays in which the low-drive partner pretends to have a sex drive and initiates sexual activity with his or her partner can be useful in helping the low-drive client track his or her emotional state during this process. In this way, individuals with low sexual drive can become more aware of their own negative attitudes and cognitions about sexuality.

The second phase of sex therapy for low sexual desire involves insight-oriented therapy. During the insight

phase, clients are helped to understand the underlying causes for the negative emotions that they have identified. Family-of-origin experiences, religious teachings, depression, fear of having children, life stress, unresolved sexual trauma or abuse, masked sexual deviations, gender identity issues, and relationship problems are explored as possible initiating and maintaining causes of the low desire or aversion. In a sense, this and the previous step are preparatory. The more active treatment follows.

Stage 3 involves cognitive and systemic therapy. This phase of therapy serves to alter irrational beliefs that inhibit sexual desire and to identify and modify relationship problems that are suppressing sexual drive. First, clients are taught that irrational beliefs may be the main cause of their emotional reactions, and they are helped to identify self-statements that interfere with sexual desire. Therapist and client generate a list of coping statements that combat the client's irrational thoughts about sexuality and help him or her to cope with, rather than avoid, negative emotional reactions to sexual situations. Typical coping statements might be "If I allow myself to enjoy sex, it doesn't mean I am dirty or bad" and "When I was younger I learned to feel guilty about sex, but I'm grown up now, and I don't have to feel that way anymore." Second, relationship problems are addressed in the dyad. In couples in which one partner is low drive, a power imbalance in the relationship is often found. This disruption in power can be expressed with either the low- or normal-drive partner having a disproportionate amount of power in the relationship. Systemic therapy addresses this issue and works to make the couple feel more equal in both their sexual and nonsexual interactions.

The final element of treatment for low desire and aversion consists of behavioral interventions. These include sensate focus, skills training and other general sex therapy procedures, as well as some interventions that are more specific to these disorders. Frequently, couples in which one partner has low drive experience a drastic decline in nonsexual affectionate behavior. The normal-drive partner might misinterpret simple affectionate behavior such as a hug as an invitation to initiate sexual activity. Consequently, the low-drive partner learns to squelch all affectionate behaviors to guard against this type of misunderstanding. An important component to treatment, then, is to reintroduce these simple affectionate behaviors to the couple. The couple identifies a number of affectionate behaviors that they agree will not be used to initiate sexual activity. Next, treatment focus is turned to the ways in which sexual activity can be initiated. Once again, role-plays are used so that both partners can illustrate how they do and do not like to be approached for sex. Additionally, they can communicate with one another about acceptable, nonhurtful ways to refuse sexual activity. These types of assertion training and communication skills training exercises help couples learn how to negotiate their sexual relationship without being coercive or rejecting of their partner.

Pridal and LoPiccolo labeled this next set of behavioral procedures "drive induction." They posited that sometimes people do not become aware of their sexual drive until they expose themselves to external cues and stimuli that trigger it, and individuals with low drive have developed an extraordinary ability to avoid these sexually relevant cues. In therapy, then, low-drive clients are asked to begin attending to sexual cues. A number of interventions are used in drive induction. For instance, low-drive clients are asked to keep a "desire diary," in which they record all sexual stimuli, thoughts, and emotions. They are also instructed to watch films that have sexual content, read erotic books and magazines, read collections of sexual fantasies, note attractive people they see, and so forth. Finally, couples are also often asked to develop erotic fantasies, both alone and together. The low-drive partner is instructed to take several "fantasy breaks" during the day in which he or she spends some time fantasizing about the sexual scenes that have been developed.

III. APPLICATIONS AND EXCLUSIONS

Since Masters and Johnson published their groundbreaking work on sexual dysfunctions, most therapists have switched from treating these disorders individually to treating the couple. However, couples originally were accepted for therapy if they had very circumscribed problems in only the sexual area. Those clients with individual psychopathology and severe marital distress were systematically screened out, as were individuals with medically complicated histories. Today, there is a greater focus on treating all of these problems, as sex therapists have become more cognizant of the fact that the incidence of "pure" sexual dysfunction without concurrent marital problems is extremely rare. Sex therapists and marital therapists find it less important to try to distinguish between sexual and relationship problems, because it is often not possible to segregate these areas of distress in people's lives. Instead, couples can be

helped to find ways of showing caring and love, to work on sex roles and role expectations within the relationship, to understand the effects that children have on the relationship, to deal with jealousy and outside interests, and to express their differing needs for intimacy, independence, companionship, and affection.

Similarly, there has also been a greater tendency in recent years to accept clients with major forms of psychopathology. Many nonsexual disorders have been associated with problems in sexual expression in the literature. For instance, low desire, erectile dysfunction, and problems reaching orgasm have all been associated with depression. Axis II disorders, such as antisocial personality and passive–aggressive personality disorders have also been found to severely complicate the treatment of sexual dysfunction. However, the presence of one of these disorders does not prevent successful sex therapy, provided that the therapist addresses the concurrent psychopathology.

Group therapy for both individuals and couples has also been found to be an effective modality for the treatment of sexual dysfunctions. Therapists often facilitate treatment groups for disorders such as female orgasmic disorder, premature ejaculation, and erectile dysfunction. Heiman and Grafton-Becker cited research in their work on female orgasmic disorder that indicates that group treatment, including assertiveness training, education, and directed masturbation procedures, can be nearly as effective as couples therapy. The group modality is particularly valuable for single individuals in that it provides an environment of mutual support and encouragement. The treatment of individuals without partners can be more difficult than couple-based treatment; however, assertiveness and social skills training, in addition to the procedures described above, can be helpful to single people with sexual disorders. Some procedures can be altered to handle the unique problems that arise when treating singles. For instance, in 1978, Bernie Zilbergeld described a treatment modification for premature ejaculation in which single men are taught skills in delaying ejaculation through masturbation and fantasy exercises. Similar modifications can be made for the treatment of other sexual disorders.

Several special populations present unique challenges to the traditional methods of treating sexual dysfunction. Sex therapy with gay men, lesbians, and bisexuals must be inclusive of sexual identity issues, the many variations of homosexuality itself, the fear of AIDS, and the internalization of heterosexism. In addition, some modification to techniques will most likely be warranted.

Treatment of clients who have experienced a sexual trauma such as rape or child sexual abuse can also be challenging. Judith Becker, in a chapter on this topic published in 1988, pointed out that some women who seek treatment for sexual dysfunction have had a history of sexual trauma. These women often present with symptoms of PTSD. Special attention must be paid to these symptoms, and the initial treatment goal should be to alleviate the impact of PTSD on sexual functioning. Finally, sex therapy with the chronically ill requires some adaptation. Cooperative work with a primary health provider, treating the client in an institutionalized setting, and adjustments in the behavioral interventions may be warranted. However, traditional treatment methods such as emphasizing education to help people understand their sexual functions and capabilities, deemphasizing genital sex as a necessary component to all sexual pleasure, and emphasizing the exploration of other forms of sexual expression beside sexual intercourse can contribute to the kind of program that is helpful for those who have to make adjustments in their sexual behavior because of a chronic medical condition.

IV. EMPIRICAL RESEARCH

This article has focused on the clinical techniques currently used to treat a variety of sexual dysfunctions. Unfortunately, much of this knowledge is based on clinical experience, rather than on empirical research. In 1980, LoPiccolo pointed out that much of the empirical literature in sex therapy is actually a series of demonstration projects that do not involve random assignment to experimental conditions, manipulation of independent variables, or assessment with objective, quantified dependent variables. Other methodological problems include the use of mixed-diagnosis samples, indirect outcome measures, and small sample sizes. Additionally, there have been very few studies attempting to identify which components of the total sex therapy package are active ingredients and which are “inert fillers.”

William O’Donohue, Diane Swingen, and Cynthia Dopke published a comprehensive review of the empirical literature for female sexual dysfunctions in 1997. In 1999, they, along with Lisa Regev, published a similar article concerning male sexual dysfunctions. They cite methodological problems, a lack of long-term follow-up data, a lack of treatment manuals, and the disregard for several disorders in outcome research as major problems that have contributed to the lack of concrete

information about the efficacy of sex therapy programs. Only approximately 20% of the published studies on male and female sexual dysfunctions met the inclusion criteria for the O'Donohue reviews: random assignment to treatment conditions, and at least one comparison or control group. For in-depth examinations of these studies, please refer to the O'Donohue and colleague reviews. For the purposes of this article, it is sufficient to note that strong arguments exist for further attention to research design and data analysis in the empirical study of sex therapy outcomes.

Despite the weaknesses in sex therapy outcome research, there is great reason to believe that the outlined treatments produce positive results in the majority of cases. As such, they have been validated in a very meaningful way. In 1995, the Task Force on the Promotion and Dissemination of Psychological Procedures included the directed masturbation program for female orgasmic disorder and behavioral treatment for male erectile disorder on their list of well-established treatments. However, further treatment outcome research is needed in order to firmly establish the efficacy of postmodern sex therapy procedures.

See Also the Following Articles

Arousal Training ■ Assisted Covert Sensitization ■ Aversion Relief ■ Couples Therapy: Insight Oriented ■ Oedipus Complex ■ Orgasmic Reconditioning ■ Women's Issues

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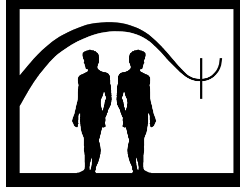

Short-Term Anxiety-Provoking Psychotherapy

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I. Description of Treatment
II. Theoretical Bases
III. Empirical Studies
IV. Summary
Further Reading

GLOSSARY

clarification The procedure aiming at the restructuring and differentiation of information brought by the patient to make certain points more easily understood.

compromise formation Connotes the product of the unconscious process in which the instinctual gratification (i.e., the discharge of sexual and aggressive instinctual impulses) and the demands of the opposing defensive forces are mutually satisfied through a compromise that partially expresses both tendencies allowing the repressed impulse to find expression in a substitute and disguised form (e.g., symptomatic phenomena).

confrontation The procedure that makes the phenomenon in question evident and explicit, aiming at the overcoming of the evasive and defensive tactics.

defense mechanisms The automatic, complex, and largely unconscious operations (e.g., repression, displacement, reaction formation, projection, etc.) used by the ego as a means of protection against internal (e.g., unacceptable wishes) or external (e.g., events, such as a loss, that elicit anxiety or painful affects) danger situations, aiming at the adaptive restoration of equilibrium.

dynamic Refers to the point of view according to which mental phenomena represent the outcome of a continuous conflict between opposing forces in general (i.e., the id, the ego, and the superego), and between the unconscious phenomena seeking discharge and a rigorous censorship (i.e., repression) aiming at their exclusion from conscious awareness in particular.

ego The agency of the psychical apparatus that mediates between the id, the superego, and the external reality, aiming at adaptation.

flight into health The phenomenon in which the resistant patient may exhibit a premature and temporary improvement of personal difficulties as a result of the unconscious wish to evade a further psychodynamic exploration of these conflicts.

focalization Refers to the active and collaborative attempt of the patient and the therapist to stay within the confines of the agreed-on focus and to work toward the attainment of specific therapeutic goals. Focalization is instrumental in the shortening of the treatment.

id The agency of the psychical apparatus that contains the instinctual drives.

interpretation The procedure of making the unconscious conscious.

object relations Refers to the distinctive organization of an individual's inner representational world, which stems from his or her interpersonal and developmental history and determines the mode of the individual's intrapsychic and interpersonal functioning. Furthermore, the term object relations, denotes the interplay between the external reality (i.e., interpersonal interactions with actual persons) and the patterns of inner mental representations (i.e., internalized object relations emerging from the interaction of the self with the external object). An inner mental representation is a mental image of the self or an object (self-representation or object representation), which constitute

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a complex enduring, cognitive structure within the ego, comprised of dynamic and effective elements. In psychoanalytic theory the term object refers to an actual person, or a thing, or an inner mental representation.

Oedipus complex Refers to the developmentally fundamental constellation of largely unconscious drives, defenses, thoughts, affects, and object relations relating to the child's wish to possess exclusively the parent of the opposite sex, which elicits feelings of rivalry, jealousy, and hostility toward the parent of the same sex and fears of severe retaliation (e.g., castration, loss of parental love) by the perceived rival parent.

Oedipal issues The derivatives of compromise formations (e.g., maladaptive coping strategies) and patterns of object relations (e.g., triangular interpersonal relationships) stemming from an unresolved Oedipus complex.

past–present link The process in which the therapist synthesizes the material brought by the patient in such a way as to help the patient understand the unconscious link between the past feelings for important people and the transference feelings for the therapist (therapist–parent or past-transference link), enabling the patient to utilize the insight to appraise personal behavior from a novel causative perspective, and to achieve a disconfirmation of the non-realistic inappropriate mode of viewing significant people in present life that entangles the patient in circular dysfunctional self-defeating patterns of relating and interacting.

psychodynamic The terms psychodynamic and dynamic are used interchangeably (See dynamic).

regression Denotes a return to an earlier, more developmentally primitive mode of mental functioning.

resistance Any kind of action, thought, or affect, which represents a manifestation of the patient's conscious or unconscious defensive functions and opposing forces, against treatment and the therapeutic progress in general, and the process of making the unconscious conscious in particular.

superego The agency of the psychical apparatus consisting of parental injunctions and inhibitions, as well as ideals and values.

therapeutic alliance The necessary condition for the progression of the psychodynamic work, consisting of an alliance between the patient's higher developmental ego processes and the therapist's facilitating analyzing ego, which alternately signifies the patient's capacity for empathic attunement and active involvement in a joint effort toward the overcoming of the patient's emotional conflicts, and further activates the patient's ability to work cooperatively and purposefully toward the accomplishment of the therapeutic goals.

transference A general, spontaneous, and universal phenomenon consisting of the process of unconscious displacement of feelings, impulses, defenses, thoughts, attitudes, expectations, and patterns of interaction derived from past interpersonal relations onto a person in the present. Transference is characterized by multiformity and ambivalence (i.e., co-existence of opposite feelings), and depending on its prevailing characteristics can be distinguished in positive (e.g., affectionate) and negative (e.g., hostile). The treatment situation fosters the development and expansion of transference, which is utilized explicitly, and helps in making feasible the resolution of conflict.

transference cure The phenomenon in which the patient may demonstrate an ephemeral symptomatic improvement in an unconscious effort to please the therapist as a result of a developing positive transference.

working through The repetitive process of assimilation and utilization of insight, aiming at the progressive elaboration and overcoming of the resistances that prevent the establishment of endurable adaptive structural, emotional, and behavioral changes.

Short-term anxiety-provoking psychotherapy (STAPP) is a radical, specialized, and research-based type of short-term dynamic psychotherapy (STDP) developed by professor of Psychiatry Peter Sifneos at the Harvard Medical School for the treatment of appropriately selected patients. This article presents the basic technical and theoretical principles of STAPP, as well as, a brief discussion on the research findings concerning treatment's effectiveness.

I. DESCRIPTION OF TREATMENT

STAPP is a kind of brief therapy based on psychoanalytic principles. The psychoanalytic principles include the analysis of transference, resistances, defense mechanisms, and unconscious processes, with the threefold aim of (a) investigating patient's psychodynamics, (b) facilitating the maturational process through the acquisition of insight (i.e., by making the unconscious conscious), and (c) working through the unconscious factors that hamper the accomplishment of the therapeutic goals.

Dr. Sifneos named his technique short-term anxiety-provoking psychotherapy (STAPP) to give emphasis to the basic technical component of his technique that consists of the constructive utilization of anxiety toward the obtainment of a higher level of psychical organization (i.e., increased capacity for anxiety, frustration and ambiguity tolerance, predominance of more adaptive ego defenses, better elaboration and reconciliation of inner conflict, improved affect regulation) and the attainment of more adaptive modes of coping. The STAPP therapist through the appropriate use of anxiety-provoking interventions (clarifications, confrontations, interpretations) is able to increase the emotional intensity during the session and to maintain patient's anxiety at an optimum

level in which it can be utilized as a motivational force toward (a) the understanding of the nature of the nuclear emotional conflict (i.e., the specific emotional conflict—such as the Oedipal conflict—underlying the patient's psychological difficulties) and the recognition of the maladaptive defensive reactions used to deal with it, (b) the achievement of emotional reeducation, and (c) the acquisition of new learning and problem-solving techniques, in a brief period of time. The treatment can be successfully completed in 6 to 14, or at most 20 sessions.

The technique of STAPP consists of specific and intertwined components, which form four successive phases: (a) the patient–therapist encounter, (b) the early therapeutic phase, (c) the central therapeutic phase, and (d) the later therapeutic phase and the termination process.

A. The Patient–Therapist Encounter

The patient–therapist encounter includes two fundamental parameters: (a) the development of a facilitating therapeutic context, and (b) the psychiatric evaluation.

1. *The development of a facilitating therapeutic context*: In STAPP particular emphasis is placed on the development of a strong collaborative relationship between the patient and the therapist. The therapist is very active throughout the treatment. Through the judicious alternating of empathic, anxiety-provoking, supportive, and didactic interventions the therapist is able to establish rapport, to maximize the therapeutic alliance, and to utilize the positive transference to create a safe environment in which self-understanding, new learning, emotional reeducation, and change can take place. This involves the education of the patient about: (a) the importance of the establishment of a full, active, and joint cooperation for the specification, understanding and resolution of the patient's difficulties, (b) the requirements and the focal, goal-oriented, problem-solving, anxiety-provoking nature of the treatment and the ensuing resistances, and (c) the patient's psychodynamics concerning the therapeutic focus. The STAPP patient is considered capable of cooperating efficiently with the therapist focusing on the goal of resolving the emotional conflicts underlying the difficulties successfully over a short period of time, while the attainment of the mutually agreed therapeutic goals is viewed as a joint problem-solving venture.

2. *The psychiatric evaluation represents a global assessment of the patient's personality organization and psychopathology, which consists of five integral components:*

a. *The assessment of patient's presenting complaints*: The evaluator's primary task is to help the patient organize the presentation of chief complaints (i.e., by making the proper questions, and by emphasizing the importance of clarity, specificity, and immediacy for the successful outcome of their joint effort) and to assemble information concerning their onset, development, intensity, duration, sequence, timing, precipitating factors, as well as, other pertinent issues, to form a clear picture of the patient's problems. The presenting complaints of STAPP patients include interpersonal difficulties, specific, mild psychological symptoms, such as anxiety, depression, grief reaction, chronic procrastination, obsessive preoccupation, monosymptomatic phobia, as well as, physical symptoms of psychological origin (e.g., headaches).

b. *The systematic developmental history taking*: The evaluator through the judicious use of open-ended and forced-choice questions is able to obtain a clear and cohesive picture of the patient's emotional development on a longitudinal basis. The history taking follows a successive order from early childhood to the patient's current life. The evaluator investigates certain areas, such as the earliest memories, childhood relations with parents and other family members or key persons, the early family atmosphere and structure, the school history, interpersonal patterns and experiences during puberty, adolescent and early adulthood, the history of sexual development, and the medical history. The systematic history taking is crucial for (a) the identification of areas of conflict, maladaptive reactions, and repetitive difficulties, and (b) the understanding of the emotional problems in psychodynamic terms, which in turn, enables the evaluator to present to the patient a psychodynamic reformulation of his or her presenting complaints.

c. *The using of the appropriate selection criteria*: The evaluator uses five clear-cut criteria for the assessment of patient's ego strength, through which it can be established that the particular patient can be successfully treated in a short period of time. The STAPP candidate must have (a) the ability to circumscribe the presenting complaints (i.e., the patient, with the appropriate support and preparation by the therapist, must be able to make a compromise and to choose one out of a variety of problems for eventual resolution), (b) a history of at least one meaningful relationship (i.e., altruistic, give-and-take) during childhood, (c) the ability to interact flexibly with the evaluator (i.e., to be willing to consider the other person's view and be able to express positive or negative feelings openly and appropriately during the interview), (d)

psychological sophistication (i.e., above-average intelligence and psychological mindedness), (e) a motivation for change, and not for only symptom relief. Motivation for change indicates the patient's willingness to work hard during the treatment assuming an active responsibility concerning the therapeutic task. According to Dr. Sifneos, the patient's motivation for change is probably the most important of all the selection criteria because it has a prognostic value concerning the therapeutic outcome. The evaluation of the patient's motivation for change is assessed on the basis of seven subcriteria: (a) a willingness to participate actively in the evaluation process, (b) honesty in self-reporting, (c) an ability to recognize that symptoms or difficulties are psychological in origin, (d) introspection and curiosity (i.e., self-inquisitiveness), (e) demonstration of openness to new ideas and ability to change, explore, and experiment, (f) realistic expectations of the results of psychotherapy, and (g) willingness to make a reasonable and tangible sacrifice (i.e., the patient is able to make a compromise concerning the appointment time or the fees of therapy) to achieve a successful outcome.

d. *The formulation of a specific focus for the psychotherapy*: The evaluator on the basis of the information offered by the patient constructs a dynamic formulation of the nuclear conflict underlying the emotional difficulties around which the treatment will revolve. The best therapeutic results can be achieved when the foci of the treatment relate to unresolved Oedipal conflicts, grief reactions, and certain difficulties relating to loss and separation issues. Concerning the unresolved Oedipal conflicts, which represent a common focus in STAPP, Dr. Sifneos proposed that there are three categories to be considered: in Category A the patient's attachment to the parent of the opposite sex is based only in the patient's fantasies of being the favorite child, while in reality there is no evidence of an actual encouragement by the parent; in Category B a more complex condition is presented that involves a reinforcement of the Oedipal attachment by the opposite-sex parent; and in Category C, which is the most difficult to resolve, Oedipal issues involve a complicated condition in which there is a combination of a strong reinforcement of the Oedipal attachment and an actual replacement of the parent of the same sex (i.e., as a result of divorce or death).

e. *The "therapeutic contract"*: The evaluator presents the therapeutic focus to the patient and expects an agreement about the resolution of the emotional conflicts underlying it. In addition the outcome criteria are formulated (these involve the specific therapeutic goals on which the success of the treatment will be evaluated). The mutual agreement concerning the therapeutic focus strengthens the patient's motivation to assume an active responsibility in expanding self-understanding and utilizing the insights to achieve the desirable emotional change. STAPP involves weekly, face-to-face, 45-min-long interviews, which take place at a mutually convenient specified time. The therapist informs the patient that the therapy will be brief but no specified number of sessions is set.

B. The Early Therapeutic Phase

In the early therapeutic phase, the patient's positive feelings for the therapist predominate. The most important technical principle involves the early utilization, and the vigorous and explicit analysis of patient's positive transference feelings. This procedure enables the therapist to establish the development of past–present links and to strengthen the therapeutic alliance.

C. The Central Therapeutic Phase

The central therapeutic phase represents the height of STAPP. The therapist uses repeated anxiety-provoking questions, confrontations, and clarifications in an effort to stay within the confines of the agreed on therapeutic focus, and to establish past–present links that constitute the fundamental technical aspect in STDP. A basic innovative unusual technical aspect of STAPP has to do with interpretations in the form of hypotheses prior to the analysis and clarification of resistances and defense mechanisms. The therapist utilizes the anxiety, which is elicited by the focal interpretive activity, to make explicit the emotional conflicts underlying the focus, as well as, to help to increase the patient's motivation for the acquisition of new more effective problem-solving strategies and for the resolution of old problems. Thus the patient is able to explicitly understand in which way his or her present mode of interpersonal relations is affected by the unconscious repetition of past interpersonal patterns. The patient's expanding awareness over hidden conflicts, fantasies, feelings, needs, and defensive operations, helps the patient to be able to exercise responsibility and control over them. Consequently the therapist by challenging the patient's neurotic entanglements and by providing empathic understanding and encouragement is able to support the patient's capacity to tolerate conflict and to explore new solutions to emotional conflicts. Through this procedure the therapist helps the patient to develop self-understanding and achieve emotional growth.

Even though it has been established through the careful evaluation process that a STAPP patient is sufficiently motivated to decisively achieve the therapeutic goals in a brief period of time, the emotional intensity of the anxiety-provoking focal interaction and the unpleasant realizations, may at times elicit strong resistance and evasive tactics. The therapist through careful note taking records certain verbatim statements of the patient, and at times of resistances is able to repeat the patient's exact words to present the facts which consolidate the patient's interpretations. Another technical tool, which is used for the resolution of the resistance-related impasse, is "recapitulation." This involves the presentation of a synopsis through which the therapist explicates how he or she arrived at the particular conclusion, based on the information that has been provided by the patient. Furthermore, the therapist by reviewing the recorded notes is able to make short-term predictions about the course and future development of treatment.

Patient's resistances and evasive tactics may include discussion of issues that are not relevant to the focus, or regression-like reactions (e.g., the patient may present him- or herself in a state of an apparently overwhelming anxiety) that actually represent a "pseudo-regression." It should be remembered that a STAPP patient has sufficient ego strength and anxiety tolerance. Under those circumstances the therapist's task is to explain to the patient the importance of focalization for the success of their specific agreed-on therapeutic goals and to reestablish the focus. The therapist through the active and systematic avoidance of early characterological issues (such as passivity, dependency, acting out, and manipulative tendencies), which may be used defensively, is able to prevent the emergence and the establishment of actual regressive modes of relatedness, and to accomplish the resolution of patient's nuclear conflicts within a short period of time.

As the therapeutic work is progressing the patient gradually internalizes the therapeutic processes. The demonstrated ability of the patient to utilize the assimilated knowledge to develop new attitudes and behavior patterns, as well as, to generate novel effective ways of dealing with past and present problems, is evidence of progress.

D. The Later Therapeutic Phase and the Termination Process

In the later therapeutic phase the therapist's task is to look out for tangible evidence of change, as well as, to make sure (e.g., through the exploration of specific examples brought by the patient) that the patient's improvement does not represent a fortuitous change, or a flight into health, or a transference cure that involve a superficial and transient symptomatic improvement without a clear-cut understanding of the psychodynamics concerning the emotional conflicts underlying the presenting difficulties. The acquisition of sufficient insight about the focal conflicts results in the establishment of tangible evidence of change and signals that the time has come for the termination process. Consequently the termination of the treatment takes place promptly when both patient and therapist agree that the basic therapeutic goals have been accomplished.

II. THEORETICAL BASES

STAPP is based on psychoanalytic theoretical premises consisting of six viewpoints: the topographical, the dynamic, the structural, the genetic, the economic, and the adaptive. A person's behavior or symptoms are interpreted as disguised representations of underlying unconscious processes (topographical viewpoint). The patient's difficulties or symptoms are viewed as an outcome of a conflict and a dynamic interaction in general, and a maladaptive compromise formation in particular (dynamic viewpoint), between: (a) the warded-off pleasure-seeking instinctual drives stemming from the id, (b) the restrictions by the reality-oriented ego that institutes defense mechanisms to maintain psychic equilibrium, (c) the prohibitions imposed by the superego (structural viewpoint). In addition, the patient's current conflict and maladaptive pattern of behavior are seen as parts of a continuum from infancy to adulthood (genetic or developmental viewpoint), consisting of two fundamental interrelated factors: (a) the nature of progressions, regressions, and fixations (economic viewpoint) in relation to the psychosexual development (oral, anal, Oedipal, latency, and genital stage), and (b) the quality of interpersonal relations and environmental influences and circumstances to which the individual adjust and to which he or she acts on (adaptive viewpoint).

Dr. Sifneos developed STAPP, while he was the director of the Psychiatry Clinic (from 1954 to 1968) at the Massachusetts General Hospital (a teaching hospital of Harvard Medical School). The prototype for STAPP was a 28-year-old male patient complaining of an acute onset of nervousness and phobias for all forms of transportation, who came to the clinic, requesting therapy to overcome his fears and be able to get married during the next 3 months. Dr. Sifneos decided to proceed with a therapeutic regimen that was successfully completed

in eight sessions. A subsequent follow-up established that a lasting characterological dynamic change had taken place and patient's focal problems had been resolved. The successful results of this treatment encouraged Dr. Sifneos to look at the patient's character structure systematically and to develop criteria for selection of appropriate candidates to receive a similar psychotherapy. It was in this way that the evaluation process was developed, as well as, the anxiety-provoking technique. In sum the evaluation, techniques, and outcome, which were studied and improved over the years have made STAPP a systematic comprehensive and useful psychotherapeutic treatment.

III. EMPIRICAL STUDIES

STAPP represents the oldest type of brief therapy based on systematic research in the United States, and its effectiveness has been validated by several follow-up studies in United States and Europe. Between 1960 and 1987 Dr. Sifneos conducted extensive controlled research studies. These involved follow-up investigation of "experimental" patients who were immediately treated, and wait-list "control" patients who received treatment after a period of time. Impressive follow-up findings were presented, and studies in Europe showed similar and significant long-term follow-up results, as reported in 1985 by Dr. Ragnhild Husby in Norway.

An important educational and research tool in STAPP is the use of videotapes, which Dr. Sifneos called the "microscope of the psychiatrist." The videotape of the evaluation, the treatment, and the follow-up of patients who are willing to participate in research and to give an informed consent, makes the accomplishment of a detailed and systematic analysis of the therapeutic process and outcome, as well as, the accurate comparison of the pre- and the posttreatment condition feasible. The assessment of the efficacy of STAPP in follow-up studies is based on the evaluation of eight specific outcome criteria concerning patient's improvement in psychological or physical symptoms, interpersonal relations, self-understanding, the acquisition of new learning, the development of new effective problem-solving strategies, self-esteem, work or academic performance, and the development of useful new attitudes. According to follow-up outcome studies the STAPP patients after termination are able to efficiently utilize the new learning and problem-solving skills that they have assimilated during their treatment, through a process which Dr. Sifneos called "internalized dialogue," to solve new problems. This process, which facilitates continuous growth and maturation relates to the patient's ability to reconstruct the therapeutic dialogue with the therapist, to reproduce a therapeutic problem-solving effect for the resolution of new difficulties.

IV. SUMMARY

Short-term anxiety-provoking psychotherapy (STAPP) is an innovative, specialized, and systematically studied type of short-term dynamic psychotherapy (STDP), developed by Professor of Psychiatry Peter Sifneos at the Harvard Medical School. It is based on psychodynamic theoretical premises and constitutes the treatment of choice for the resolution of mild neurotic symptoms in appropriately selected patients. The basic technical principles include the establishment of a therapeutic focus, the use of anxiety-provoking interventions, the early utilization of positive transference feelings for the consolidation of a therapeutic alliance and the establishment of past–present links, the avoidance of characterological issues for the prevention of the development of regressive modes of relatedness, and the achievement of an early termination. STAPP is characterized by the establishment of clear-cut specific criteria for the selection of patients (i.e., circumscribed focus, history of a meaningful relationship, flexible interaction with the evaluator, psychological sophistication, and high motivation for change), and the evaluation of the therapeutic outcome (i.e., improvement in symptoms, in interpersonal relations, in self-understanding, in new learning and problem-solving strategies, in self-esteem, in work or academic performance, and in the development of new effective attitudes). The effectiveness of STAPP has been documented by extensive research studies in the United States and Europe.

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See Also the Following Articles

Brief Therapy ■ Confrontation ■ Interpretation ■ Object-Relations Psychotherapy ■ Oedipus Complex ■ Resistance ■ Supportive-Expressive Dynamic Psychotherapy ■ Working Alliance ■ Working Through

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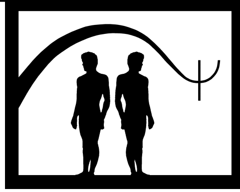

Single-Case Methods and Evaluation

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I. Approaches and Methods
II. Clinical Research and Practitioner Applications
III. Basic Principles of Single-Case Design
IV. Summary
Further Reading

GLOSSARY

external validity Concerns the extent to which experimenters can generalize their findings from one particular set of observations (e.g., individual clients, settings, therapists) to another.

idiographic The study of the individual. Common themes are identified by looking for similarities that emerge across individual profiles.

internal validity Concerns the extent to which observations of change can be interpreted as direct evidence that an intervention had a specific effect on the clinical outcome.

nomeothetic The study of groups of individuals. A common theme is extracted from the collective behavior of the group. This is usually based on the average of the group's responses.

Single-case methods can be defined with respect to psychotherapy, as a collection of techniques for evaluating the efficacy of a specific intervention(s) within a single clinical case or a series of cases. This article overviews the range of approaches and applications of these methods to psychotherapy research and practice. In particular, a set of principles underlying the implementation of the single case design within clinical practice is described.

I. APPROACHES AND METHODS

The fundamental questions within psychotherapy research about which treatments are the most effective or what works for whom are frequently mirrored in the mind of the clinician. Am I using the right approach with this client, are they really showing signs of improvement, should I be adopting a different approach? These questions and doubts are answered through the experience and judgments that clinicians make when reflecting on their practice either alone or when in supervision with other therapists. Nevertheless the search for evidence that therapy has been effective has always been part of the process of psychotherapy.

How can we reliably and objectively demonstrate clinical change within the individual? On a day-to-day basis, effectiveness of our interventions are demonstrated via our own perceptions of what seems to work; the satisfaction of the client that may be expressed verbally in terms of compliments or complaints; behaviorally by gifts, nonattendance, and the unplanned discontinuation of therapy; by comments from carers and relatives; or by peer evaluations during the process of "supervision" or clinical audit. However, do these sources of information really constitute evidence of effectiveness? Even if clinical

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change is observed, how confident are we that it was our own specific intervention, as opposed to a myriad of other influences ranging from the client's family through to other possible interventions of the multidisciplinary team, that brought about the real change? Single-case experimental designs have been developed in an attempt to provide proof of effectiveness within the individual. Accordingly, it can be argued that these techniques should provide therapists with an objective means of demonstrating the efficacy of their interventions. As such, they represent one approach to evidence-based practice that the psychotherapists might exploit to demonstrate their own effectiveness to a sometimes skeptical world.

Originally, evidence was presented in the form of what has become known as a "case study," which usually included an extensive account of the client including background history and problems, what happened within therapy frequently based on a session-by-session account, and also the therapist's attempts to understand and account for the process of therapy as described. Indeed, the case study became the major vehicle for documenting the nature of psychotherapy and communicating advances in the understanding of therapy to other practitioners. This approach is typified particularly within writings on psychoanalysis and the classical case studies published by Sigmund Freud.

Although case studies continue to be written, particularly during the course of training psychotherapists, today they are no longer considered as providing sufficient evidence that a particular therapy has been effective. Essentially they have been superceded by what are considered as more scientifically rigorous methods. Generally contemporary clinical research is based around the study of large samples of individuals who have been exposed to various different therapeutic approaches or regimes. So-called robust research methods have been developed relying on double blind procedures and randomized control trials to answer and further tease apart the questions of psychotherapy efficacy. Nevertheless there are circumstances when it is still appropriate to ask questions of effectiveness within a single client by a single therapist. This might arise in the course of developing an innovative therapeutic technique, treating a rare condition, or even as a means for therapists to satisfy themselves and others that their therapy has been effective. The purpose of this article is to describe methods that have been developed for systematically evaluating clinical evidence within the single client.

Single-case methods represent a wide range of approaches that have been used extensively across many different areas of study. The intensive study of the individual, as opposed to the usual nomeothetic approach of studying groups of individuals, can be readily identified across a range of different disciplines. The clinical case study is widely used within medicine and other clinical disciplines, but individually focused research strategies are also commonplace within educational research, experimental psychology, and sociology. Moreover, although it is common within psychology as a discipline to criticize single-case idiographic approaches on the grounds that they fail to generalize to groups of individuals, many basic laws of behavior within psychology have arisen by the careful and intensive study of just a few selected and usually well-trained individuals. With respect to psychotherapy, single-case methods can be defined as a collection of techniques for evaluating efficacy of a specific intervention(s) within a single clinical case or a series of cases.

The range of applications of single-case approaches is also reflected in a diversity of methods. Even the use of the term "case study" extends from anecdotal reports of therapy published in books through to the publication of brief clinical reports in journals, and formal presentations of case studies. The later are frequently used as assessments of assumed clinical competence within many forms of psychotherapy training. However, in 1981, Alan Kazdin in a now-classical journal article criticized the traditional clinical case study for being biased and unscientific. The subsequent demise of the clinical case study has given way to a range of more scientifically focused techniques, which are commonly described as "single-case experimental designs." These approaches commonly involve the comparison of data derived from a baseline period prior to when no intervention has been offered, with data obtained from an intervention period. The use of a follow-up assessment some months or years following the treatment is also frequently undertaken. These approaches are often termed AB designs, the letters referring, rather confusingly, to baseline (A) and intervention (B), respectively. Because they usually involve the collection of large amounts of data collected daily over time, they are also referred to as "time series" designs. The comparison between baseline and treatment is also frequently repeated either giving rise to "ABAB" designs or the use of several different measures concurrently that are termed "multiple baseline or phase designs." Occasionally, these designs will be repeated across a small series of individuals and this approach is called "a small *N* design."

In addition to the quantitative experimental approaches described earlier, the case study has also been developed to yield a range of qualitative methods that

are commonly used within sociology. Indeed, observational case studies of particular services or institutions have resulted in dramatic insights and changes in attitudes. A classic example is Erving Goffman's ethnographic study of institutional life conducted in the 1950s and 1960s. Although qualitative approaches are not the main focus of this entry, their potential for understanding therapeutic processes are becoming increasingly recognized by psychotherapy researchers.

II. CLINICAL RESEARCH AND PRACTITIONER APPLICATIONS

Single-case experimental designs have a wide range of applications, which ought to prove useful to both researchers and practitioners. From a clinical research perspective, not every piece of clinical work will be treated as a potential piece of psychotherapy outcome research. Similarly, most practitioners will not be participating in psychotherapy outcome research. As a means of bridging this gap whereby practitioners become more involved in psychotherapy research, it could be argued that evaluating efficacy within a single clinical case is the bottom line as regards "evidence-based medicine." Indeed, it maybe that single-case methods are about to experience a renaissance as the requirements of demonstrating both the evidence base and clinical effectiveness for specific psychotherapy practices becomes more prevalent due to the influence of the "managed care" movement. David and Robin Morgan have recently made such an argument within an article in the *American Psychologist.*

A. Clinical Research Applications

There are several situations when therapists have a particular reason for evaluating their own work and communicating its outcome within the public domain. The most common reason for employing single-case designs is when the therapist is engaged in an innovative approach to therapy and wishes to disseminate through scientific publication the results of this new treatment approach. Single cases have provided the starting points for many commonly used therapeutic techniques that are widely employed today. For example, the cognitive treatment of panic disorder owes its origins to a series of single cases on the use of rebreathing and reattribution techniques published by David Clark and his colleagues some 20 years ago. Similarly, the cognitive therapy of psychotic symptoms was first published in 1994 by Paul Chadwick and Max Birchwood as a single-case series. Although these publications by themselves do not meet the full rigors of evidence-based medicine they have provided useful starting points for more systematic approaches to therapy. Indeed, in the case of both these examples, evidence from single-case studies has now been superseded by the findings from randomly controlled trials. Within psychotherapy outcome research, therefore, the single case plays a pivotal position as providing a starting point for the development of new therapies. It is also seen as a means by which regular practitioners may involve themselves in research because the demands of single-case methods tend to be less resource hungry than psychotherapy group evaluations.

Another reason for employing single cases includes the study of rare clinical conditions whereby the limited availability of clients precludes a group evaluation approach, especially in the first instance. Examples of this particular strategy include the evaluation of behavioral treatments of tic disorders and the in-depth investigation of neuropsychological patients with specific and unique head injuries. Single cases can also provide important illustrative material particularly about the practical implementation of new treatment approaches. Such accounts are frequently to be found in the appendices of published studies, which have relied on more traditional group evaluative approaches to outcome research. One particularly, important area for the use of such case material is when therapy is ineffective. Single-case approaches have much to offer the study of treatment-resistant cases. However, the degree to which unsuccessful cases are published and discussed tends to be limited by the implicit bias of scientific journals only to publish positive results. This form of bias may seriously distort the perceived efficacy of treatments, which have been evaluated using single-case approaches. It is usual, therefore, that only positive accounts of new treatment strategies are published at the expense of negative findings. A typical example of this involves the use of "ear plugs" to control auditory hallucinations in psychosis whereby singular and enthusiastically published positive results have tended to give way to later publications of case series that have been more skeptical and negative.

B. Practitioner Applications

The adoption of a single-case approach to clinical work may also have some benefits for clinical practice that are completely independent of research. For example, these approaches can be employed to demonstrate

individual effectiveness of a particular approach to skeptical colleagues or managers. Within the context of cognitive behavioral work, using single-case approaches for data collection facilitates a collaborative relationship between therapist and client that can enhance both the client's motivation and "self efficacy." The approach enables client and therapist to sit down together to identify agreed treatment goals, decide on how individual outcomes should be assessed, and how the impact of therapy can be monitored. It is acknowledged, however, that such an open and goal-directed approach to treatment would not be consistent or appropriate for all forms of psychotherapy.

The demonstration of clinical change using objective measures can be particularly important when working indirectly with care staff. Many researchers have demonstrated that staff's subjective perception of clinical change is frequently biased and may not match more objective change measures, especially for chronic or irregular problems. It has been suggested that this might be due to "recency or memory effects," whereby care staffs' perceptions are determined by recent events that then makes it difficult for them to track accurately change over an extended period of time. The use a single-case approach allows a more objective assessment to take place. This can be particularly useful in motivating and informing staff that their efforts do yield positive effects particularly with individuals with challenging and chronic or even deteriorating problems who have previously been resistant to change.

Social work educators have argued that the use of evidence-based techniques such as single-case methods might also enhance the overall effectiveness of practitioners. They have suggested that training in single-case methods enhances clinical skills associated with assessment, formulation, and the implementation of therapy. If this were the case, the routine use of single-case approaches would not only provide the evidence of therapy efficacy but would also lead to enhanced effectiveness. To test these ideas effectiveness of various intervention programs have been compared when therapists have been differentially trained in and encouraged to use single-case approaches. Preliminary evidence from this research would suggest that training in these techniques does enhance therapy and that clients also may have a preference and greater satisfaction for working with a practitioner trained in single-case methods.

Finally, it is commonly believed that single-case methods can only be used by therapists working in either a behavioral or cognitive-behavioral framework. Although, it is undoubtedly the case that many examples of single-case work are published within behaviorally oriented journals, this doesn't have to be the case. Single cases have been studied using a wide variety of different therapeutic frameworks. What is required, however, are that certain goals of therapy can be established, that they are measurable in some way, and that there is a framework (e.g., formulation) that links the therapeutic model to intervention, together with some hypotheses relating to clinical change. The basic principles underlying single-case work will be further elaborated in the next section.

III. BASIC PRINCIPLES OF SINGLE-CASE DESIGN

Single-case experimental designs rely on several widely recognised and important principles, which have been widely discussed in classic texts such as David Barlow's and Michael Hersen's book published in 1984. These usually include: (a) repeated measurement, (b) stable baselines, (c) single and well-specified treatments, (d) reversibility, and (e) generalizability. To understand implementation of single-case designs, it is essential to appreciate the relevance of these principles. Moreover, it is these characteristics that distinguish the experimental single case from the ordinary case study. If a clinical study is unable to address these principles, it is likely that it will be classified as a case study.

Before expanding on the relevance of the earlier principles it is important to understand what a single-case design is attempting to accomplish. As emphasized by Alan Kazdin and others, the traditional case study is flawed because it relies on post hoc explanations that can be subject to different sources of bias and alternative interpretations. The purpose of single-case design is to identify these potential sources of bias, and control for their influence, and in so doing, to eliminate them as potential alternative explanations for the observed pattern of results that constitutes the case study.

What are the potential sources of confounding that might obscure the interpretation that a particular intervention has had a specific effect within a client on a particular outcome? For example, if during the course of therapy a client's relationship breaks down or a colleague alters the level of prescribed medication, to what extent is any clinical change a function of the therapy provided, the relationship difficulty experienced by the client, the change in medication or a combination of all three? Although some might argue that to attempt to disentangle these factors may be totally artificial, the

single-case design attempts to place on the case study certain limits or boundaries that might distinguish or minimize the impact of these confounding variables.

A. Threats to the Validity of a Case Study

One of the foundations of experimental design in psychology is the identification of confounding variables that need to be controlled to rule out alternative accounts of a study designed to test particular hypotheses. These sources of confounding are frequently referred to as threats to internal and external validity. Internal validity concerns the extent to which the findings can be interpreted in support of the proposition that an intervention had a specific effect on the clinical outcome. A series of possible scenarios exist that if present would severely compromise the study and limit the validity of the conclusions drawn. These circumstances include the following:

- *History*: Here extraneous concurrent events (e.g., relationship break-up, change in medication) may happen alongside the clinical intervention studied. These events may either be known or unknown to the experimenter.
- *Maturation*: This refers to a change process, which may be endogenous to the client and independent of the applied experimental intervention or treatment. For example, neuropsychologists and physiotherapists frequently attempt early interventions aimed at facilitating recovery from brain injuries such as a stroke or a closed head injury. However, if left "untreated," most individuals with head injuries show a degree of spontaneous recovery in functioning following the injury. Any measurement of clinical change must, therefore, be interpreted against a moving baseline of endogenous change associated with recovery.
- *Testing (reactivity)*: The exposure of a client to the assessment process itself is not a neutral act, particularly when structured forms of assessment such as questionnaires or self-monitoring diaries are employed. The very task of inviting the client to self-assess requires a possible shift in self-awareness and focusing on possible new information. The nature of questionnaires might seek to clarify a client's understanding or attribution of events and by doing so, challenge their existing attributions and explanations. Thus, the very act of participation and assessment within a case study may bring about therapeutic change. Indeed, such changes are frequently observed during the baseline phase prior to the introduction of any formal intervention.
- *Instrumentation (reliability)*: Nearly every assessment tool, which a clinician will employ, will have associated with it some error of measurement, and it is, therefore, important that these incidental changes in measures across time are not misinterpreted as specific treatment effects.

Other sources of internal confounding include regression to the mean, multiple intervention problems, and instability.

Threats to external validity have also been identified as important sources of confounding that require experimental control. These concern the extent to which experimenters can generalize their findings from one particular set of observations to another. With respect to case studies, generalization refers to the degree to which a finding observed within a single individual can be extended to other individuals and in other settings. Essentially, two sources of bias that might limit generalizability may be identified:

- *Selected individuals/samples*: The degree to which individuals or samples are specifically identified will limit the generalizability of the findings. The more heterogeneous the sample from which individual cases are drawn, the more likely that the results will generalize across individuals. In the case of psychotherapy, the importance of generalizing across variables such as social class, education, gender, and ethnicity will be important for establishing the widespread applicability or otherwise of psychotherapeutic approaches throughout across service provision.
- *Biased interventions/settings*: The setting or the specific manner in which an intervention is delivered might affect the specific outcome within a particular individual. For case studies, the issue here is one of clinical replication. Are results obtained within specialized research clinics by presumably highly trained therapists, generalizable to practitioners attempting to replicate similar interventions within routine clinical practice?

These threats to validity need to be carefully considered by researchers wishing to employ single-case designs. Only by being aware of these threats, can the researcher consider and exclude common alternative explanations regarding the relationship between intervention and outcome. The use of a traditional case study exposes the researcher to a variety of interpretative biases that, at best,

have to be accounted for when interpreting the results and, at worst, may be confounded with specific treatment effects leading to misleading conclusions. To compensate for these biases, "experimental" case study designs have been evolved that attempt to control for or minimize these threats to internal validity. For example, a common control for historical concurrent extraneous events is to repeat or replicate the treatment effect. If a specific treatment-outcome relationship can be observed, and this result is repeated a number of times on different occasions, it is unlikely that some other event unrelated to the intervention will have occurred successively to account for this particular repeating pattern of results. The more consistent the replication of the finding, the less likely it is that some other concurrent event has occurred alongside the specific intervention. Traditionally, group evaluation designs address historical threats to validity by examining replication of findings over a sample of different individuals. For single-case research, the replication is over different occasions within the same individual. Another example of designing against threats to validity concerns maturational effects. As discussed earlier, such endogenous changes may take the form of recovery functions. They may be distinguished experimentally from intervention effects, by observing within an individual the form of the recovery function under baseline conditions in the absence of an intervention, and comparing it following the introduction of the intervention. A specific treatment effect would predict a change in the gradient of any preexisting recovery function.

B. Design Principles

The following principles have been evolved for single-case designs to control for threats to validity and include repeated measurement, stable baselines, single well-specified treatments, reversibility, and generalizability. To understand the rationales underlying these principles, it needs to be acknowledged that their origins extend back to experimental studies of animal learning conducted largely in the middle of the previous century. Essentially, psychologists interested in animal learning conducted single-subject/animal experiments to investigate the effects of changes in various environmental contingencies on patterns of animal behavior. Hence, the knowledge base of animal learning derives very much from single-case experimental studies, together with replications, and has relied predominantly on the visual analysis of the graphical displays of results. This is in marked contrast to group nomeothetic approaches, used elsewhere within psychology, and the reliance on statistical testing.

It is these basic principles that have been extended to single-case experimental designs. An obvious reason for this extension was the application of learning theory in the form of applied behavioral analysis to a whole range of human problems, but particularly within the fields of learning disabilities and special education within the United States. This resulted in learning theory paradigms and methodologies being transferred into the clinical domain. It has to be emphasized, however, that the single-case approaches that these methods have inspired, are frequently used to evaluate interventions that are no longer associated with learning theory. In these circumstances, it is possible that rationales developed on the basis of learning theory may no longer apply. An example, which we will return to, is the use of either withdrawal or reversal techniques to demonstrate the specificity of an intervention. From a learning theory perspective, strong evidence of an environmental effect can be demonstrated if the contingencies can be manipulated to obtain withdrawal effects or reversals in the pattern of responding observed. Hence, a particular environmental event (e.g., social praise) could be shown to reinforce particular desirable behaviors (e.g., social interaction) in a young person with learning disabilities, if the behaviors increase when the praise is contingently offered but remains constant or decrease when the praise is withheld. Observation of a direct and repeated effect between the behaviors and the environmental effects provides evidence that the contingencies are reinforcing the behavior. However, this is based on certain learning theory assumptions concerning both the short-term and reversible nature of environmental contingencies. As we discuss later, these assumptions do not apply to the vast majority of interventions that are employed within psychotherapy. The evidence, therefore, that can be gathered from reversal or withdrawal designs is limited only to situations whereby the intervention will have short-term and reversible effects, and if these assumptions cannot be made, then the utility of reversal designs as a principle underlying single case methodology is markedly curtailed.

Bearing in mind the origins and possible limitations of the design principles underlying single case designs, each principle will now be briefly reviewed.

1. Repeated Measurement

Perhaps the most important distinguishing feature between a case study and a single-case experimental study is the number of observations or data points that have been obtained. A basic aim of an experimental study is to demonstrate within each individual intra-subject change

using repeated measures. It is hypothesised that when comparing within an individual measures obtained prior to treatment with those during and following treatment, some therapeutic effect will be observed. The greater number of repeated measures obtained, and the greater the consistency of change across these measures, the more confidence that an effect has taken place. This is analogous to a group design comparing say therapeutic and placebo groups whereby the repeated measures are obtained across the different individuals constituting the groups, as opposed to the single case whereby the repeated measures are derived from a single individual but at many different points in time.

To achieve repeated observations, the measures used have to be easily replicable. This means that they can easily be repeatedly administered, reliable, and relatively free of error or bias. This may discount many traditional forms of psychotherapy outcome evaluation that use extensive psychometric questionnaires or interviews designed only to be used on a single or infrequent sessional basis. Instead, daily measures derived from structured self-report diaries or staff observational schedules are frequently employed. Hence, the case study that includes only a single psychometric measure of pre- and postintervention change should not be considered as a single-case design. However, inclusion of additional repeated daily diary measures would allow such an evaluation to be made. The question arises, therefore, as to what the minimum number of repeated measures has to be obtained? The strict minimum according to Barlow and Hersen is probably at least three baseline and three intervention observations per single measure.

2. Stable Baselines

The basic premise for using repeated measures is that clinical change will be self-evident following the introduction of some therapeutic intervention. The degree to which change is discernible depends both on the magnitude of the therapeutic impact and also on the nature of the preintervention baseline. The greatest confidence about therapeutic impact can only be made when a stable baseline has been obtained. If the baseline is unstable (i.e., it displays an existing trend or slope, cyclical variability or excessive variability or noise), the confidence of detecting therapeutic change is much reduced. It is frequently suggested that baselines should be collected until they demonstrate stability. However, this may not be practical within the psychotherapeutic situation and a frequent question posed is what is the minimum length of baseline acceptable? A review of the size of baselines used in 881 studies published in the *Journal of Applied Behavior Analysis* ranged between 3 and 10 observations. In practice, it is likely that baselines will be obtained perhaps within the second and third sessions as part of an overall assessment process. If derived from daily ratings, it is feasible to collect baseline data ranging from 7 to 20 or so observations across a period of a few weeks that ought to be more than sufficient, although this will depend ultimately on the type of analysis to be employed.

3. Treatments Are Well Specified and Documented

In order to assess the effects of an intervention, it is important that essentially only a single treatment is applied at any one time and that its nature can be specified. Many therapists have difficulties with this limitation because it forces them to assess and formulate the case and prescribe a particular therapeutic approach in advance. However, this does not mean that case reformulation and changes in therapy cannot occur; they need to be, if possible anticipated, and incorporated into the design. Another issue of contention is exactly how is "a single intervention" defined? Again this is the responsibility of the therapist and depends largely on why the case is being evaluated in the first place. Therapists frequently argue that they plan to use a combination of different treatment strategies or techniques. If the aim of the evaluation is to assess the overall impact of this package of strategies, then the package, if it can be defined, becomes synonymous with a "single treatment." Another problem frequently encountered is the presence of other therapeutic work such as medication or other inputs from a multidisciplinary team. Two possible approaches to this common problem are available: to negotiate keeping external therapeutic inputs constant (i.e., no planned changes in medication) or directly involving the other therapists in the design and attempting to evaluate the comparative effectiveness of these other approaches with respect to the psychotherapeutic intervention.

4. Designing against Threats to Validity: Replications, Reversibility, and Withdrawals

A myraid of single-case designs have evolved in an attempt by clinical researchers to rule out the various threats to internal validity that have been previously described. Usually these designs involve complex comparisons of different phases of intervention and baseline manipulated across behaviors, settings, and participants. The logic of many of these designs also originates from applied behavior analysis and the application of fundamental learning theory assumptions. As such it is debatable how relevant this complex myriad

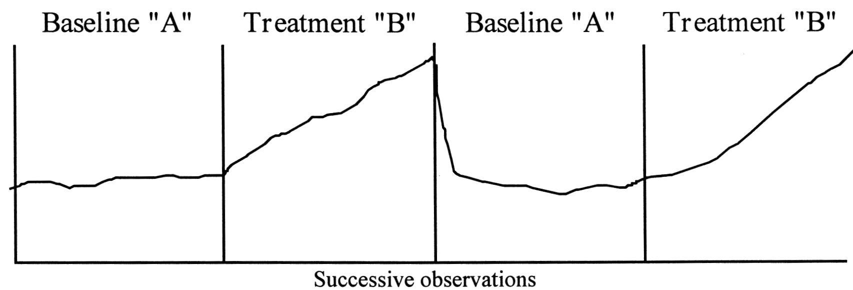

FIGURE 1 Withdrawal and reversal designs. The ideal single case design relies on intrasubject replication and is exemplified by the ABAB withdrawal design. The replication of a treatment effect (i.e., increasing slope) on both occasions that the treatment ("B") is introduced, and the return to baseline on the second baseline occasion ("A"), are seen as strong evidence that the original treatment effect is real and not spurious.

of designs is for psychotherapeutic applications? Accordingly we have avoided describing these different designs in any great detailed. Several of the cited references in Further Reading specify different designs, their rationales, and uses. Instead, we concentrate on the most influential design feature, which surrounds the questions of replication.

It is argued that greater confidence in the impact of treatment on intrasubject change can be demonstrated if the effects can be replicated within repeated measures, across different phases of a design, and that the effect of the intervention on the measures can be directly manipulated through either reversals or withdrawals. Replication is largely a means to protect against either historical or maturational threats to internal validity. Hence, if the results from the simplest AB design (baseline vs. treatment) can be replicated, then it less likely that some extraneous event can account for the original but replicated change from baseline to treatment. This is in essence the logic of ABAB design (see Figure 1), which is frequently advocated as a standard for experimental single cases. However, within the context of many psychological therapies such designs have important limitations. Essentially, their rationale depends on reversible treatment effects analogous to contingency manipulations employed within applied behavioral analysis. Fortunately, at least for the client, many interventions are considered as long lasting and hopefully resistant to reversal, relying on dynamic intrapersonal changes (e.g., cognitive therapy will promote schema changes). It is, therefore, neither theoretically likely nor ethically desirable that a positive treatment effect can be reversed. Hence, ABAB or ABA designs have their limitations because replication due to withdrawal of treatment and return to baseline may not actually be predicted due to the irreversible nature of the intervention employed.

Non-reversible treatments that are usually identified include psychoeducational approaches, skills-based therapies, schema-directed therapies, altered therapeutic environments, staff attitudes and training, and surgical or long-term pharmacological interventions. Nevertheless, introduction of a brief second baseline can be useful to assess and demonstrate the permanence or otherwise of therapeutic change. This can be practically incorporated into "therapeutic holidays," whereby clients are encouraged to assess progress by putting aside what has recently been learned or suspending temporarily homework exercises or self-coping techniques. Ethically this is defensible on the principle of demonstrating efficacy to the client of an intensive therapeutic regime. It is also likely, that a second baseline will also be introduced at the termination of treatment in the form of a follow-up to specifically assess the permanence and stability of change. If there has been deterioration in therapeutic improvement, this might argue for the introduction of "booster sessions": such a protocol would result in baseline and treatment phases not that indistinct from a classic ABAB design. A frequent rejoinder to those that criticize the ethics of single-case designs is that it might be considered a greater ethical problem to conduct psychotherapy in the absence of evaluation per se rather than to attempt evaluation through some manipulation of the therapy itself.

5. Evaluation and Interpretation

It is essential for a single-case design that the therapist has engaged in some critical and systematic evaluation of the data. There have been two competing approaches within single-case research: visual inspection and statistical analysis. Traditionally, single-case data have been analyzed visually using graphical presentation, sometimes presented alongside some simple descriptive statistics such as mean or medians. This tradition derives

very much from applied behavior analysis and emphasizes the utility of complex designs that require phase changes and demonstrate intrasubject replication via reversals and withdrawals of treatment components relative to baseline. However, as the scope for replication based around the assumption of reversible treatments becomes less applicable, some authors have argued for a more systematic approach to evaluation using statistical methods. There has also been a concern that visual inspection might be biased toward "Type one statistical errors" where significant change is expected and inferred but not actually substantiated, and at the same time, biased away from "Type two statistical errors" whereby the inherent variability within single-case data prevents the easy detection of reliable change. Unfortunately, due to a unique statistical feature of single-subject data termed serial dependency, the assumptions underlying most of the commonly used statistical tests are violated and hence, this severely limits their application. Accordingly, application of statistical models of single-case data is a specialized area of evaluation and one that requires serious consideration by the single-case researcher.

Finally, even if change could be reliably inferred between treatment phases and baseline conditions, the meaning of these changes requires interpretation. Due to the design limitations of a single case and threats to both internal and external validity, it is essential that observed differences are not simply considered as treatment effects. The limitations of single-case designs are such that it is essential that the clinical researcher is able to identify and where possible rule out alternative interpretations or threats to validity. It is very unlikely that the rigor of the design will have already excluded these possibilities as maybe the case when employing double-blind, randomized control designs within group comparison studies of psychotherapy outcome.

6. Generalizability

A common misconception about single-case designs is that they involve only a single subject. To derive general explanations or laws of behavior change, effects should be generalizable. The converse of this is that these laws ought to account for known sources of variability, and this is often obscured in group designs. Although a single *N*=1 design has limited generalizability, a series of *N*=1 designs should identify sources of variability and lead to greater generalizability. Different types of generalizability include across individual clients or clients with similar attributes, across different therapists, and across different settings or situations. The issue of generalizability is resolved, therefore, through replication across different clients, therapists, and settings. Hence, *N*=1 studies lead on to *N*=1 series, small *N* designs with homogenous subjects and well-controlled conditions. Indeed recent exponents of single-case methods have also described meta-analysis procedures analogous to those used in group outcome studies with which to evaluate and summarize the results from a series of individual studies. Finally, it is also important to ensure that single-case research is not only generalizable but also clinically replicable within ordinary clinical settings.

IV. SUMMARY

We have attempted to review the general principles underlying single-case design and to suggest that they might play a role in helping to establish both the efficacy and effectiveness of psychotherapeutic interventions. Such a methodology might assist psychotherapists to address the combined agenda established by the influential "evidence-based medicine" and "managed care" movements and in doing so, encourage practicing clinicians to evaluate their clinical work and engage in clinical research. However, it should be recognized that much of the work published using single-case methods has derived from more experimentally based psychotherapies and that many of the fundamental principles underlying this approach might be antithetical to some psychotherapies, especially those that are more dynamically oriented. Notwithstanding these potential obstacles to the implementation of single-case approaches, I should like to invite the interested therapist to explore how these approaches might be integrated with their own therapeutic work. To achieve this, it will be important to identify clear clinical formulations, which link to therapeutic strategies. These strategies need to identify various therapeutic goals that can then be assessed as clinical outcomes and reliably and repeatedly measured. In addition, the clinician will also need to be disciplined so as to follow a predetermined therapeutic strategy but also to be sufficiently flexible so as to engage the client and be ready to reformulate and redirect the therapy, as the therapeutic process unfolds.

See Also the Following Articles

Efficacy ■ Outcome Measures ■ Research in Psychotherapy ■ Single-Session Therapy ■ Solution-Focused Brief Therapy ■ Termination

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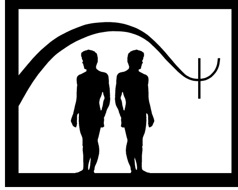

Single-Session Therapy

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I. Overview
II. Theoretical Underpinnings
III. Research Findings
IV. Summary
Further Reading

GLOSSARY

brief therapy Psychotherapy, typically of short duration, in which efficiency in achieving change is an explicit aim. Sometimes referred to as time-effective or short-term therapy.

Ericksonian therapy Psychotherapy, typically brief, derived from the work of Milton Erickson. It seeks to maximize therapist influence through the strategic use of language, the accessing of altered states of mind via hypnosis, and the use of directed tasks.

single-session therapy A form of brief therapy in which there is a planned attempt to address the presenting concerns of clients within a single visit. Often makes use of techniques derived from Ericksonian, strategic, and solution-focused therapies.

solution-focused therapy Form of brief therapy that seeks to identify and/or construct exceptions to client problem patterns and reinforce these as solutions. Inspired by Ericksonian and strategic therapies.

strategic therapy Form of brief therapy that seeks to interrupt and alter self-reinforcing patterns in which attempted solutions to problems actually contribute to their maintenance. Inspired by Ericksonian therapy.

I. OVERVIEW

Single-session therapy is a general term that is used to describe any form of psychotherapy that seeks to address the presenting problems of clients within a single visit. It is hypothetically possible for any form of psychotherapy to be conducted in a single session and, indeed, Freud's case studies include cures that were achieved after one meeting. In practice, however, it is unusual to find either cognitive-behavioral or psychoanalytic brief therapists conducting single-session therapy. This is because the models of change underlying these approaches emphasize the value of repeated experience in building new patterns of thought, feeling, and behavior. The learning models associated with cognitive-behavioral modalities, for example, emphasize the acquisition of skills through deliberate rehearsal. Such practice generally requires more than one visit. (A notable exception would be massed practice in behavioral therapies, where desensitization might be undertaken in a single, extended session, as in the implosive therapy of Levis.) The relationship models underlying brief psychoanalytic therapies stress the importance of creating powerful emotional experiences for clients, which also are rarely undertaken in a highly abbreviated span.

Most single-session therapies draw on contextual models of change that emphasize the constructed nature of client presenting problems. Problems are seen as client construals, not necessarily as illnesses or problems that possess an independent existence. These construals

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are maintained by elements in the client's intrapersonal and interpersonal contexts and become reified over time. From this perspective, a long-standing problem is not necessarily any deeper than a recent one and might be amenable to short-term treatment. By shifting the contexts in which the client is operating and providing insights and experiences that dislodge problematic construals, therapists can catalyze significant change in a single meeting.

The majority of single-session therapies emphasize the role of the therapist in initiating change, rather than effecting a cure. Although problems can be dislodged and new construals introduced in a single visit, it is generally not possible for clients in single-session therapy to generalize these changes to a variety of life situations. As a result, single-session therapies are not seen as ideal treatment modalities for all people. Commonly cited contraindications for single-session therapy include the following.

- *Chronic, severe presenting problems*: The client with long-standing problems that significantly impair functioning often needs coordinated efforts at rehabilitation, rather than a brief episode of therapy. Although techniques derived from the brief and single-session literatures may be helpful for such individuals, they typically do not meet the full spectrum of client needs.
- *High need for support*: Clients who have poor support systems may want to rely on the therapist as a support and, indeed, may need that support to assist them in leaving an abusive relationship or changing an addictive pattern. A single-session treatment, by definition, cannot offer ongoing support to such individuals and could even prove detrimental to clients with issues related to attachment and separation.
- *Troubled interpersonal history*: Single-session therapies are effective to the degree that they utilize techniques that maximize the influence of the therapist. Clients who have experienced a history of abusive, neglectful, or highly troubled relationships often need an extended period of time before they can learn to trust a therapist. This severely limits the usefulness of single-session work.
- *Low readiness for change*: Clients who are ambivalent about making changes generally need to explore problem patterns and their consequences before developing the motivation to initiate and sustain efforts at change. This generally extends the duration of therapy beyond brief parameters, and certainly beyond the length of a single session.

Although these contraindications are significant, single-session therapies may be more useful for clients than is commonly acknowledged. Studies of utilization of therapy in outpatient settings suggest that approximately one third of all clients only attend a single session, often reporting that the brief intervention was sufficient for their needs. Appropriately utilizing highly abbreviated treatments for clients can preserve resources for others who most need them in capitated settings and clinics with staff limitations. Generally, clients who are the best candidates for single-session therapy display:

- *Adjustment problems, situational problems, and nonsevere disorders of recent origin*: Individuals who are not overwhelmed by their presenting problems are most likely to be able to take the results of a single visit and apply them to their lives.
- *High levels of motivation*: Because there will not be future sessions to carry the change process forward, clients who are to benefit from single-session work need to be able to sustain their own efforts at generalization.
- *Awareness of a focal problem*: Limiting therapy to a single session places therapist and client in an action mode from the start. If clients lack a focus for therapy, it is likely that more than one session will be needed to define and implement a therapeutic contract.

Although there are several different approaches to single session therapy, all share features that differentiate them from lengthier brief therapies. These include the following:

- *Beginning therapy before the first session*: A number of writers on single-session work emphasize that change begins at the time the first appointment is made. Often, the therapist will talk with the client at the time of first contact and suggest a task that can be accomplished prior to the first session. By encouraging pretherapeutic efforts at change, therapists can use their single session to focus on positive efforts already under way.
- *Addressing time at the outset of therapy*: Many approaches to brief therapy aim to be efficient but do not expressly address time during the first session. Single-session therapists generally preface treatment with an explanation that one visit is often enough for clients, even as they leave the door open for further meetings as needed.
- *Active attempts to utilize ideas and language introduced by the client*: Single-session therapists do not

have the luxury of stimulating and working through the resistances of clients. Rather, they attempt to build on frameworks already utilized by the client to elicit cooperation.
- *Rapid introduction of impactful interventions*: With a limited time available for catalyzing change, single-session therapists must move quickly from a problem-based mode to one in which new patterns are introduced. Often this is accomplished in ways that will maximize their impact, by employing vivid language, hypnotic suggestions, directed tasks, and novel reframings.

Just as brief therapy appears to represent an intensification of the common factors that account for the effectiveness of all therapies, single-session therapies are, in essence, a distillation of methods utilized in brief treatments. The quick establishment of rapport, rapid definition of a treatment focus, and active introduction of novelty in pursuit of change make single-session therapy a brief version of brief therapy.

II. THEORETICAL UNDERPINNINGS

Much of the writing on single-session therapy owes its inspiration to three strands of practice in the brief therapy literature:

1. *Ericksonian therapy*: A number of authors, including Jay Haley, Richard Bandler, John Grinder, and Stephen Lankton, have attempted to identify the elements of practice that distinguish the work of Milton Erickson. These elements include the creative use of language to influence clients, the introduction of hypnotic trance to shift clients' perception, and reliance on directed tasks to interrupt existing problem patterns. Many of these methods are attempts to bypass the normal, verbal, conscious awareness of individuals and introduce change experientially and emotionally. By affecting clients directly, Erickson found that the duration of therapy could be greatly reduced.

2. *Strategic therapy*: Therapists operating from a systems perspective, including Paul Watzlawick, John Weakland, and Richard Fisch, extended Erickson's pioneering work, creating short-term approaches to therapy that could be used for families and individuals. A central tenet of this strategic approach is that presenting problems are artifacts of self-reinforcing cycles, in which attempted solutions maintain the initial problems. For instance, a spouse hurt and angry over a perceived lack of attention may attack the partner, producing even further distance. By placing clients in contexts that could not support the self-maintaining cycles, strategic therapists provide powerful experiences that break the old patterns and allow for the introduction of new ones.

3. *Solution-focused therapy*: A new tradition was inspired by the work of Steve deShazer who conceptualized therapy as a search for solutions rather than an exploration and analysis of problems. This solution-focused approach, elaborated by such therapists as William O'Hanlon and Jane and Walter Peller, can be readily adapted to the single-session framework. By focusing on client goals and quickly initiating a search for imagined or experienced exceptions to client patterns, solution-focused therapists are able to quickly move treatment to an action phase, greatly abbreviating the change process.

Common to all three approaches is a postmodern epistemology, which emphasizes that reality is actively constructed, both in the cognitive processes of the individual and in social interaction. When something negative happens on multiple occasions, it becomes an object of attention and may be construed as a problem. Once so identified, the behaviors in question typically elicit further distress and efforts at coping. Many of these dampen distress in the short run, but exacerbate the initial concerns. By introducing novel approaches to the situation, through metaphor, story, or directed task, the therapist aids in the construction of a new reality. This opens the door to more flexible responding and the possibility of developing constructive behavioral patterns.

This postmodern conceptualization of problem formation and change provides much of the rationale of single-session therapies. Many alternate conceptions of therapy emphasize the existence of a problem that must be evaluated and subjected to various therapeutic interventions. The postmodern perspective stresses that the problem, in an important sense, does not exist other than in the eyes of the client; it is part of the client's mental map—not an enduring feature of the landscape. Even relatively small shifts in the map can produce new patterns of thinking, feeling, and acting that can assume a life of their own. This can be observed in the "pivot chords" described by Robert Rosenbaum, Michael Hoyt, and Moshe Talmon, who use ambiguity in client verbalizations to open the door to new ways of construing problematic situations.

An additional theoretical assumption that permeates single-session modalities is the notion that clients essentially possess all they need to overcome their problems.

Rather than view individuals as existing in a deficit state where they need treatment from professionals, single-session therapists emphasize their existing adaptive potentials. This is most clearly seen in solution-focused approaches, in which the emphasis of therapy is on exceptions to presenting problems and patterns. These exceptions may be imagined ("What would life be like if you did not have the problem?") or may be inferred from the client's own experience. By framing such exceptions as constructive actions that the client can initiate, the single-session approaches bypass much of the early phase of problem definition and analysis and quickly move to an action stage.

III. RESEARCH FINDINGS

Controlled outcome studies comparing single-session therapy to other forms of intervention have yet to be reported in the literature. Nonetheless, several strands of research represent initial attempts to build an empirical basis for these approaches. Moshe Talmon reports several studies that have found 30% of all clients attending therapy for a single session. Follow-up investigations with those clients found that approximately 80% were satisfied with the limited intervention and reported some or much improvement.

Studies at the Brief Family Therapy Center in Milwaukee have generally supported the effectiveness of solution-focused therapy and have found that pretreatment interventions result in noticed positive change in 60% or more of all clients. This is particularly true of Formula First Session Tasks, which ask clients to observe what is happening when things are going positively. Clients performing such tasks have been found to be more cooperative in therapy than clients not performing the tasks and have reported greater improvement by the second session. Other studies have found that the amount of change-related talk engaged in by therapists and clients is predictive of success.

Although these studies are encouraging, it will remain for controlled outcome studies comparing single-session interventions to other modalities to establish the long-term success of very brief work and the degree to which outcomes are attributable to specific interventions rather than general factors.

IV. SUMMARY

Single-session therapies are a collection of approaches that attempt to maximize change within a single visit. Most of these approaches owe their genesis to the pioneering work of Milton Erickson and the subsequent development of strategic and solution-focused therapies. Built largely on a postmodern epistemology, they emphasize the constructed nature of client concerns and the role of the therapist in identifying contexts and experiences that allow for alternate constructions. Such approaches are best suited for clients who are motivated to change focal patterns, especially those who are experiencing situational or adjustment concerns and are capable of establishing a rapid therapeutic alliance.

See Also the Following Articles

Brief Therapy ■ Cost Effectiveness ■ Individual Psychotherapy ■ Minimal Therapist Contact Treatments ■ Relapse Prevention ■ Solution-Focused Brief Therapy ■ Termination

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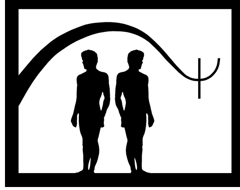

Solution-Focused Brief Therapy

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I. Basic Posture
II. SFBT Procedures and Techniques
III. The Miracle Question
IV. Theoretical Foundation
V. Follow-up Studies
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GLOSSARY

coping questions Techniques that are designed to empower clients to manage their life more effectively by addressing their coping style.

miracle question Technical intervention in which the client is asked to think in an unlimited range of possibility and to identify changes that they want to see happen.

scaling questions Technical approach that encourages the client to prioritize and put into an ordinal relationship various issues, including efforts to problem solve, as well as problems.

SFBT (Solution Focused Brief Therapy) is an approach to delivering psychotherapy based on a variety of theoretical positions, such as Milton Ericson's ideas and Wittgenstein philosophy of language. SFBT focuses on solutions rather than problems.

Solution-focused brief therapy (SFBT) was developed through the work of Steve de Shazer, Insoo Kim Berg, and their colleagues at the Brief Family Therapy Center in Milwaukee, Wisconsin. It is a model that has been developed inductively based on 30 years of sessions with clients. It has been used successfully in a variety of settings including rehabilitation centers, psychiatric hospitals, residential treatment centers, child protection agencies, schools, and private practices. This treatment model is based on the hypnotherapeutic work of Milton H. Erickson, as discussed by Haley in 1967, and influenced by the 1974 work of John H. Weakland, Paul Watzlawick, and Richard Fisch of the Mental Research Institute.

I. BASIC POSTURE

As the name suggests, SFBT is defined by its emphasis on solutions rather than problems. Different from problem-based therapies in which a great deal of time is spent assessing problems, understanding in as much detail as possible what a client is doing wrong, or developing hypotheses about what is wrong with the client and family system, and the therapist prescribing solutions, SFBT focuses on finding solutions and gives minimal attention to defining or understanding presenting problems.

A description of the SFBT treatment model includes the following: therapist attitudes, socializing, goal negotiation, miracle question, exception questions, scaling questions, coping questions, and the consultation break and intervention message. In addition, three types of client–therapist relationships are described: visitor type, complainant-type, and customer-type.

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Therapists' beliefs and attitudes influence how and what they listen to when talking with clients. SFBT emphasizes attitudes of client competence, and the importance of how language is used in conversation with clients. All therapists, regardless of their approach, come with certain attitudes and philosophies that affect how they do treatment. For example, all therapists are selective in their choice of what they ask about and what they ignore, depending on the underlying assumptions they hold about what is useful and helpful for their clients to talk about. Far from serving the "objective" purpose of "merely" gathering data, the questions therapists actually raise with clients influence and change clients' thinking about themselves. Solutions for clients are not scientific puzzles to be solved by practitioners, but rather changes in perception, patterns of interacting and living, and meanings that are constructed within the clients' frame of reference. The SFBT therapist assumes that clients are competent at conceptualizing an alternative more satisfying future and at figuring out which of their strengths and resources they can draw on to produce the changes they desire. The client is the expert of his or her problems and has legitimate goals and ways to facilitate change. For example, a client with an alcohol problem may want to improve his relationship with his wife and children and may not initially want to stop drinking. Accepting this initial goal as a reasonable first step makes it possible to further examine his desired state of life.

The therapist assumes a collaborative stance, with the client and therapist working together to bring about goals the client decides on. Berg and De Jong in 1996 described exploring and affirming clients' perceptions as clients describe them as a major share of what is done in SFBT. Even when clients are considering extreme actions—suicide or violence—they do so within a context of several associated perceptions. For example, to a client who thinks of hitting a child, an SFBT therapist might say, "What's happening in your life that tells you that hitting your child might be helpful in this situation? What else? Does it work? Suppose you were to do that, what would be different between you and your child? What would be different between you and your other children, the courts, your family?" As clients are respectfully asked about their perceptions, they usually are able to talk about less extreme possibilities. Berg and De Jong in 1996 described the therapist assuming a "not knowing" or curious stance in talking with clients. The therapist is always in the stance of learning the clients' perceptions and explanations, never knowing a priori the significance of the client's experiences and actions.

Finally, the therapist's job is to learn the language of the client. Rather than believing that language describes reality, it is believed that language also conveys information about what the therapist is interested in learning from the client. Being problem focused, clients often use language as if to describe their relationships and experiences, assuming, for example, that "being close" means the same for everyone. Often, although their language is very meaningful to them, it may be vague to a therapist. Clients use language to describe their relationships and experiences. Examples of techniques that begin to clear up the ambiguity are for the therapist to repeat key words used by a client, clarify what a client means by certain words, and use the actual words a client uses in the conversation. The therapist listens carefully for and explores each client's choice of words. This not only demonstrates respect for the client, it also begins a process in which, as therapists speak the client's language, clients begin to speak the solution-focused language of therapists.

II. SFBT PROCEDURES AND TECHNIQUES

All therapy, regardless of model, begins with a phase of socializing and orienting clients to what is to come. de Shazer and Berg describe initial questions directed at areas in which clients are successful or from which they draw satisfaction or esteem. Early on in the conversation, the SFBT listens for and highlights client strengths and successes. For example, beginning a conversation with clients by asking them what they are good at, what they enjoy, their job, hobbies, talents, past achievements, or ambitions for the future begins a dialogue between the therapist and client about identifying issues they both can agree are going well for the client. Client strengths, resources, and abilities are highlighted rather than their deficits and disabilities. This approach tends to look for what is right and how to use it. Asking clients early on what they are good at sets a different conversational path than "what problem brought you here today?" This communicates to the client that the therapist recognizes that even though the client has problems, he or she also has areas that are successful. Often these strengths, although unrelated to the presenting problem, bring early clues about how the client will solve their problems.

Co-constructing goals with clients is a very important feature of SFBT. Clients generally are much more aware of, for example, the problems and what they do

not want in their lives than they are about what they want to be different. Many clients begin the discussion of goals as the absence of problems; however, SFBT conceptualizes goals as the presence of what the client wants. Berg and Miller describe goals as criteria that the client and therapist determine together that would tell them they have succeeded and can end therapy. They include the following: Goals must be important to the client and be viewed as personally beneficial; they must be small enough so they can be achieved; they must be concrete, specific, and behavioral and stated in positive, proactive language about what the client will do instead of what he or she will not do. Goals must also be perceived as involving hard work for the client. For example, instead of drinking, a client may make an arrangement for a designated driver before going out on the weekend, or get to work on time. This is in contrast to a vague goal of improving one's self-esteem or being happy.

III. THE MIRACLE QUESTION

Berg and De Jong describe how the miracle question gives clients permission to think about an unlimited range of possibilities, and identify changes they want to see happen. Because the question has a future focus, it begins to move the focus away from their current and past problems and toward a more satisfying life. The miracle question stated in the following way frequently draws a rich response from clients.

> Suppose (pause) after we talk today, you go home (pause) and sometime in the evening you go to bed (pause) and in the middle of the night (pause) while you are sleeping, a miracle happens and the problem that brought you here today is solved (pause), but because this happens while you are sleeping, you don't know that the miracle happened until you wake up in the morning. So when you wake up tomorrow morning, what will make you wonder, "something is different, maybe there was a miracle last night?"

Getting details of the miracle is important and the therapist's follow-up questions are crucial. Asking "what else will be different, what else?" is a helpful question to explore. The more opportunities a client has to rehearse a successful outcome verbally, the more chance the miracle has of beginning in small ways to become real for him or her. The miracle question can be an empowering experience for clients as they begin to imagine a painful life transformed to a more successful and fulfilling life. The gift of hope and a vision can be a truly healing experience for clients.

Exception finding questions are another tool used in SFBT. An exception to a problem occurs when the client engages in nonproblem behavior (e.g., does not drink, does not feel depressed, and does not fight with his wife). The therapist's job is to listen for and magnify a client's successes through repeated emphasis on those few, but important, exceptions. When repeated often and examined in detail, successes become more real to the client. The client can then begin to see their success and recognize that they actually have taken steps to improve their life. Thus the client can take responsibility and credit for the solution. An example would be exploring in detail those times when a client does not drink: What was she doing?—Who was she with?—Where was she?—What did other people notice during that time? Other questions to ask include inquiring about times when things have gone better between sessions, and helping clients describe times when some pieces of the miracle have already happened before therapy began. Getting as much detail about what was happening during these times (who, what, when, where, how) and including other important persons behaving differently during these times, provide further contextual information in these important moments.

Scaling questions are another useful technique used in SFBT. As deShazer states, "there is magic in numbers." An example of a scaling question is "on a scale from 0 to 10, with 0 representing the worst things could be for you and 10 the day after the miracle, where on the scale would you say you are now?" Frequently, clients will give a rating of "3." The therapist then helps them describe the differences between "0" and "3" and how other people might see those differences, and what it might take to "get all the way up to 3." Suppose a client answers "1." The therapist may respond "How are you able to keep going?" "What gives you the strength to continue?" When a client is asked to put problems, successes, hope, and level of self-esteem on a numerical scale, it gives the therapist useful information about a client's relationships, confidence in change, and self-esteem, and helps to determine an end point for therapy. An example is, "At what number on the scale will you be when things are going well enough that you no longer feel you need therapy?" It can also help the client describe contextual details of his or her experience. An example is, "Where would your mom/dad/best friend/spouse/boss/probation officer say you are on the scale?" Finally, scaling questions can also help clients create small goals for change. Asking a client what will be different when they go from

a 3 to a 4 (not a 10), forces clients to think about taking small, more realistic steps toward change.

Coping questions can also be very useful in SFBT. Questions about how clients are managing their life can be very empowering to clients. Examples, include, "How are you able to keep going when your life feels like it's falling apart?" "How do you manage day to day?" Questioning clients about how they are coping with big problems shifts the conversation from hopelessness to hope and a sense of control. However small it may seem, the small things the client does to "barely cope" are the very things that the client must do more of "one day at a time" in order to create a basis on which to build more successes. "How come you life is not worse?" is used to "blame" the client for their success. Such "positive blame" assigns the responsibility for positive, helpful behaviors to the client.

Frequently, an SFBT session includes a team behind a one-way mirror and the therapist meets with them 10 to 15 minutes before the end of the session to develop a closing message to the client. Working alone (which is the most common practice) and taking a 5 to 10 minute break after 45 minutes of a session allows the therapist to review the session, take time to think about whether there are well-formed goals, and to decide on a feedback message for the client.

SFBT feedback messages include compliments, which are used with all cases and throughout the treatment process. All cultures use compliments as a means of cementing social relationships at all levels. Clients have personal qualities and past experiences that, if drawn on, can be of great help in solving their difficulties and creating more satisfying lives. Compliments can be direct or indirect. During the interview, for example, direct compliments can be developed from times when clients are resilient in the face of hardships, sober for even 1 week, able to hold down a job, care about their children, work hard, or are willing to come get help. Compliments are best when they are based on reality and incorporate the client's language. Indirect compliments are questions that imply that the client has done something positive. For example, "How have you managed to stay sober for one week?" "How have you managed to stay calm when things are so hectic?" This allows clients to speak aloud themselves about the details of their success. When clients are able to speak themselves, they appear more empowered in their ability to find solutions.

Suggestion for homework is frequently prescribed at the end of an SFBT interview. Deciding on what type of intervention to prescribe depends on what stage of relationship the client has with the therapist. SFBT describes three types of client–therapist relationships: visitor-type, complainant-type, and customer-type. Visitor-type relationships are those in which the client has not yet created a workable goal. Often these clients are mandated through probation officers, employers, or parents. Interventions with these clients focuses on giving frequent positive feedback on what the client is already doing that is helpful and working. Providing these clients with many compliments is often a very different message than what they have frequently heard, and may help make these clients more interested in treatment. Complainant-type relationships involve clients that have created some workable goals, but view their solutions lying outside of their control. In addition to using compliments, suggestions are made to shift the client's perception from someone who is a helpless victim to someone who can create solutions. Interventions encouraging clients to "observe and think" about what they will notice will be different when the miracle happens is an example. Because these clients are observers, but not yet "doers," this meets the client where he or she is. Customer-type relationships are those in which the client is willing to actively "do" something differently, to actually take steps to find solutions in his or her life. Clients are frequently asked to do more of what is working, pay attention to any part of the miracle that is happening, or imagine a miracle day.

IV. THEORETICAL FOUNDATION

The theoretical underpinnings of SFBT come from several sources including social constructionism, Wittgenstein's philosophy of language, and Milton Erickson's ideas on therapy. Social constructionism maintains that people develop their sense of what is real through conversation with and observation of others. Social constructionism holds that reality, as each individual perceives it, is by definition subjective and created through the process of social interaction and the use of language. SFBT asserts that problems occur in interactions between individuals and do not rest within any one individual. People define and create their sense of what is real through interaction and conversation with others, a form of negotiation carried out within the context of language. SFBT helps clients do something different by changing their interactive behaviors or the interpretations of behaviors. This approach makes no assumptions about the "true" nature of problems. SFBT has a strong orientation toward the present and future and further believes that everyone's future is

negotiated and created. How clients are currently living their lives and their future goals are emphasized, thus orienting the client away from the past problem toward the future solution.

This model differs from the traditional "medical model" in a number of ways. Rather than assessing problems, signs, and symptoms, SFBT assesses for solutions, exceptions to problems, and strengths within an individual and his or her social context. It further focuses on past successes, coping strategies, and resources and collaboratively co-constructs a solution with the client.

Language is a resource that is vital to all therapists' practices and relationships with their clients. The importance of language in SFBT is crucial. Gail Miller and Steve de Shazer in 1998 wrote about how meanings of words are inseparable from the ways in which people use them within concrete social contexts. Problem-focused language emphasizes what is wrong with people's lives, and frequently portrays the sources of our problems as powerful forces that are largely beyond our control or understanding. In contrast, solution-focused language focuses on finding ways of managing one's problems. Solution-focused therapists ask, "Since we talk ourselves into problems and solutions anyway, why not emphasize solutions." This is not to deny the deprivations and injustices in clients' lives, but to help get through and beyond them. This model uses postmodern assumptions that problems and solutions are talked into being, and meaning is changeable based on our use of language.

V. FOLLOW-UP STUDIES

Having been inductively developed in clinical settings by de Shazer in 1985, Berg in 1994, Berg and Reuss in 1997, and Berg and Kelly, in 2000, rigorous research that shows its effectiveness is only beginning to emerge. There is a great deal of informal studies scattered throughout in a variety of settings. However, a rigorous study design using random selection of population, controlled, and experimental groups, and pre–post measures is just beginning to emerge. We recognize that such data are necessary. What has emerged so far seems to show promise in its effectiveness and cost in terms of human suffering and dollars.

In 2000, Gingerich and Eisengart performed a review of SFBT outcome research. This article critically reviewed a total of 15 studies. Additionally, it reviewed early follow-up studies documenting SFBT outcomes.

Early follow-up studies used follow-up surveys by asking clients at 6 to 18 months whether they had met their goal. In the first study, de Shazer in 1985 reported an 82% success rate on follow-up of 28 clients. The next year, de Shazer et al. reported a 72% success rate with a 25% sample of 1600 cases. Subsequent studies by De Jong and Hopwood in 1996 and Kiser in 1988 have reported similar results. Other follow-up studies of SFBT have similar, but somewhat smaller success rates and have used subjective outcome measures, such as those by Lee in 1997, Macdonald in 1997, Morrison, Olivos, Dominguez, and colleagues in 1993, and Schorr in 1997. Although these follow-up studies provide feedback on SFBT outcomes, their lack of experimental control does not permit causal inferences to be made about the effectiveness of SFBT.

Gingerich and Eisengart reviewed 15 controlled studies that implemented SFBT, employed some form of experimental control, assessed client behavior or functioning, and assessed end-of-treatment outcomes. These studies were further divided into well-controlled, moderately controlled, and poorly controlled studies based on the number of standards met for assessing empirical support for psychological treatments developed by the American Psychological Association.

The well-controlled studies included studies on depression in college students, parenting skills, rehabilitation of orthopedic patients, recidivism in a prison population, and antisocial adolescent offenders (the studies were those of Cockburn, Thomak, and Cockburn in 1997; Lindforss and Magnusson in 1997; Seagram in 1997; Zimmerman, Jacobsen, MacIntyre, and Watson in 1996; and Sundstrom in 1993). Four found SFBT to be significantly better than no treatment or standard institutional services. Because these studies did not compare SFBT with another psychotherapeutic intervention, they were not able to conclude that the observed outcomes were due specifically to the SFBT intervention as opposed to general attention effects. One study by Sundstrom in 1993 compared SFBT with a known treatment (IPT) and found SFBT produced equivalent outcomes (no significant differences were found). None of the five studies met all of the stringent criteria for efficacy studies and thus one cannot conclude that SFBT has been shown to be efficacious. They do, however, provide initial support for the efficacy of SFBT. The remaining 10 studies contain methodological limitations that preclude drawing firm conclusion, but their findings are consistent with the general conclusion of SFBT effectiveness.

Gingerich and colleagues identify several future areas of need in subjecting SFBT to empirical test. First is the specification and proceduralization of SFBT itself with the consistent use of detailed treatment manuals

and treatment adherence measures. In addition, future efficacy studies will need to compare SFBT with other empirically validated interventions where therapist allegiance is equally balanced between treatments. Other considerations include specification of study sample, selection of the comparison group, adequate sample size, and using conventional diagnostic groupings.

Although the current studies fall short of what is needed to establish the efficacy of SFBT, they provide early support that SFBT is useful to clients, according to Gingerich et al. The wide variety of settings and populations studied suggests a broad range of applications, but this conclusion awaits more careful study.

See Also the Following Articles

Outcome Measures ■ Single Session Therapy ■ Working Alliance

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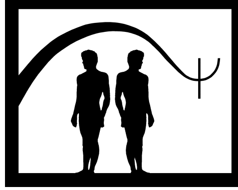

Somatoform Disorders

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I. Description of Treatment
II. Theoretical Bases
III. Empirical Studies
IV. Summary
Further Reading

GLOSSARY

behavioral therapy Psychotherapy directed at changing observable and measurable behavior through a variety of techniques including monitoring, incremental change, shaping, and operant conditioning.

body dysmorphic disorder A preoccupation with an imagined defect in appearance.

cognitive therapy Psychotherapy directed at identifying and changing dysfunctional thoughts, perceptions, attitudes, and beliefs.

conversion disorder A symptom that mimics a neurologic problem (i.e., blindness, paralysis) that is not due to any neurologic problem, other medical condition, or substance but rather is thought to be due to psychological distress from a social stressor or psychological conflict.

factitious disorder Physical or psychological symptoms that are intentionally produced to assume the sick role.

hypnosis A mental state characterized by relaxation, concentration, and suggestibility in which perception and memory may be altered.

hypochondriasis A long-standing worry or fear of having serious illness in which one misinterprets physiologic sensations and minor symptoms.

iatrogenic Caused by a physician or his or her treatment.

narcotherapy An interviewing and psychotherapeutic technique involving sedative drugs, usually sodium amytal to induce relaxation.

pain disorder Pain complaints not completely attributed to a general medical condition. Purely psychological and combined medical and psychological types are described in DSM–IV–TR.

personality disorder A pervasive maladaptive pattern of relating to the environment and others that impairs function. Usually personality disorders arise in adolescence or the early adult years.

primary gain The decrease in anxiety or other unpleasant feeling attributed to the unconscious suppression of internal drives or conflicts.

psychoanalytic psychotherapy Psychotherapy derived from the theories of Freud that emphasizes the use of free associations, dream interpretation, and analysis of transference to bring to awareness repressed emotions and unconscious conflicts. Psychoanalytic psychotherapy focuses these techniques on the current conflicts and problems in the person's life rather than the very early life experiences and conflicts central to classical psychoanalysis.

psychodynamic psychotherapy Psychotherapy that incorporates a role for unconscious conflicts and motivations in human behavior but also recognizes the influence of life experience, current situational stressors, and biological predisposition in determining behavior. Techniques and issues emphasized are more varied than in either classical psychoanalysis or psychoanalytic psychotherapy.

secondary gain The support obtained from other people or systems due to a symptom or illness or the avoidance of an unpleasant, aversive situation due to a symptom or illness.

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selective serotonin reuptake inhibitor (SSRI) Antidepressants that prevent the neuron from recycling serotonin released into the synaptic cleft, thereby increasing the amount of serotonin present at the synapse.

serotonin A neurotransmitter implicated in many mental disorders, especially major depression and obsessive–compulsive disorder.

social learning theory The theory that individual behavior is determined in large part by behaviors one has observed in others.

somatization The general process of presenting physical symptoms and concerns that are not explained by a general medical illness presumably as a manifestation of psychological distress or conflict or social stress.

somatization disorder A long-standing disorder involving multiple physical complaints and many organ systems usually developed at an early age and stable over time.

somatoform disorders The *Diagnostic Statistical Manual of Mental Disorders* category describing disorders that involve physical symptoms not attributable solely to general medical conditions or substances.

supportive therapy Psychotherapy directed at reinforcing a patient's defenses as a way of improving the ability to cope with psychological distress.

I. DESCRIPTION OF TREATMENT

Treatment of individuals with somatoform disorders represents a unique challenge for the psychotherapist in that the core deficit in these individuals is the inability to recognize the role of psychological and social conflicts and stressors in the development of their physical symptoms. These individuals are unlikely to present to psychotherapists for treatment initially and are often resistant to referral for psychiatric or psychological consultation. For many patients with somatoform disorder, the most important therapeutic relationship remains the primary care physician. The mental health consultant may assist this physician in maintaining a therapeutic stance with these often taxing and frustrating patients. For instance, the psychiatrist in this consultant role may assist the physician and patient by confirming the diagnoses and advising the referring physician about the general principles of management of somatoform disorders:

1. Maintain regular, consistent contact with a single physician.
2. Minimize invasive diagnostic procedures and aggressive treatments without objective evidence of physical disease.
3. Gradually, and in a nonconfrontative manner, work toward helping the patient recognize the connection between stressors in their lives and their physical symptoms.

The process of somatization is not limited to individuals with somatoform disorders. Other disorders, especially depression and anxiety disorders, frequently present with prominent somatic symptoms. In addition, individuals with somatoform disorders often suffer from other mental disorders such as depression, anxiety, and personality disorders. Treatment of these co-existing disorders may improve the individual's function even when the somatoform disorder persists.

The somatoform disorders, as described in *DSM–IV–TR* are a heterogeneous group of disorders that currently are lumped together due to the common characteristic of a physical complaint or complaints that are not completely explained by a general medical condition or a substance. Included in this category are somatization disorder, undifferentiated somatoform disorder (an abridged form of somatoform disorder), conversion disorder, pain disorder, hypochondriasis, body dysmorphic disorder, and somatoform disorder not otherwise specified (a residual category for presentations that do not fulfill criteria for the other somatoform disorders). Somatoform disorders vary greatly in the number and type of symptoms presented and systems affected, the duration of symptoms, the age of onset, the gender distribution, and the prognosis. In contrast to factitious disorder, the physical symptoms are not believed to be intentionally produced. Treatment approaches, for somatoform disorders, although unified by the general management principles already described also vary. Despite the fact that many of these disorders, especially somatization disorder (also known as hysteria, or Briquet's syndrome), conversion disorder (also named conversion reaction or hysterical conversion), and hypochondriasis have received much attention in the history of psychotherapeutic theories and treatments, there remains a dearth of well-controlled psychotherapeutic trials specific to each disorder. A general summary of treatment approaches for the principle types of somatoform disorder follows. Details of these treatments are discussed under the Empirical Studies section.

A. Somatization Disorder

Somatization disorder is characterized by the onset at an early age, usually late teens to early 20s but by

definition by age 30 of multiple physical complaints. Females are afflicted over males by a ration of 10 or 20: 1. The disorder by definition has been present greater than 6 months. This disorder has in the past been known as Briquet's syndrome or hysteria. The complexity of the criteria has diminished over the years but still requires the presence of multiple symptoms involving several organ systems. The typical patient has had many surgeries at an early age, preceded by multiple workups for a variety of physical complaints. These individuals seldom seek psychiatric or psychological treatment because from their point of view, their problems are physical not mental in nature. In addition, to multiple surgeries and procedures, these patients may also suffer from iatrogenic side effects from a multitude of medications. Direction to the family physician to schedule regular, not as needed appointments, which include focused physical exams, to minimize testing and treatments and to gradually shift the focus of attention from physical complaints to stressors in the patient's life may help decrease health care utilization and avoid complications of procedures and treatments. Group therapy aimed at coping with the stress of a chronic medical condition has also been recommended. In a group setting, these individuals are said to be capable of recognizing and confronting this pattern of somatizing to an extent not possible in individual therapy. In addition, they may benefit from the support of others with similar conditions.

B. Conversion Disorder

Conversion disorder is characterized usually by only one symptom at a time, and this symptom, by definition, mimics neurologic disease. Historically, the type of symptoms has extended beyond those that mimic neurologic disease but neurologic-like symptoms (seizures, paralysis, numbness, deafness, or blindness) have always also been the most prominent. Commonly, the patient has both underlying diseases as well as conversion symptoms. Conversion disorder also is more common in women than in men and is found in both chronic (greater than 6 months) and acute (less than 6 months) forms. Due to the relatively high rate at which individuals either are later diagnosed with neurologic disease or have concurrent neurologic disease, the recommendation to minimize workups to exclude organic causes, generally made for somatoform disorders, is not applicable to conversion disorder. However once this workup is completed, the same principles of supportive, benign management prevails. Most authors advocate a nonconfrontative yet authoritative explanation that recovery is expected over a relatively brief period of time. An explanation that medical tests do not show signs of any serious progressive disease should be provided without confrontation or argument and without suggesting that the problems are "all in your head." These straightforward prescriptions for recovery allow most individuals to return to normal function. In cases in which suggestions and reassurance alone do not result in recovery, physical rehabilitation and other behavioral techniques such as relaxation and rest may be added. If the stressors presumed to be responsible for the conversion symptom in the first place cannot be ascertained from a standard history, then interviewing techniques such as narcotherapy or hypnosis may be used. The primary purpose of identifying the stressors is to be able to modify them through therapy. Narcotherapy and hypnosis may also be used to enhance the suggestion and expectation of recovery from the conversion symptom. Longer-term psychodynamic therapy is advocated by some for those individuals with chronic or recurrent conversion symptoms. Given that the stressor may well include marital or family issues therapy aimed at these areas may also be necessary.

C. Hypochondriasis

The essential feature of hypochondriasis is fear or worry that a symptom (often a minor physiologic sensation) represents a serious illness. This disorder is equally common in men and women. By definition, this preoccupation with disease must be present for longer than 6 months. The same general principles of conservative management with the primary care physician as principle clinician apply. Treatment of concurrent anxiety and depression is important. Cognitive therapies aimed at diminishing the focus and attention of these patients on physical sensations and reinterpreting these sensations as non-disease events has been used individually and in a group therapy format. Framing these therapies as techniques for dealing with physical distress, rather than a more direct psychological approach, may have positive results.

D. Body Dysmorphic Disorder

The essential feature of this disorder is a belief that a physical attribute is deformed or defective. These patients also do not seek mental health treatment but rather see dermatologists, plastic surgeons, and orthodontists. Psychotherapy using cognitive-behavioral

techniques has seen the greatest use in recent years. Pharmacotherapy, particularly antidepressants which inhibit reuptake of serotonin into neurons, has also been shown to be effective.

E. Pain Disorder

Pain, even when the underlying cause is established, has long been known to be influenced by the psychological and social context in which it is experienced. Likewise, psychological techniques, as well as somatic treatments have long been known to modify the experience of pain. The overlap between pain disorder described as a somatoform disorder (those for which psychological factors are thought to play a major role in pain either alone or combined with a general medical condition) and pain due solely to a general medical condition is great. Pain disorder will not be dealt with extensively in this article, but the management principles of carefully coordinating care with one physician, minimizing potentially dangerous evaluations and treatments (especially addictive drugs and radical surgeries), focusing on improving function despite pain rather than curing all pain, and gradually helping the patient recognize the role of stressors in symptom exacerbation share much in common with management of the other somatoform disorders. Although pain management must be carefully coordinated by a primary physician, the multiple techniques employed often require a multidisciplinary team. Behavior therapy is the psychotherapy employed at least initially in most pain programs.

II. THEORETICAL BASES

As mentioned earlier, the disorders currently considered somatoform are quite varied. Historically, they have been united by an assumption that they represented the physical expression of an unrecognized underlying psychic conflict or a reaction to a social stressor. For somatoform disorders, the production of physical complaints is not believed to be under voluntary control as would be the case for a factitious disorder. More recent theories about the development of somatoform disorders have shifted to the role that social learning, amplification of bodily sensations, and even genetics may play. For somatization disorder, there appears to be a link between childhood trauma, especially physical abuse, illness as a child, growing up with an ill family member, and an increased likelihood of developing this disorder. Family studies of somatization disorder in females link it with sociopathy and alcoholism in male relatives. The great importance of establishing a therapeutic alliance, usually with a family doctor, which does not depend on ongoing physical complaints or illness behavior to be maintained ties together many of these etiologic theories. It is postulated that for many of these individuals, being ill themselves was the only way to either receive nurture and care or to avoid or counter mistreatment or abuse. Unfortunately, the frustration that these patients can engender in physicians and the invasive tests and procedures that they demand may easily lead to further abandonment or punishment-like experiences. Some neuropsychological studies indicate individuals with somatization disorder may have deficits in attention and memory as well as frontal lobe dysfunction and greater nondominant hemisphere dysfunction.

Conversion disorder contains in its definition an implication of the etiologic role of stress or conflict in the development of symptoms. These symptoms have been conjectured to have symbolic meaning, that is, being unable to hear due to a torrent of past verbal abuse or being unable to move one's arms after killing another in war or in an accident. However, studies have been unable to uphold this conjecture. Similarly, the belief that patients with conversion present with a "la belle indifference," showing little reaction or emotion to great impairment has not shown to be more characteristic of conversion symptoms versus impairment, due to an organic cause. The presence of secondary gain, whereby, the patient either derives some positive attention or care for the impairment or avoids some aversive responsibility or consequence, also was once believed to discriminate conversion symptoms from other medical conditions, but this does not appear to be true. Psychosocial factors that increase the likelihood of conversion symptoms include sexual abuse, exposure to medically ill relatives, lower social economic status, less education and a rural background, and having a neurological illness oneself. Theoretical outlook has shifted from one emphasizing unconscious conflicts, that is, aggression, sexuality, dependency, which are symbolically expressed to decrease anxiety and are complicated by a resistant indifference and secondary gain, to one that retains the idea that conflicts and stressors play a critical role in development of conversion symptoms but view these as more transparent to both the therapist and the patient. Treatment has shifted emphasis from longer uncovering insight-oriented psychodynamic psychotherapy to brief supportive therapy, which emphasizes suggestion, reassurance, and the prediction of recovery. This is sometimes coupled

with behavioral and physical therapy approaches to address any issues of secondary gain, deconditioning, and other physical sequela and allow a face-saving mechanism for the patient to use in recovery. Psychodynamic therapy is still recommended by some for more chronic or relapsing cases of conversion symptoms.

Theories regarding the development of hypochondriasis include not only how it arises, but also whether it is a discreet disorder or simply a manifestation of other psychiatric illnesses such as anxiety or depression. With respect to anxiety disorders, analogies have been drawn between hypochondriasis and panic disorder, (both are sometimes involved in misinterpretation of normal physiologic sensations), hypochondriasis, and obsessive–compulsive disorder, (both incorporate the need to constantly check and be reassured that something bad hasn't happened with only temporary abatement of anxiety once reassured), and hypochondriasis and generalized anxiety disorder, (both are characterized by overreacting to and dwelling on common worries, often accompanied by physiologic symptoms of muscle tension, aches and pains, and hypervigilance). Somatic presentations of depression also show considerable overlap with hypochondriasis. Comorbidity is common, and treatment for concurrent conditions, for example with SSRI antidepressants may improve patients' overall function and in some cases ameliorate the hypochondriacal symptoms themselves. Psychodynamic theories have included a variety of beliefs including Freud's theories of object libido and later disturbed object relations, in which anger toward others is displaced as hostility toward the body. Other dynamic theories have described guilt, dependency needs, the need to suffer, as well as anger and hostility toward others as important in hypochondriasis. More recent psychological theories have focused on mechanisms of social learning and cognitive and perceptional distortions such as amplification, either alone or in combination. Hypochondriacal patients seem to misattribute normal physiologic sensations as evidence of underlying disease and believe to be free of serious illness one should be relatively free of any symptoms or distress. They are not, as they believe, more sensitive or accurate in detecting bodily sensations or symptoms, but rather they make errors of misattribution and overreporting. Because these patients then inaccurately identify themselves as ill, they then view themselves as entitled to assuming the sick role.

A direct or indirect experience with the sick role is thought by some to be an etiologic factor in development of hypochondriasis, however, data does not exist to confirm this theory. Cognitive-behavioral therapies have been developed to address the misperceptions and misattribution which hypochondriacal patients make. These therapies may be more successful and better accepted in the setting of a general medical clinic. As with somatization disorder, the initial focus of therapy may be on coping with physical distress rather than a more overtly psychological approach. The general management principles used for somatization disorder (for instance regular appointments with a single physician and minimizing testing procedures and treatments) are essential for hypochondriasis.

Body dysmorphic disorder has shared with hypochondriasis the debate whether it is a discreet disorder or arises from a spectrum of mood or anxiety disorders, especially obsessive–compulsive disorder. Recent successful treatment approaches with SSRI antidepressants and cognitive-behavioral therapies reinforce the belief that body dysmorphic disorder may be etiologically related to depression and/or obsessive–compulsive disorder. As with the other somatoform disorder, psychodynamic theories regarding the dysmorphic symptoms representing a displacement of a conflict on a body part had been made. Some have also commented on the role that societal preoccupation with appearance may play in the development of body dysmorphic disorder.

As noted earlier, the experience of pain has long been recognized to have a number of psychological, physical, and social determinates. Description of the specific theories of pain is beyond the scope of this article.

III. EMPIRICAL STUDIES

Because the somatoform disorders are quite different one from another, empirical studies typically focus on one specific syndrome, and the results from studies of one disorder should not be generalized across the entire category. With respect to general management principles of somatoform disorders, the most study has been done on somatization disorder. G. Richard Smith and coworkers in 1986 described the positive effects on decreasing health care utilization, without worsening health outcomes or changing patients' satisfaction with care, using psychiatric consultation followed by a letter to the referring primary care physician. The letter describes somatization disorder and recommends management with regularly scheduled appointments, physical exam at each visit, avoiding tests and procedures unless clearly indicated, and discourages physicians from telling patients "It's all in your head." This group published in 1995 a similar study on somatizing

patients who did not meet full criteria for somatization disorder, showing similar positive results following a psychiatric consultation letter. The active ingredient here may be education of and support to the primary care physician. The importance of the therapeutic alliance between the primary care physician and the somatizing patient may need to be attended to in a way not formally done in most primary care settings. The primary care physician is coached to offer an analog of the "holding environment" more common psychotherapy settings. That is, to find a safe, predictable forum for the patient to present their distress albeit in the form of physical symptoms without fear of being rejected or abandoned by or overwhelming the physician, and without the sometimes unrecognized danger of being subjected to unnecessary tests and treatments.

When patients will accept overt psychological treatment, either individually or in a group setting, cognitive-behavioral therapies have been shown to improve the function of patients with somatization disorder as well as the other somatizing patients. As noted earlier, these patients may accept referral for these treatments when they are framed as "stress management." Disorders that have been shown to respond to cognitive-behavioral therapies include somatization disorder, hypochondriasis, body dysmorphic disorder, pain disorders, as well as a number of other illnesses in which somatic complaints figure prominently, including chronic fatigue, irritable bowel, chronic headaches, and non-cardiac chest pain.

Some studies of somatoform disorders, especially hypochondriasis, have attempted to answer whether or not these patients experience physiologic sensation differently or whether the error of somatization occurs secondarily in the area of interpretation, attribution, and reporting. Attempts are beginning to be made to discover whether these differences are learned or genetically determined. Explanatory therapy, an approach that emphasizes educating patients with accurate information about somatic sensations, including instruction regarding the amplification due to selective attention, providing reassurance and clarification and using repetition of this information was advocated by R. Kellner in the 1980s and was reintroduced in 2000 by G. A. Fava and colleagues for the treatment of hypochondriasis. They believe it is a simpler approach than cognitive-behavioral therapy and found it effective in a study of 20 patients.

Conversion disorders, sporadic and usually time-limited impairments, by nature have led to a relative lack of randomized control trials of therapeutic approaches. Anecdotal reports and clinical experience have led most to advocate suggestion and the expectation of recovery along with behavioral and physical therapy approach.

Supportive therapy to help patients identify and modify the psychological stressor postulated to be responsible for the conversion symptom may also be helpful. Sodium amytal interviews and hypnosis are also employed. However, well-controlled trials regarding these techniques for conversion disorder cannot be found. Further complicating studies is the broad range of conversion symptoms and the varying degree of functional impairment, for instance, hemi-paresis versus pseudoseizures. Taking into account the methodological weaknesses, there appears to be the most empiric support for suggestive and behavioral approaches. Amytal and hypnosis, although enjoying a long tradition of use for assessment and treatment of conversion disorder, suffer from the lack of control trials regarding efficacy. Some advocate there is enough suggestion of positive result utility that further studies are warranted. K. A. Phillips summarizing psychotherapeutic approaches for body dysmorphic disorder relates that cognitive-behavioral therapy including cognitive restructuring, exposure, and response prevention have been shown effective in body dysmorphic disorder. However, these studies have small numbers of participants, and as with other somatoform disorders more studies are needed.

In contrast to the few studies on body dysmorphic disorder, pain management has a relatively large literature. Pain disorders respond to cognitive-behavioral techniques, which include both cognitive restructuring and operant conditioning. Further review of the empiric studies of pain disorders is beyond the scope of this article.

IV. SUMMARY

The treatment of somatoform disorder involves both commonalties and differences. Those disorders that involve a chronic view of oneself as physically ill, somatization disorder and hypochondriasis, frequently present only to the primary care physician and the management principles of regularly scheduled rather than symptom dependent visits have already been summarized. Also critical is the avoidance of unnecessary diagnostic and therapeutic procedures and interventions. Those somatoform disorders in which a specific distortion of thinking can be identified, hypochondriasis and body dysmorphic disorder, are amenable to cognitive techniques aimed at this belief as well as behavioral therapy to change inappropriate behavioral responses such as reassurance seeking. Conversion disorder usually responds to suggestion, reassurance, and expectancy. Behavioral

and physical therapy may enhance these general techniques. Pain disorder is best treated psychotherapeutically with cognitive-behavioral techniques. Although the somatoform disorders, especially somatization disorder, hypochondriasis, and conversion disorder provided some of the formative clinical material for psychiatry, especially psychodynamic psychotherapy, in practice psychodynamic therapy rarely finds itself at the forefront of treatment of somatoform disorders. In some cases of conversion disorder, particularly those for which the psychosocial stressor or conflict is not immediately apparent or which have a relapsing course, psychodynamic therapy continues to be utilized. In addition, skills in marital and family therapy are sometimes necessary particularly when somatoform disorders have resulted in patterns of secondary gain that involve couples or family systems.

See Also the Following Articles

Cancer Patients: Psychotherapy ■ Comorbidity ■ Medically Ill Patient: Psychotherapy ■ Pain Disorders

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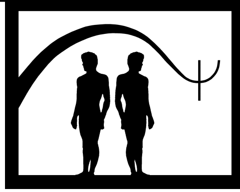

Sports Psychotherapy

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I. Performance Enhancement and the Role of the Sports Psychologist
II. Family Therapy and the Athlete
III. Life Span Development of the Athlete
IV. Drug Use among Athletes
V. Eating Disorders among Athletes
VI. Rehabilitation from Athletic Injury
VII. Neuropsychological Assessment and Concussion
Further Reading

GLOSSARY

anorexia athletica Unofficial diagnostic term used to describe a syndrome found among athletes that closely resembles anorexia nervosa (AN), with the exception that an athlete's muscle mass maintains him or her above 85% of the minimum body weight.

creatine Performance-enhancing drug that increases energy transfer for muscle contraction.

deselection Forced suspension of play or retirement due to lack of physical competitiveness.

human growth hormone Performance-enhancing drug that stimulates skeletal and soft tissue growth.

neuropsychological assessment Systematic evaluation of learning and memory abilities commonly performed after an athlete sustains a head injury.

sports psychology Subspecialty of psychology that develops and applies psychological strategies to enhance and optimize athletic performance.

Yerkes-Dodson inverted U hypothesis Theory stating that optimal performance occurs at moderate levels of anxiety, while low and high levels of anxiety disrupt performance.

Sports psychotherapy is a subspecialty of psychotherapy that addresses the unique challenges and needs presented by athletes when they seek mental health services. Although sports psychotherapy has its roots in the sports psychology movement that has sought to enhance athletic performance, it extends beyond this practical goal. This article will present seven broad categories that illustrate the unique considerations of sports psychotherapy, including common psychological problems among athletes (drug use, eating disorders, and adverse reactions to injury) as well as the special developmental, social, and family factors that affect the athlete's mental health.

I. PERFORMANCE ENHANCEMENT AND THE ROLE OF THE SPORTS PSYCHOLOGIST

Performance enhancement refers to psychological interventions designed to increase an athlete's effectiveness and chances for success in competition. In a rapidly growing subspecialty, these interventions are designed and implemented by sports psychologists who provide consultation to college and professional athletic teams. In February 2001, a special issue of the American Psychological Association's journal *Professional Psychology: Research and Practice* discussed the roles and challenges of sports psychologists. For

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example, Frank Gardner noted that, particularly in professional sports, modern-day athletes are regarded as extremely valuable (even a kind of financial investment) and hence worthy of psychological support and protection that might optimize their performance. In the same special issue, Mark Andersen, Judy Van-Raalte, and Britton Brewer observed that sports psychologists often resemble coaches more than they do clinicians and have a correspondingly looser set of boundaries between themselves and their clients. For example, sports psychologists may accompany an athlete to a practice, a training meal, or a game.

Despite the fact that sports psychologists may not be regarded as mainstream clinicians, many of the techniques and interventions they employ are borrowed from psychotherapy treatments. In addition, the immediate goal of a performance enhancement intervention is often to reduce some negative feeling or cognitive state, although the more practical concern is competitive success. For example, performance enhancement interventions are often aimed at changing levels of competitive state anxiety, or the level of tension that an athlete feels at game time. Therapists may be guided by the "Yerkes-Dodson inverted U hypothesis," which states that optimal performance follows moderate levels of anxiety (while low and high levels of anxiety disrupt performance). To achieve this moderate level of anxiety, psychotherapists may use progressive muscle relaxation (PMR), deep diaphragmatic breathing (DDB), guided imagery, or hypnosis. PMR involves periodic tensing and relaxing of all muscle groups, typically beginning with the feet and working up toward the head. DDB involves breathing from the lower diaphragm rather than from the upper chest. Guided imagery involves the use of suggestions to create relaxing images (e.g., lying on the beach), while hypnosis also involves guidance and suggestion but in the context of a qualitatively different state of consciousness. Some therapists prefer PMR, DDB, and guided imagery because they are ultimately self-applied and the athlete can leave treatment with a tool to be used in better controlling his or her anxiety before and during competition.

In 1990, Richard Suinn presented a behavior therapy package called anxiety management training (AMT) designed to enhance athletic performance. In 6 to 8 sessions, athletes are taught self-control methods to manage their anxiety levels, including specific relaxation techniques and strategies to revise cognitive self-statements. AMT emphasizes between-session homework assignments that allow athletes to try the skills they have learned in real competitive contexts.

Sports performance may be indirectly enhanced via the psychotherapeutic exploration of an athlete's social support network. Social support has an established research base as a buffer against injury, stress, and the pressures of competition. Interpersonally oriented psychotherapy is one therapeutic modality that might be used by a sports psychologist to target relationship conflicts that can lead to social isolation. Through experiential role-plays and between-session practice exercise athletes can identify and change the problematic ways in which they interact with others. For example, role-plays may help an athlete get along better with teammates on and off the court, thereby improving the team's chances for success.

II. FAMILY THERAPY AND THE ATHLETE

Family therapy refers to the treatment of both individual and interpersonal problems within the context of a family system. In 1995 and 2000 expositions, Jon Hellstedt has described the "athletic family" as a family system that includes parents and their children who are involved in competitive sports. Although the athletic family is not necessarily destined to be problematic or dysfunctional in a clinical sense, it can be imbalanced if there is an overly intense and narrow focus on one member's sports activity. Family members, parents in particular, often project their own unfulfilled athletic (or financial and social) dreams onto their children, thereby becoming overinvolved and unduly pressuring.

Hellstedt has identified four common targets of psychotherapy with the athletic family: the level of cohesion, the nature of emotional boundaries, triangulation patterns, and developmental impasses in the family life cycle. Family cohesion, while it can provide a source of support and stability, may serve to hide tension and conflict. For example, the tightness of a family system may lead to undermining of a child's autonomy and decision-making; psychotherapy might explore this pattern, along with any unexpressed anger and resentment that accompany it. Boundaries refer to the space that separates the emotional and cognitive systems of different family members. These boundaries have been described as ranging from "enmeshed" (too little space between members) or "disengaged" (too much space between members). Psychotherapeutic intervention is typically directed at the two extremes, particularly the enmeshed boundaries often found among athletic families. Triangulation refers to avoidance of conflict between two people (e.g., parents) by focusing on a third

person (e.g., athletic child). For example, parents may become overinvolved in their child's athletic activity as a way of avoiding their own marital discord. Hellstedt notes that a typical presentation in this regard includes a father who becomes overinvolved with his athletic son to the exclusion of his wife. Developmental impasses in the family life cycle refer to tasks and obstacles that arise as a family negotiates transitions. For example, most children leave home for the first time around age 17 or 18. However, young gymnasts often leave their families for extended periods of time for training, resulting in separation stress occurring sooner than is typical in the family life cycle.

Hellstedt summarizes the broad psychotherapy change goals in working with athletic families: identifying sources of stress, promoting healthy independence from the family, improving communication and problem-solving, negotiating developmental transitions, and developing the supportive capacity of the family while minimizing its role as a source of stress to the athlete.

Besides its relevance to specific athletic families, family therapy has been used as a model for understanding and intervening with sports systems and teams. Athletic teams, like family systems, often pursue goals of conflict resolution and facilitation of healthy cohesion. For example, in 1993 Toni Zimmerman and Howard Protinsky offered the following recommendations when using family therapy techniques in consultation to sports teams: meeting with both players and coaching staff, requiring attendance at consultation sessions, and utilizing family therapy models to monitor problematic patterns. Just as in families, athletic teams can experience damaging coalitions (e.g., coach singling out an athlete as his favorite) and significant communication problems.

III. LIFE SPAN DEVELOPMENT OF THE ATHLETE

Life span development refers to an age-appropriate context in which to better understand psychological issues and problems among athletes. For example, youth participation in sports can result in unique, and potentially negative, consequences. In a 1993 review, Robert Brustad explored how a child's psychological readiness for competition may impact on his or her emotional reactions to athletic activity. Psychotherapy with children who engage in sports competition too young (or perhaps too intensely) may involve discussion of the frustration, low self-esteem, and inappropriate achievement goals that have resulted from this involvement. When parents place undue pressure on children to perform the whole family can become involved in the problem, thereby necessitating a family therapy intervention to establish more realistic and healthy patterns of encouragement.

Undergraduates involved in intercollegiate sports are another group that have unique psychotherapeutic needs. Treatment must acknowledge their dual roles as both students and athletes. Stress management interventions are common among this group of athletes as they struggle to establish and balance multiple priorities. Particularly in Division I schools that serve as a training ground for professional sports, athletes may be exceedingly goal-oriented. This characteristic can be both an asset (e.g., compliance with psychotherapy homework assignments) and an obstacle (e.g., rigidity in the face of revising unrealistic or unhealthy goals) to treatment. Due to the college environment and related subcultural norms, student athletes often present with substance abuse problems, eating disorders, and adverse emotional reactions to sports injury (see later).

A third set of developmentally influenced issues arises in treatment with elite amateur and professional athletes who are retiring. In a 1993 review, Bruce Ogilvie and Jim Taylor discussed three factors that can precipitate career termination: (1) chronological age, (2) deselection (no longer physically competitive), and (3) injury. Although all three of these precipitants necessitate a process of acceptance in psychotherapy, they each bring additional unique considerations. For example, deselection often leads to marked erosion of self-esteem. Young, highly successful professional athletes who suffer career-ending injuries may need to clarify and revise their self-identity in long-term psychotherapy. Ogilvie and Taylor recommend proactive, preventive interventions for athletes who know they are facing retirement. These interventions might help athletes clarify values and goals beyond athletics, or perhaps encourage expression of feelings of frustration, doubt, and loss.

IV. DRUG USE AMONG ATHLETES

Drugs used by athletes include alcohol, recreational illicit drugs, and performance-enhancing drugs. Although there are no reliable data on the prevalence of substance abuse among athletes, alcohol, marijuana, and cocaine remain the most common recreational drugs of choice. Anabolic-androgenic steroids (AAS) are the most commonly used class of performance-enhancing drugs. AAS maximize gains in muscular strength and size, thereby conferring some competitive advantage to the athlete.

More recently athletes have begun to use human growth hormone and creatine to optimize performance.

An understanding of the reasons for drug use among athletes forms a starting point for many psychotherapeutic approaches to the problem. The question of why athletes abuse drugs has perplexed some members of the sports community who find it puzzling that individuals so committed to physical fitness would knowingly undermine this very commitment. In the case of performance-enhancing drugs, the motivations for use are relatively clear (e.g., the use of anabolic steroids for muscular power, the use of stimulants for cognitive focus and endurance), although these drugs can have unintended and negative psychological side effects. The reasons for athletes' use of other addictive recreational drugs are less clear. In 1991, Jim Taylor hypothesized that athletes at the professional and collegiate levels use recreational drugs because they have not developed effective interpersonal skills to cope with the pressures exerted by the media and fans. The peer pressure that originates in sports team subcultures can be especially potent, leading some athletes to use drugs to ensure acceptance. Finally, especially talented athletes may be less adversely affected by drug use, somehow still able to perform better than average when using, and thus more likely to deny that a problem exists.

Each of these potential reasons for drug use may lead to different psychotherapeutic interventions. For example, social skills training and anxiety management can be emphasized with athletes who are using recreational drugs as a coping strategy. Although the teaching of alternative coping strategies may help athletes who are using recreational drugs, long-term group-based rehabilitation may be necessary if serious addiction has resulted (see later). Psychoeducation may help athletes understand the short- and long-term risks of using performance-enhancing drugs (e.g., cardiovascular complications, liver damage, acne, mood swings, aggressive and antisocial behavior) and this alone may be sufficient in treating the problem, particularly where no addictive process has taken hold.

Confidentiality is a significant concern when athletes seek, or are required to receive, treatment for drug abuse. The potential stigmatizing effects of being labeled a drug abuser can be long lasting. Additionally, athletes may be very concerned about how initiation of treatment will limit their play, fearing that a sudden suspension will destroy the confidentiality of their treatment since teammates may not otherwise know a problem exists.

Long-term psychotherapy treatment programs for drug-abusing athletes, like those for members of the general population, usually include rehabilitation groups. For example, Alcoholics Anonymous and related 12-step programs may be especially effective if groups are composed of athletes with similar backgrounds. Often, athletes begin this kind of treatment at a residential inpatient (or at least day-treatment) facility where they can be fully immersed in the notion of sobriety and an alternative lifestyle. In the early 1980s, Gregory Collins was involved in one of the first organized programs for treating and preventing drug use among professional athletes. In a 2000 book chapter, Collins describes a self-help model used with the Cleveland Browns football team that included regular meetings of drug-involved players in a group called the "Inner Circle." This group placed a special emphasis on relapse prevention. Because the "Inner Circle" is composed of athletes at different stages of sobriety, members can discuss common pressures and triggers to use substances, provide and share effective support and coping mechanisms, and monitor each other's treatment progress.

Besides treatment of drug abuse, both college and professional sports teams have emphasized prevention. Although mandatory drug testing is one way of detecting a problem for early intervention, athletic staff would rather take action before a problem begins. For example, many teams have adopted programs to disseminate accurate information about drugs and to teach effective coping skills. Some prevention programs include required video and workshop orientations for new players where they are educated not just about drugs and their effects, but also about the availability of support and treatment services.

V. EATING DISORDERS AMONG ATHLETES

Sports that overvalue aesthetic appearance of the body (e.g., dance, gymnastics), low body fat (e.g., swimming, running), or maintenance of body weight (e.g., wrestling, horse-racing) may place athletes at a higher risk for developing eating disorders and related body image distortions. In 1994, Jorunn Sundgot-Borgen used the term "anorexia athletica" (diagnosed Eating Disorder, Not Otherwise Specified in *DSM-IV*) to describe a syndrome that closely resembles anorexia nervosa (AN), with the exception that these athletes do not meet AN diagnostic criteria because their muscle mass maintains them above 85% of the minimum body weight. As a clinical subpopulation, athletes are likely to respond to a distorted body image not just by restricting food intake

but also by overexercising, which can in turn lead to further illness and injury (see later).

In a 1998 review, David Garner, Lionel Rosen, and Declan Barry emphasize the importance of confidentiality in working with athletes suffering from eating disorders, noting that they may be especially sensitive to how coaches and teammates will regard their problems. They specifically discourage the treating clinician from talking to other teammates about the athletes' eating problems. To avoid related marginalization, these authors recommend that athletic activity be suspended only if the athlete poses a physical health risk to themself.

Psychoeducation can be especially useful in psychotherapy with athletes suffering from eating disorders, specifically in motivating healthy dietary behavior change. For example, detailed discussion of the negative effects of restricted calorie intake on physiology and performance (e.g., reduced strength, impaired coordination, slower recovery from competition) can mobilize athletes at least to consider alternative strategies to enhance performance.

Recommended psychotherapeutic treatments for athletes with eating disorders include cognitive-behavior therapy (CBT) or interpersonal therapy for bulimia and CBT for binge-eating disorder. CBT attempts to bring eating habits under control through a system of monitoring and dietary change. Interpersonal therapy focuses on how the athlete's disrupted relationships with others (perhaps teammates) result in the impetus to engage in binge and purge cycles.

VI. REHABILITATION FROM ATHLETIC INJURY

Athletic injuries may result from relatively acute, discrete trauma, or from overtraining/overuse. Although it is rather obvious that athletic injury necessitates physical rehabilitation, only recently have psychotherapists become involved in the recovery process. Psychotherapy may facilitate both physical and emotional recovery. As an adjunct to physical rehabilitation, clinicians may help athletes set realistic goals for recovery, which is particularly important for "overuse injuries" and for those athletes who are characteristically overachieving or overexerting. Psychotherapists may also work to increase motivation about and adherence to rehabilitation regimens. For those athletes who have negative thoughts and attitudes about the prospects for recovery, cognitive-behavioral therapists may help an athlete identify cognitive distortions (e.g., an athlete who catastrophizes by assuming "this is the end of my career") and work to challenge and revise these thoughts. Psychotherapists may also indirectly affect commitment to rehabilitation and recovery rate by facilitating positive, healing imagery (e.g., "picture the tissue repairing itself"). In a 1991 study, Lydra Ieleva and Terry Orlick found that athletes using goal-setting, stress control, positive self-talk, and healing imagery recovered faster than those who did not receive these psychological interventions.

Emotional responses to athletic injury, particularly career-ending injury, often resemble reactions to loss. For example, athletes have been observed to move through Kubler-Ross's five grief stages: (1) denial and isolation, (2) anger, (3) bargaining, (4) depression, and (5) acceptance. A first step in psychotherapy is to normalize this grief process. Before acceptance can be forged, athletes may spend extended periods consumed by anger, depression, and even posttraumatic stress. These emotional problems may necessitate targeted psychotherapeutic interventions. For example, injured athletes may experience a precipitous drop in activities they enjoy or "pleasurable events," a common behavioral trigger for major depression. Therapy may identify alternative pleasurable activities and then use behavioral reinforcement contingencies to improve mood functioning. Alternatively, depression following injury may be understood within a cognitive context—sustaining an injury may provoke feelings of vulnerability and the belief that life is a series of uncontrollable events. Cognitive therapy would attempt to change these unnecessarily extreme and distorted beliefs.

Common defense mechanisms employed by athletes to avoid the unpleasant emotion associated with injury include reaction formation (displaying emotions that are the opposite of what is really felt) and intellectualization (discussing the injury in terms of thoughts and ideas without mention of emotion). Permissiveness to feel anger and sadness, and perhaps even induction of these emotions, is a primary objective of psychotherapy with athletes who are unable or unwilling to acknowledge their feelings.

The process of accepting a career-ending injury may require longer term psychotherapy to address erosion of self-esteem, particularly if an individual's valuation of himself or herself was primarily based on athletic success. This work may involve detailed discussion of what needs were fulfilled by athletic experiences and which alternative activities may now be substituted. Encouragement of seeking role models who have suffered career-ending injuries may help some athletes in

psychotherapy, or even a support group of similar others if available.

Sports injury can be strategically exaggerated or even feigned by an athlete looking for secondary gain. For example, an athlete may wish to avoid some negative event (e.g., having parents watch him play) or acquire some positive benefit (e.g., insurance claim) by being injured. This kind of psychological motivation for injury may be addressed in psychotherapy by skills training that would emphasize (1) identifying more active and direct ways of making or denying requests from others, and (2) satisfying needs in a more forthright fashion.

VII. NEUROPSYCHOLOGICAL ASSESSMENT AND CONCUSSION

Neuropsychological assessment and concussion refers to the evaluation of cognitive functioning (e.g., learning and memory abilities) following a sports-related head injury. A developing body of research has suggested that multiple head injuries can have long-term negative psychological and physical health effects, with some players particularly susceptible to repeated head injury. In 1996, the National Hockey League (NHL) began an experimental pilot program to formally assess players who experienced head injuries. This program was intended to prevent a hasty return to play and thereby minimize the risk and consequences of multiple head injuries. The NHL extended this assessment program league-wide in 1997 while the National Football League also began to institute similar protocols.

In 1999, Michael Collins, Mark Lovell, and Douglas McKeag observed that there is some confusion as to when athletes should be examined because there is no universally accepted definition of concussion (e.g., some believe that loss of consciousness is central whereas others do not). Although evaluation of postconcussion effects may be conducted in a medical rather than psychotherapeutic context, sports clinicians are expected to be familiar with the testing and typical findings. For example, athletes with a history of concussion may experience slowness in processing speed (i.e., pace of response to verbal and visual stimuli) and decrements in executive functioning (i.e., ability to plan and execute decisions). When psychotherapists work with athletes who have suffered these kinds of effects from multiple head injuries, the content and pace of psychotherapy is usually adapted, as it is among other clients who present special cognitive considerations (e.g., young children, older adults).

See Also the Following Articles

Addictions in Special Populations ■ Cognitive Behavior Treatment ■ Collaborative Care ■ Eating Disorders ■ Family Therapy ■ Substance Dependence: Psychotherapy

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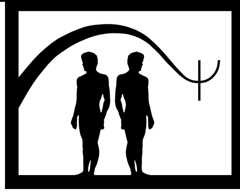

Spouse-Aided Therapy

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I. Description of Treatment
II. Theoretical Bases
III. Empirical Studies
IV. Summary
Further Reading

GLOSSARY

communication skills training A behavioral procedure designed to decrease stress in a couple by teaching attentive listening skills, effective ways to express positive and negative feelings, and how to request behavioral change in a nonhostile manner.

exposure Repeated confrontation with, or approach to, the object that is avoided.

interpersonal therapy Psychodynamically based treatment that aims to alter negative interpersonal situations that maintain depression. The focus is on one of the following domains: (1) loss, (2) role disputes, (3) role transitions, and (4) interpersonal deficits.

problem-solving training Teaching a set of sequential steps for solving problems that minimizes negative emotional undercurrents while maximizing the identification, evaluation, and implementation of the optimal solutions.

systems theory The basis premise of this theory is that the problem shown by the "identified patient" is a sign that something is wrong with the entire family. Problems of the patient are seen as only a symptom of more basic family problems. System-theoretically derived treatment deals with the relationship between the individual family members and the family system, rather than focusing on overt pathological symptoms.

I. DESCRIPTION OF TREATMENT

For present purposes spouse-aided therapy is defined as any psychological intervention in which the partner of the patient with a psychiatric disorder (e.g., anxiety disorder, depression, substance use disorders) is actively involved in the treatment, and the focus of the intervention is primarily on the psychiatric disorder. This means that marital therapy directed exclusively to the marital difficulties of the couple without due attention to the specific psychiatric disorder involved is not discussed here.

There are several advantages for spouse-aided therapy: (1) The spouse is informed about the psychiatric disorder and the kind of treatment delivered, (2) the spouse can give additional information about symptomatology of the patient and treatment progress, (3) the spouse can be emotionally supported, since living with a patient is often a heavy burden; and (4) the spouse can learn to deal more adequately with disorder-related situations, and, if necessary, general communication between partners can be improved.

A. Anxiety Disorders

In anxiety disorders, two different formats of spouse-aided therapy can be distinguished. In partner-assisted exposure the partner accompanies the patient to each treatment session. The couple receives a treatment rationale, in which the focus is on exposing the patient to phobic situations. The partner can assist in making a

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hierarchy, consisting of gradually more difficult exposure tasks. At each session the patient is given a number of exposure homework assignments. The role of the partner is to stimulate the patient to do these exercises, to help in confronting the phobic situations, to accompany the patient if necessary, and to reinforce the patient in mastering these exposure exercises successfully. The actual presence of the partner is gradually faded out during the exposure exercises. At the beginning of each new session, the patient's performance on the exposure tasks and the assistance of the partner are discussed with the couple and new homework assignments are given. More difficult tasks are given only if tasks lower in the hierarchy have been performed successfully. The pace at which the patient works through the hierarchy is determined by the couple. Thus, treatment focuses on the phobia. Relationship problems, if any, are not discussed.

Other spouse-aided approaches in anxiety disorders have focussed on interpersonal difficulties thought to maintain agoraphobic symptoms. These approaches include communication training and partner-assisted problem solving directed either at phobia-related conflicts or at general life stresses and problems.

B. Depression

Partner-assisted cognitive-behavior therapy for depression is based on Peter Lewinsohn and Aaron Beck's individual therapy of depression. It is assumed that depressed individuals do not engage in pleasant activities and hence do not get adequate reinforcement, resulting in mood disturbance. During spouse-aided therapy, partners join all sessions. Treatment focuses on the depression and on ways both partners can deal more adequately with depression-related situations rather than on relationship aspects per se. Therefore, spouses are involved in devising reinforcing activities, in stimulating patients to engage in rewarding activities, and participating in role-playing. Further, spouses are asked to attend to the dysfunctional thoughts of the patient and to discuss these with both patient and therapist. In addition, partners are actively involved in designing behavioral experiments to test (irrational) beliefs and are encouraged to take part in challenging the assumptions held by the patient.

In conjoint interpersonal therapy the partner is involved in addressing patient-related unresolved difficulties in one of the following domains: loss (e.g., of a child or parent), role disputes, role transitions, and interpersonal deficits. Moreover, five sessions of conjoint communication training are included.

In cases with co-occurring depression and marital discord, conjoint behavioral marital therapy may be applied. Here, the emphasis is not only on the mood disorder, but also on the communication between the partners. Generally, in the earlier phase of therapy problems associated with depression that could hinder a successful application of marital therapy are dealt with. Examples of such problems are complicated grief or a low activity level in the depressed patient. Later on the focus of the therapy is shifted to the training of communication skills in both spouses.

C. Substance Abuse

In general behavioral couple treatment for alcohol use disorders focuses on behavioral self-control and coping skills to facilitate and maintain abstinence, improving spouse coping with drinking-related situations, improving relationship functioning in general, and improving functioning within other social systems in which the couple is currently involved. The degree of emphasis on each of these four domains and the techniques used to target these domains varies across different treatment protocols. Two well-known protocols are the ones used in the Harvard Counseling for Alcoholics' Marriages (CALM) project by Timothy O'Farrell and the Alcohol Behavioral Couple Treatment (ABCT) protocol used by Barbara McCrady. The main differences between these two protocols are that O'Farrell's treatment is designed to be used in conjunction with or subsequent to a treatment focusing on cessation of drinking, whereas the treatment developed by McCrady is designed as a stand-alone treatment. Also, part of the CALM treatment is delivered in a group format whereas McCrady's treatment is delivered during individual couple sessions.

Some techniques often used are the sobriety or Antabuse contract to reduce conflict and distrust between the couple, identifying high-risk situations and teaching both partners alternative skills to cope with these situations, and improving communication between the partners by using role-play to reduce conflict, enhance marital satisfaction, and reduce the chance of relapse.

Behavioral couple treatment for substance use disorders other than alcohol are derived from these (and other) alcohol treatment protocols, focus on the same four domains, and use similar behavioral techniques. Another behavioral intervention in which the spouse is usually involved, but also other family members and other individuals from the patient's network, is Azrin's community reinforcement approach. Consistent with operant conditioning principles, this treatment is designed to remove drinking reinforcing behaviors by teaching family and friends to ignore drinking and reward nondrinking.

Originally designed for treating alcoholics, this treatment has been adapted by Stephen Higgens and colleagues for treating cocaine and other drug abusing patients.

II. THEORETICAL BASES

A. Anxiety Disorders

Systems-oriented clinicians hold that phobias and other anxiety symptoms have interpersonal meaning in relationships. For example, Jay Haley defined the martial relationships of agoraphobic patients as compulsory marriages, in which partners do not stay together out of love but are forced to stay together because of the symptoms. Further, the partners of patients with an anxiety disorder have been described by system-oriented clinicians as negativistic, hostile, compulsive, and anxious. It was assumed that improvement of the anxious patient would lead to an exacerbation of symptoms in the partner and/or to marital distress.

No convincing evidence has been provided that partners of patients with anxiety disorders are psychologically abnormal themselves. However, recent empirical studies comparing agoraphobic and obsessive–compulsive couples with healthy control couples suggest there might be some differences regarding marital satisfaction, adjustment, and interpersonal problem-solving skills. These differences, however, are usually rather small. Nevertheless, this view has given impetus to involving the partner of agoraphobic and obsessive–compulsive patients in the treatment.

B. Depression

Depressed persons are characterized by an aversive interpersonal style to which others respond with negativity and rejection. The interaction of depressed individuals with their partner has been characterized by a lower proportion of positive verbal behavior and a greater proportion of negative verbal and nonverbal behavior. A substantial number of depressed patients presenting for treatment also experience marital distress, whereas in approximately half of the couples who have marital problems at least one of the spouses is depressed. These data suggest that depression and marital distress are closely linked. Furthermore, marital distress is an important precursor of depressive symptoms. In addition, persons who, after being treated for depression, return to distressed marriages are more likely to experience relapse. When patients are asked about the sequence of depression and marital distress, most patients hold that marital distress preceded the depressive episode. Results of these studies suggest that it might be important to enroll the partner in the treatment of depressed patients.

C. Substance Abuse

From a behavioral or social learning perspective alcoholism is a biopsychosocial process, the course of which is determined by multiple factors. According to this model, alcoholism, as well as other addictive behaviors, are habitual, maladaptive methods for attempting to cope with the stresses of daily living. This maladaptive coping is triggered by internal and external cues and reinforced by positive rewards and/or negative punishment. Formerly spouse-aided interventions with substance use disorders were regarded most appropriate for only a subset of clients with severe marital or family problems. These clients were presumed to be in an "alcoholic relationship" with a specific pathological marital structure, in need of different treatment interventions. Research now points in the direction of also involving a significant other, across a broader spectrum of clients.

Within a behavioral framework drinking or drug taking is assumed to have a negative effect on communication between partners and marital satisfaction, and has also been linked to other marital issues such as domestic violence and sexual dysfunction. Research has differentiated families of alcoholics from healthier control families in that the former typically manifest poor communication, organization, problem-solving, conflict management, and affect regulation processes. However, comparing alcoholic couples with nonalcoholic but distressed couples revealed that the latter group was characterized by similar dysfunctional processes as the former. Alcoholic couples do differ from nonalcoholic couples in that they report more domestic violence. Even in nonalcoholic couples more drinking is associated with increased violence.

There is some evidence that specific behaviors of the spouse can function either as a cue or reinforcer in drinking or drug-taking behavior. Furthermore, marital stability has been found to be positively related to success of treatment. In studies of alcohol abusers recovering without treatment intervention, social support, especially from a spouse, was significantly related to successful changes in drinking behavior. Finally, there is some evidence that restoring marital satisfaction and reducing conflicts reduces the chance for relapse. Taken together, the results of these studies suggest a need to investigate the effectiveness of spouse-aided interventions in substance abuse.

III. EMPIRICAL STUDIES

A. Anxiety Disorders

In contrast to expectations derived from general systems theory, there is no evidence that exposure therapy with patients with agoraphobia or obsessive–compulsive disorder has adverse effects on the relationship or the partners' symptoms. The controlled studies in this area suggest that the relationship remains stable or improves slightly, and no exacerbation of symptoms in the partner of the patient has been reported. Thus, the empirical evidence does not support the systems conceptualization of anxiety disorders as being a symptom of more serious marital problems.

Studies investigating the effects of spouse-aided therapy in individuals with agoraphobia and obsessive–compulsive disorder have indicated partner-assisted exposure to be as effective as treatment by the patient alone. The results of the studies that have been conducted thus far indicate that it is not essential to include the spouse in the exposure treatment of patients with agoraphobia or obsessive-compulsive disorder.

The results of studies that evaluated the efficacy of interpersonal skills training interventions are rather mixed, so no general conclusions are allowed. Treatment focusing on general life stress rather than on relationship difficulties was found to be less effective than exposure by the patient alone. In contrast, studies that focussed on relationship issues in addition to exposure led to slightly better results, especially on follow-up. Notably, this was also the case in couples that were not maritally distressed. Given the finding that criticism of the spouse may be related to relapse at follow-up, this may require specific attention to communication training in couples with a critical partner.

B. Depression

In this paragraph only studies are reviewed in which at least one individual of a couple was clinically depressed. Marital distress hinders treatment of the depressive disorder and, given the link between relapse and being in a distressed relationship, increases the chance of relapse in the future. To date, three controlled studies have shown that conjoint behavioral marital therapy in depressed–maritally distressed couples may be a good alternative for individual cognitive-behavior therapy. Taking the results of these studies together, in depressed–maritally distressed couples behavioral marital therapy seems to have an exclusive effect on the marital relationship, which is not found in individual cognitive-behavior therapy, while it is as effective as cognitive therapy in reducing depressed mood. Not surprisingly, behavioral marital therapy was hardly effective in depressed patients who did not experience marital problems.

Thus far, only one controlled study has investigated the effects of partner-assisted cognitive-behavior therapy and only one the effects of conjoint interpersonal therapy in depressed individuals. The results of partner-assisted cognitive-behavior therapy were comparable with those of individual cognitive-behavior therapy. Both treatments led to statistically significant improvement on depressed mood, behavioral activity, and dysfunctional cognitions. However, none of the treatment formats affected relationship variables, which comes as no surprise because all couples were non–maritally distressed prior to treatment. Thus, partner-assisted cognitive-behavior therapy was as effective as individual cognitive-behavior therapy in depressed individuals. In addition, conjoint interpersonal psychotherapy was equally effective as individual interpersonal psychotherapy on measures of depressive symptomatology. There was some evidence that the conjoint version was slightly more effective than the individual therapy on relationship variables. Finally, there is some evidence that treatment focusing on the interaction of depressed couples is slightly more effective than antidepressants.

C. Substance Abuse

The results of spouse-aided treatment programs in substance use disorders are encouraging. Research suggests that spouse involvement in the treatment of alcohol and drug use disorders produces significant reductions in alcohol and/or drug use, and improves marital functioning. There are also indications that behavioral couple therapy reduces violence in violent alcoholic couples. It should be noted, however, that most research to date was conducted in academic centers and has focused on white, male, higher educated alcoholic subjects. Typically, subjects in these studies had few other axis I or axis II disorders and were in relatively steady relationships with non–substance-abusing partners. It remains to be shown whether these spouse-aided treatment protocols will be as effective when delivered to other populations in a community setting.

IV. SUMMARY

Spouse-aided therapy consists of psychological interventions in which the partner of the patient with a psy-

chiatric disorder is actively involved in the treatment, which focuses primarily on the psychiatric disorder.

Spouse-aided exposure has shown to be effective in treating anxiety disorders (e.g., agoraphobia and obsessive–compulsive disorders). However, there is little evidence of it being more effective in reducing anxiety symptoms, compared to individual exposure treatment programs. There is some evidence that spouse-aided therapy focusing not only on the phobic disorder but also on communication is more effective than treatment of the patient alone. Specific attention to communication training may be required in anxious patients with an overcritical partner.

Evidence suggests that spouse-aided therapy that focuses not only on the mood disorder, but also on improving communication skills and problem-solving skills of both partners, should be the treatment of choice in maritally distressed patients with dysthymia or major depression. Finally, the results of spouse-aided treatment programs in substance use disorders are encouraging.

Although a number of studies have evaluated the effectiveness and efficacy of spouse-aided therapy in anxiety disorders, depression, and substance use disorders, no conclusions may be drawn from these findings regarding its efficacy in other disorders. There is some clinical evidence that spouse-aided therapy might also be used in chronic pain management and in schizophrenia, but controlled studies are needed before firm conclusions about the effectiveness of spouse-aided therapy in these disorders are warranted.

See Also the Following Articles

Aversion Relief ■ Behavioral Marital Therapy ■ Communication Skills Training ■ Couples Therapy: Insight Oriented ■ Family Therapy ■ Home-Based Reinforcement ■ Homework ■ Interpersonal Psychotherapy ■ Parent-Child Interaction Therapy ■ Psychodynamic Couples Therapy ■ Sex Therapy

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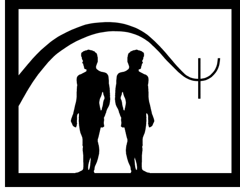

Stretch-Based Relaxation Training

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I. Introduction
II. Review of Clinical Trials
III. Technique
IV. Representative Clinical Application
V. Summary
Further Reading

GLOSSARY

masticatory muscle pain Chronic muscle pain disorder affecting the muscles used for chewing and moving the jaw.

musculoskeletal pain Pain involving structures of the musculoskeletal system that includes muscles, bones, joints, ligaments, and tendons.

PBS A three-step strategy for reducing muscle tension that focuses on positioning (P), breathing (B), and stretching (S).

self-monitoring Process of making regular assessments of personal behavior or activity for the purpose of understanding the frequency with which those behaviors or activities under study occur.

stretch-based progressive relaxation A progressive relaxation training approach that uses gentle muscle stretches to teach sensory awareness of muscle groups and to promote volitional relaxation.

Stretch-based relaxation training was developed as an alternative to more traditional progressive muscle relaxation procedures focusing on muscle tension exercises to teach relaxation skills. In contrast to the tense-release strategy of traditional progressive muscle relaxation, the stretch-based approach uses gentle stretches of major muscle groups to teach sensory awareness and volitional control of muscle activity. Results from randomized clinical trials have demonstrated the clinical efficacy of the stretch-based approach for addressing a range of problems that include face pain, neck pain, and general anxiety. This article presents the theoretical rationale, outcome data, and clinical applications of stretch-based relaxation training.

I. INTRODUCTION

Psychotherapists are faced with a broad array of options for conducting relaxation training. Generally, the goal of relaxation training is to reduce activation, both physical and mental, and promote self-efficacy for regulation of internal states. These skills of self-regulation can be used to enhance the management of personal and interpersonal challenges. Although there are a variety of relaxation training approaches, the use of progressive relaxation is often a method of choice.

Progressive relaxation was introduced just after the turn of the 20th century by Edmund Jacobson. As a physician, he became interested in the processes by which his patients controlled their own levels of physical and psychological activity. He believed that control over muscle tension and cognitions could be obtained through guided practice where an individual learned to

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manage her or his level of muscle tension and focus of attention. His primary strategy for teaching this control was conscious activation and relaxation of various muscle groups in a systematic manner. Originally, he conceptualized relaxation training as requiring 40 to 60 sessions of deliberate practice in tensing and relaxing various muscles. Often an entire hour-long session was devoted to only one muscle group. This rather laborious technique of relaxation training spurred an interest among other practitioners for developing shorter progressive relaxation training programs.

One of the most popular variants of Jacobson's original relaxation procedure was the abbreviated progressive relaxation (APR) approach developed by Bernstein and Borkovec. The original series of Jacobson's exercises was reduced to 16 major muscle groups in the initial APR training session. Like the Jacobsonian approach, the basic strategy for APR is to tense the muscle group for 15 to 20 seconds and then quickly release the muscle tension and let the muscle relax for an extended period. The sequence of muscles that are relaxed generally begins with the hands then progressively moves upward to the head and down to the feet. There is a substantial literature attesting to the effectiveness of APR for a wide variety of clinical problems, as is documented in Carlson and Hoyle in 1993 and Carlson and Bernstein in 1995. This literature includes information on anxiety disorders, depression, and medical conditions such as headache, insomnia, and hypertension.

There are conditions, however, where the use of muscle tensing strategies is not indicated. In cases where muscle tension increases pain, or there is a history of cardiac disease such as arrythmias, muscle tensing strategies should be avoided. Furthermore, the muscle contractions used in progressive relaxation training may increase muscle nerve sympathetic activity and not promote general relaxation. Finally, the rationale for use of muscle tension–based strategies that increase tension in order to reduce tension can often be difficult for clients to accept in the initial phase of treatment when pain, tension, or anxiety is intense. Because of these issues, an alternative to the use of muscle tensing exercises for progressive relaxation training is needed.

From a physiological perspective, if a muscle is contracted, a slow, gentle stretch of the muscle that does not overstretch or tear the muscle fibers will foster the relaxation of the muscle when the stretch is released. One common example of this principle is the familiar case of the "Charley horse" in which the muscle spasm of the lower back leg is most easily reduced by stretching that muscle gently (by moving the toes several inches toward the head and holding them in that position) for an extended period of time. Physical therapists and athletic trainers use muscle stretching on a regular basis to quiet contracted, overly active muscles. Muscle stretching results in reduced excitability of the motoneuron pool that can lead to reduced muscle activity, increased blood flow, and less pain. The value of muscle stretching is well-recognized in the empirical literature related to muscle function.

Jacobson's original intent in using muscle tensing exercises was primarily to teach the discrimination of muscle groups so that one's sensitivity to motor activation was enhanced. His ultimate goal for a client was to learn how to relax without the use of muscle tension exercises. The tense-release sequences were not a necessary part of the process of relaxing a muscle, but rather a learning tool to foster the acquisition of relaxation skills by teaching awareness of subtle sensations of muscle tension. Substituting a gentle stretch of a muscle for a contraction of that muscle is an alternative means by which sensory awareness can be improved while at the same time taking advantage of the natural relaxation effects associated with the release of a gentle muscle stretch.

Given this background, muscle stretches were developed for each of the 16 major muscle groups associated with the APR procedures of progressive relaxation. Although muscle stretches of these muscle groups cannot be performed by an individual without using some muscle tension (e.g., stretching the muscles of the lower back leg by gently drawing the toes of the feet toward the head), the focus of the procedures was on the muscle stretches themselves and the sensory experiences following the stretches. The sequence of the muscle stretches began with the lower legs and proceeded upward to the head region. Each of the muscles was stretched for 15 to 20 seconds and followed by relaxation for 60 seconds. An example of the instructions for a muscle stretch of the forehead (frontalis region) from Carlson and Collins follows:

> In order to stretch the muscles of the forehead, place the fingertips of both hands slightly above the eyebrows and gently push the fingers upward toward the hairline, stretching the muscles by applying light pressure. When you reach the hairline, hold the stretch by maintaining the upward pressure of your fingers on the skin.

The stretch-based progressive relaxation approach is presented in either a five-session format for individuals or a six-session group format. The protocol includes therapist scripts, home practice guidelines, audiotape

for home practice, and videotape for therapist training. Diaphragmatic breathing entrainment is included in the presentation of the relaxation procedures to aid in relaxation, as well as to assist in the timing of the stretch-relaxation sequences. The goal of this program is to teach volitional skills of relaxation in as efficient manner as possible using a focus on muscle stretching procedures.

II. REVIEW OF CLINICAL TRIALS

Following completion of a successful clinical case study involving the use of the stretch-based relaxation approach to address a generalized anxiety, 24 individuals self-referred for moderate muscle tension and anxiety were assigned randomly to a stretch-based relaxation group, tension-based relaxation group, or a wait-list control group. After the treatments were delivered, participants in the stretch-based group reported significantly less muscle tension at four muscle sites (right trapezius, right brachioradialis, left tricep, and left tricep) and had significantly less electromyogram (EMG) activity in the right masseter region than did participants in the tension-based relaxation group. These preliminary data from this randomized clinical trial indicated that the stretch-based progressive muscle relaxation procedures were effective in reducing both subjective and objective indices of muscle tension in persons reporting moderate tension and anxiety.

Carlson and colleagues then applied the stretch-based approach to persons with masticatory muscle pain disorder. Masticatory muscle pain disorder is a disorder where there is no evidence of temporomandibular joint pathology, but the muscles of mastication (primarily masseter, temporalis, and pterygoids) are painful enough to cause impaired chewing function. A group of 34 persons with masticatory muscle pain were assigned randomly to either a stretch-based relaxation protocol or to a condition in which the participants were asked to rest in relaxed positions. Results revealed that persons with elevated muscle activity assigned to the stretch-based group had greater reductions in EMG activity at both left and right masseter sites than persons assigned to the rest control condition. There were, however, no differences in self-reports of muscle tension between the two groups. For persons with masticatory muscle pain disorders, the use of the stretch-based relaxation approach was an effective means for reducing ongoing muscle activity even though reductions in self-reports of muscle tension did not differ from persons given instructions to relax by assuming positions of rest.

Kay and Carlson in 1992 directly compared the stretch-based relaxation approach to the tense-release and rest control relaxation procedures in a group of 60 persons reporting chronic neck muscle tension. The effectiveness of the procedures was evaluated by having the participants use one of the relaxation strategies after being exposed to a standard laboratory stressor. Participants were randomly assigned to one of the experimental groups and it was found that those assigned to the stretch-based condition reported greater overall reductions in muscle tension and lower left trapezius muscle activity than those assigned to either of the other two groups. Additionally, the stretch-based group had an overall increase in peripheral skin temperature, whereas the other two groups did not. This latter finding suggests that sympathetic nervous system activity was reduced for the participants using the stretch-based relaxation procedures. Overall, these data indicated that the stretch-based relaxation approach provided an effective relaxation strategy for persons with chronic neck tension.

Sherman and colleagues in 1997 evaluated the influence of stretch-based relaxation procedures on the immune function of persons experiencing persistent facial pain. Twenty-one participants were assigned randomly to either a stretch-based relaxation condition or a rest-control condition. Participants in the stretch-based relaxation condition had greater salivary immunoglobulin A (IgA) secretion rates than those in the rest-control condition. These results indicated that stretch-based relaxation training may have benefits beyond reduction of muscle tension for persons with chronic pain conditions.

Finally, Wynn in 1995 and 1998 conducted a series of controlled trials of stretch-based relaxation training with persons at risk for developing hypertension. This first study involved 32 young adult males with a family history of hypertension. Participants randomly assigned to six sessions of stretch-based relaxation training displayed lower heart rate and blood pressure (systolic and diastolic) responses to a laboratory stressor than did a comparable group of persons randomly assigned to a control condition. Additionally, participants trained in stretch-based relaxation reported less anger and anxiety than the controls. These findings were followed-up in a second study of 48 Black American males at risk for developing hypertension. It was found that those randomly assigned to the stretch-based relaxation protocol demonstrated lower diastolic blood pressure reactivity to a laboratory stressor, as well as lower emotional reactivity than did persons randomly assigned to a group that underwent a health

education program as a comparative control. Taken together, these two studies demonstrated the efficacy of the stretch-based relaxation protocol for reducing reactivity to laboratory stressors in persons at risk for the development of hypertension.

Overall, the data from a series of clinical trials support the use of stretch-based relaxation among persons with muscle tension and facial and neck pain, and those prone to excessive reactivity to environmental stressors. One of the shortcomings of the presently available data is that they are based on studies conducted within the clinical laboratory of the primary author of the stretch-based relaxation protocol. Other well-controlled clinical trials outside the author's laboratory are needed to provide independent confirmation of the effectiveness of the stretch-based relaxation approach. Based on the available data, however, there are strong preliminary data indicating the efficacy of the stretch-based progressive relaxation protocol.

III. TECHNIQUE

A. Initial Evaluation

Before beginning stretch-based relaxation training, the clinician should complete a thorough initial evaluation with the client to ensure that relaxation training is appropriate for that individual. The primary concern in this initial consultation is to determine the nature of the presenting complaints and to understand how the use of progressive relaxation training may be of benefit. There are also conditions for which stretch-based relaxation training may be contraindicated. These conditions would include a history of loss of contact with reality or an ongoing thought disorder whereby there would be significant difficulty with interpreting or understanding instructions. Medical conditions such as diabetes or seizure disorders may be contraindicated in some cases, or need to be closely monitored by medical personnel during the training program. Women who are pregnant should have the approval of their health providers before beginning a relaxation program. Any medical condition that requires ongoing medications (e.g., hypertension) also requires an approval of the health care provider responsible for prescribing the medication, because relaxation training may potentially alter how the body responds to current medication intake. Progressive relaxation training has the potential to alter the level of an individual's overall physiological activity, in addition to altering cognitive and emotional processes. Therefore, clients should be carefully screened for their participation in a progressive relaxation training program.

B. Presentation of Program

There are four elements to the initial presentation of the stretch-based relaxation program. The first element is to provide the client a historical overview of progressive relaxation training and the stretch-based approach. This overview would include a discussion of the natural use of muscle stretching and the value of systematic application of muscle stretching in the strech-based relaxation protocol. The second element to discuss with the client is the concept of learning the skill of muscle relaxation. The emphasis of the program is to develop specific and effective skills of quieting the body whenever the individual chooses to do so. The third element of the initial presentation involves the importance of regular practice of the skills introduced in the training sessions. Without systematic practice, the skills are difficult to perfect and to employ in ongoing daily routines. Finally, the central focus of the program is on learning relaxation skills that are under volitional control. The program is not about a therapist "relaxing" the individual, but rather it is about the individual learning how to relax themself with the skills that she or he has learned through regular practice.

C. Introduction to Basic Techniques

The basic series of 14 muscle stretches is introduced by first describing the importance of not invoking or increasing pain with any of the stretch-based relaxation activities. The client must be assured that the program is not centered on "enduring pain" in hopes of future gains. Then the client is told that each muscle stretch is done for 15 to 20 seconds and followed by a 60-second period of relaxation. The stretching of muscles is always done slowly and only to the point at which a slight muscle stretch is felt. Overstretching or "bouncing" of muscles is not appropriate.

After introducing the general approach to stretch-based relaxation, the client is shown each of the muscle stretches that includes both lower legs, both upper legs, the lower right/left back, stomach, chest, forehead, eyes, jaw, right/left neck, lower arms, and upper arms. The stretches are usually performed from a comfortable, reclined position in which the client's head is supported, eyes are closed (not necessary if closing the eyes creates discomfort), hands in curled and relaxed position, and legs are quiet with toes pointing away from one another at a 45 to 90 degree angle. Breathing

slowly and regularly is also part of the relaxation program and will be important in later sessions of practice as a timing mechanism for each of the stretch-relaxation exercises.

Once the introduction of the exercises has been completed, the client is reminded of the importance of maintaining a relaxed and comfortable position throughout the period of training. Any tight clothing (e.g., belt) may want to be loosened for the training session, and if eyeglasses, contact lenses, heavy jewelry or watches are bothersome, they should be removed for the duration of the training session as well. When the client is ready to begin the relaxation training, the therapist can begin with the following instructions from Carlson and Collins in 1997:

> Before beginning the first exercise, take time to breathe in and out slowly and regularly (wait 2–3 minutes).
>
> We are ready to begin the exercises now. For each exercise I will first describe the exercise. Then, when I say the words, "ready, begin" I want you to begin the stretch.
>
> The first exercise involves stretching the muscles in the lower right leg. When I say "ready, begin" you are going to stretch the muscles in the lower right leg by pulling the toes of the right foot toward your head until you meet resistance in the muscles along the back of the right leg. Ready, begin the stretch by pulling the toes toward your head until you feel resistance. Hold the toes at that position while you feel the muscles stretching in the back of the right leg. Hold the stretch (wait 15 seconds) and now release the stretch and let the toes return to a resting position. Notice the difference in the muscle sensations in the back of the lower right leg as the muscles are now relaxing. Just let the muscles relax and become quiet (wait 30 seconds). You can help the muscles continue to relax by focusing your attention on the muscles in that lower leg and encouraging them to become less tense (wait 30 seconds).

Each of the remaining exercises follows a similar format and is done in a prescribed sequence. The sequence of the muscle stretches is designed so that if a muscle is activated to perform a stretch, it will then be stretched, in turn, to foster further relaxation of that muscle. The exercises are sequenced to move from the feet to the head region.

Following completion of the relaxation instructions, the client is encouraged to reactivate herself or himself with the following:

> At this time, I will begin counting backwards from 5 to 1. With each number you should gain more awareness. When I reach "1" you will be fully alert and ready to begin you next activity but you will still be feeling relaxed and comfortable. 5—begin to move your feet and legs. 4—move your arms and hands. 3—move your head and neck. 2—open your eyes. 1—you should now be alert with your eyes open; feeling relaxed and refreshed. Should you be lying down, you may want to roll to your side or stomach and then begin to lift yourself. That concludes your initial training session.

The relaxation exercise series should be practiced at least once a day for 5 out of the next 7 days. Generally, the training sessions are spaced at one week intervals. Audiotape instructions are available to assist in this home practice as it has been shown by Carlson and Holye in 1993 that audiotapes can improve the effectiveness of relaxation training. It is also helpful for the therapist to review with the client the importance of practice and addressing common beliefs such as "these exercises are so easy, I don't need to practice," "I can't relax, so why would these exercises work," or "When I relax, I am afraid that…". Finally, the client should be given some sort of self-monitoring forms to take home to record periodic levels of muscle tension on a daily basis and to record when relaxation practice sessions occurred. One effective self-monitoring strategy involves the use of 10 cm visual analogue scales (anchored at one end with "least tension" and at the other with "most possible tension") that the client can fill out periodically. These can be quickly and efficiently scored with a computer program. Another recently developed strategy is to use a hand-held computer that has been programmed to prompt for and to accept self-monitoring data.

The stretch-based relaxation protocol has four additional elements of training after the first session. The first additional element involves completing the entire series of stretches with a shortened set of instructions. The second element involves the use of music during the session and the use of breathing to self-pace the stretches. The third element includes muscle scanning, a procedure for taking "mental measurements" of muscle tension throughout the body, skills for reducing any areas of identified tension, and a shortened version of the muscle stretching protocol. The skills for reducing areas of identified muscle tension involve a stepped-process involving changes in posture, control of breathing, and isolated muscle stretches of those muscle areas identified as tense. The posture, breathing, and stretching (PBS) provides a systematic and progressive strategy for managing tension in the natural environment. The shortened version of the muscle stretching protocol begins from the stomach region so that the stretches of the legs and lower back are

eliminated from the relaxation procedures. The fourth and final element of the relaxation program involves coping with thought intrusions, deepening levels of relaxation, and addressing life stressors that may be contributing to muscle tension. Each of these four elements is introduced in each of the subsequent sessions following the initial training session.

IV. REPRESENTATIVE CLINICAL APPLICATION

The use of stretch-based relaxation training in the clinical environment is generally part of a comprehensive and multicomponent approach to problem management. Within many clinical settings, stretch-based relaxation training can provide a foundation on which to build a comprehensive set of self-regulation skills. It is rare that progressive relaxation training is the sole focus of treatment.

This can be illustrated by the sample case of Ms. X. Ms. X was a 48-year-old female who presented with the chief complaint of excessive muscle tension, pain, and anxiety following an automobile accident. During the initial consultation, the client reported that she now had intense and persistent fears associated with being in and driving an automobile. The fears were so acute that she was very anxious and sweated profusely while in the car. Moreover, she was only able to drive very slowly and in certain geographic areas of her community. There were areas of her community that she fastidiously avoided for fear of being in another accident. Ms. X's clinical presentation was consistent with the diagnostic criteria for Specific Phobia of *(DSM-IV)*.

After the initial evaluation, Ms. X was presented with a formulation that described the events leading up to the development of her phobia, accounted for the subsequent elaboration of her phobia, and explained its continuation. Additionally, she was presented with a treatment plan that included a program of systematic desensitization. The first step in the treatment plan was to establish skills in control of muscle tension. Since she reported muscle pain in the region of her neck and shoulders, she was first asked to receive medical clearance for relaxation training. Following the receipt of medical clearance, the stretch-based program for progressive relaxation training was introduced.

Following the five sessions of the individual stretch-based relaxation training, Ms. X reported a decrease in overall tension and pain, but her fears of driving remained high. Therefore, the second phase of treatment that included constructing a desensitization hierarchy and performing systematic desensitization was initiated. The stretch-based relaxation skills, especially the PBS strategy for decreasing noticeable levels of tension, was used during the desensitization program. The treatment ultimately included an *in vivo* session in which the client demonstrated her driving skills while maintaining control over her level of anxiety and muscle tension.

V. SUMMARY

There are many successful approaches to progressive relaxation training as indicated by the substantial experimental clinical literature that is available (for example, see Carlson and Hoyle in 1993 and Carlson and Bernstein in 1995 for reviews). The stretch-based progressive relaxation protocol provides the clinician with an alternative to the traditional tense-release progressive relaxation programs. It is an approach based on fundamental physiological principles and experimental clinical data. Application of stretch-based relaxation can help a client develop a set of self-regulation skills to maintain volitional control of muscle tension. Particularly for persons with musculoskeletal pain disorders, the stretch-based relaxation protocol offers a viable alternative to the tense-release strategies for achieving effective relaxation skills.

See Also the Following Articles

Applied Relaxation ■ Applied Tension ■ Breathing Retraining ■ Pain Disorders ■ Progressive Relaxation ■ Relaxation Training

Further Reading

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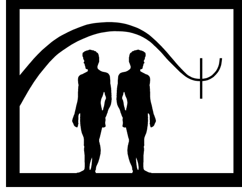

Structural Analysis of Social Behavior

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University of Utah

I. Description of Treatment
II. Theoretical Bases (Conceptual Underpinnings)
III. Empirical Studies
IV. Summary
Further Reading

GLOSSARY

AG and DAG Attachment group and disaffiliative attachment group. Specific normal and pathological behaviors described by the SASB model.

case formulation A specific method of connecting the presenting problems to patterns learned in relation to early caregivers.

complementarity Natural interpersonal matches described by the SASB model.

copy process Links between current problem patterns and early attachments. The three main copy processes are (1) be like him or her; (2) act as if he or she is still there and in control; (3) treat yourself as did he or she.

core algorithm Focus each story on input, response, and impact on the self. Include the ABCs (affect, behavior, and cognition) and try to enhance the growth collaborator while minimizing the regressive loyalist.

five steps in IRT (1) Collaboration; (2) learn what your patterns are, where they are from, what they are for; (3) block maladaptive patterns; (4) enable the will to change; (5) learn new patterns.

growth collaborator (GC, or Green) is the part of the person that wants to be happier and more functional.

introjection SASB model descriptions of what happens when you treat yourself as you have been treated.

IPIR Important person and his or her internalized representation.

regressive loyalist (RL or Red) is that part of the person that is loyal to the old problem rules, norms, beliefs.

SASB Structural analysis of social behavior classifies interpersonal and intrapsychic interactions in terms of attentional focus and two dimensions: love/hate and enmeshment/differentiation. For example, maternal protectiveness consists of focus on other that is friendly and moderately powerful. Complex behaviors can be described by using more than one code. For example, demanding dependency is: <u>TRUST</u> plus **BLAME**.

similarity SASB model codes when you choose to be like him or her.

I. DESCRIPTION OF TREATMENT

Structural analysis of social behavior (SASB) is to the therapist as a telescope is to an astronomer. You can see some activity in the sky with the naked eye, but there is much more to see and understand if you have an instrument that effectively amplifies available information. In the interpersonal domain, the SASB lens can go beyond the familiar and help the clinician see the quintessence of interpersonal and intrapsychic patterns more clearly. The SASB model also can provide specific predictions about interactions. Of special interest in psychotherapy are the predictions about developmental antecedents and expectable consequences of identified patterns.

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The SASB model and technology have been applied by researchers and clinicians to many aspects of psychotherapy, including interpersonal and intrapsychic assessment, therapy process, therapy outcome, and therapy relationship. The model is not limited to any one ideology. It has been successfully used by investigators exploring a variety of approaches such as client-centered, psychodynamic, psychoanalytic, interpersonal, and cognitive-behavioral therapies. Its usefulness extends beyond dyadic individual psychotherapy. There also are published SASB-based reports on individual, marital, family, and group therapy. The SASB system has been used to investigate related problems such as psychopathology, psychophysiology of interpersonal interactions, behavioral genetics, personality, therapist training, and more. For any approach that involves interpersonal or intrapsychic interaction, the SASB system offers precision in description of interactions, predictions, measurement methods (questionnaires for self-ratings, coding system for objective observer assessment), and software (to create well-validated cross-sectional and sequential parameters for use in clinical feedback or research hypothesis testing).

Although SASB technology is useful in a variety of contexts, this article focuses on Benjamin's recommendations for how to use the SASB model to define a specific individual's psychopathology and choose interventions in psychotherapy that consistently target the core of that individual's pathology. These recommendations have emerged from three decades of using the SASB model in research and practice. They are collected under the heading Interpersonal Reconstructive Therapy (IRT). IRT offers a tightly operationalized SASB-based method for assessing a patient's presenting problems, relating them to presumed underlying motivation, developing a treatment plan that explicitly and consistently addresses the organizing underlying motivators of the problem patterns, and then implementing and assessing the success of that treatment plan. Because SASB itself is generic, it is no surprise that IRT directs the clinician to draw from all schools of psychotherapy, using any available method of intervention. The guidelines require that the intervention conform to the case formulation, to the treatment plan, and to the IRT core algorithm. IRT is particularly appropriate for "nonresponders," people who have failed to improve in response to treatment as usual (medications and/or psychotherapy). Typically, these nonresponders carry the label personality disorder. IRT can facilitate profound change in some but certainly not all members of this population. It cannot, for example, help individuals who are unable or unwilling to control alcohol or substance use.

The IRT approach will be illustrated by a case example. Mary had an inpatient consultation with L. S. Benjamin following her second overdose attempt. During hospitalization and after discharge, Mary participated in psychotherapy with a graduate student learning IRT. Data presented here were gathered immediately after discharge and 4 months later, at the end of the school semester. Her history and presenting features, like those of many nonresponders, were severe and complex. She began this therapy with most scale scores on a symptom checklist at or beyond the 98th percentile for outpatients. Mary continued therapy with the same therapist through the next school year. She did quite well in that she made no further suicide attempts, needed no additional hospitalizations, discontinued medications, performed well in her new job, and improved in key social relationships. When the student therapist left on internship, Mary terminated earlier than necessary and said she did not need to use our offer of a referral to a new therapist. She failed to return any research forms at that time, but clearly had dropped a palpable distance from her original high level of symptomatology. But neither was she "cured."

Although IRT usually seeks to address the total picture, restricted aspects of Mary's presentation and the related history will be addressed here, because of space limitations. The selected focus is Mary's suicidality, very low self-esteem, and her apparent inability to look after her own interests.[1] These interpersonal and intrapsychic problems will be described in terms of the SASB model, shown in Figure 1.

The poles of the axes of the model, starting at the right-hand side and moving clockwise, are Love, Enmeshment, Hostility, and Differentiation. Points between poles consist of components of the nearest poles. Bold type indicates transitive focus on other; underlined type indicates intransitive focus on self. Italics depict introjected focus from other. For example, **IGNORE** describes behaviors relevant to focus on another person that is hostile and autonomy giving. <u>WALL-OFF</u> involves an intransitive focus on self reacting to another person with hostility and autonomy

[1] IRT theory prescribes that specific affects accompany specific interpersonal positions. Therefore, working with interpersonal patterns can help relieve symptoms. For a simple example, a person who fears rejection may be anxious. Transforming the fear as well as learning to handle actual rejection can reduce anxiety.

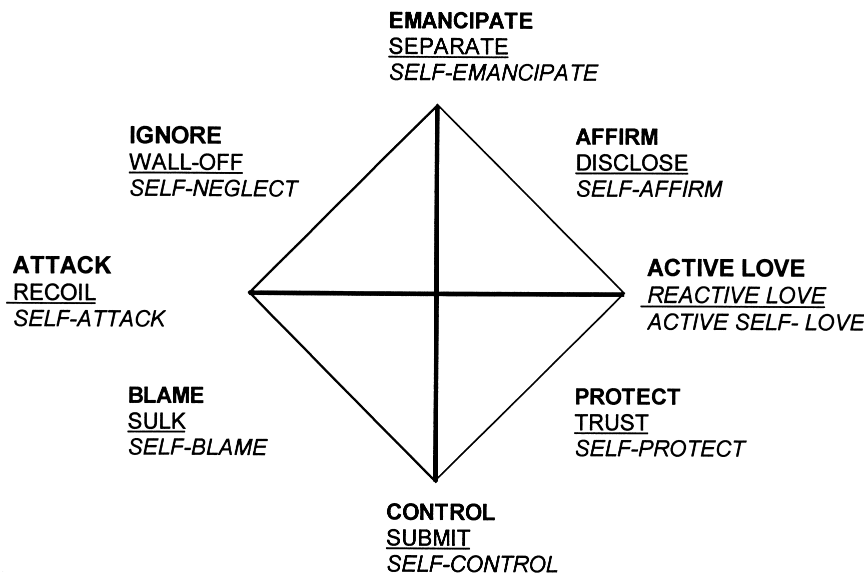


FIGURE 1 The simplified SASB cluster model. The poles of the axes, starting at the right-hand side and moving clockwise are Love, Enmeshment, Hostility, and Differentiation. Points between poles consist of components of the nearest poles (see text for further explanation). From Benjamin, L. S. (1996). *Interpersonal Diagnosis and Treatment of Personality Disorder,* 2nd ed. New York: Guilford Press.

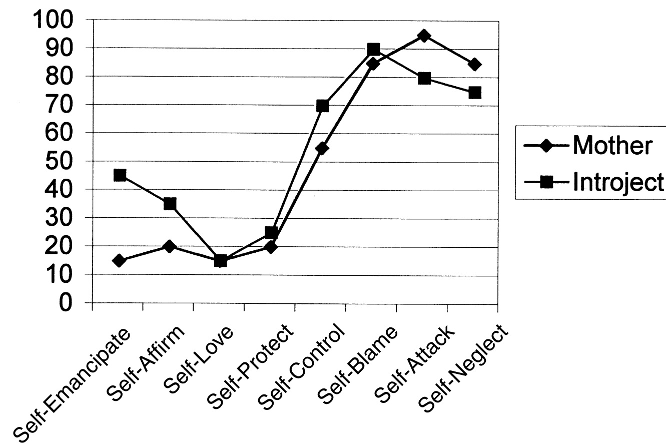
taking. *SELF-NEGLECT* represents uncaring transitive focus on the self that is hostile and autonomy giving. Opposites are located at 180 degrees. For example, **PROTECT** is the opposite of **IGNORE.** Complements are show by adjacent **BOLD** and UNDERLINED pairs. For examples, WALL-OFF matches **IGNORE** and TRUST complements **PROTECT.**

Mary rated herself and important other persons on the SASB Intrex questionnaires. Selected results appear in Figure 2. The top part of Figure 2 shows the SASB-based description of Mary's self-concept (squares) compared to her view of the way in which she remembered her mother focusing on her when she was a child (diamonds).

A glance at the figure shows that Mary rated her mother high on items describing **BLAME**, **ATTACK**, and **IGNORE**. This picture is highly consistent with the content of the clinical narrative. Mary's mother was alcoholic and spent much of her time in bars. Mary, the oldest child, was responsible for running the household. If mother came home in the middle of the night and found a speck of dirt on a dish in the cupboard, Mary would be yanked out of bed and beaten and forced to wash every dish in the cupboard. The mother called Mary all kinds of names and assured her that no man would ever love her.

The data for Introject show how Mary internalized these messages. The two curves at the top of Figure 2 are similar. Mary's mother **BLAME**d her and she *BLAMED* her*SELF.* Her mother **ATTACK**ed her and she *ATTACK*ed her*SELF*. Mother **IGNORE**d her, and Mary *NEGLECT*ed her*SELF.* The current suicidal episode included all these elements. The suicidal attack was a conscious internalization of her husband's rejection and criticism ("Nobody wants to be married to me. I deserve to die") and after discharge from the hospital, she neglected herself markedly. For example, she moved out with essentially no overt protest and then she failed to engage a lawyer. Although she needed money and was a competent worker, she did not groom herself before her initial job interviews.

The lower part of Figure 2 compares Mary's self-concept at the beginning of the outpatient treatment (squares), and 4 months later (diamonds). The two curves are starting to separate, with the later assessment suggesting a shift in the direction of more friendly self-control. Her IRT therapy had initially focused precisely on these issues: the need to engage in more self-control and self-care. Her student therapist was competent and warm (**PROTECT**ive) and it is assumed that Mary internalized the structure and caring. The therapist's warm control offered the opposite of



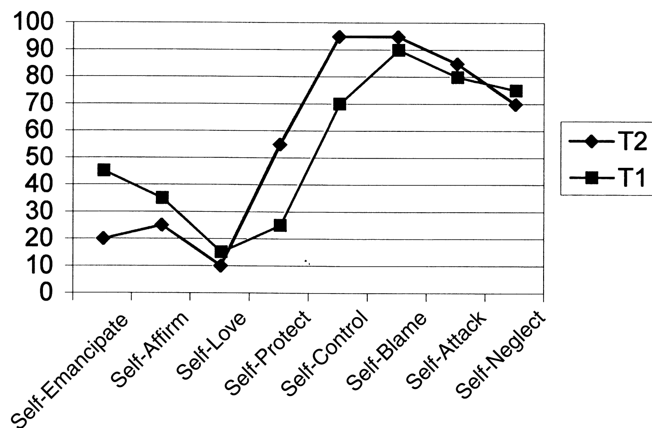


FIGURE 2 Mary's view of her mother is reflected in her introject (top). Her self-protectiveness and self-control began to improve early in IRT therapy (bottom).

Mary's mother's barhopping, coded, **IGNORE.** As she continued IRT, Mary internalized aspects of this corrective experience, and came closer to (but did not reach) the goal of letting go of the hope of rewriting childhood (discussed below). As time went by, the therapist offered less overt structure. Mary began to work on other skills, which included self-discovery, self-definition, and other "higher level" goals.

In general, the case formulation method in IRT requires that each presenting problem be linked to a key figure (usually a caregiver in childhood) by one of three copy processes. These are (1) be like him or her; (2) act as if he or she is there and in control; (3) treat yourself as did he or she. These processes of internalization are respectively called identification, recapitulation, and introjection. Usually copy processes are described directly by the SASB predictive principles. Copy process #1 applies the principle of similarity. Mary did not exhibit this process. Process #2 often reflects complementarity. Mary had recapitulated the violence in her relationship with her mother in her first marriage to a violent man. She retained the role of victim. Her second husband was

not physically abusive, but he did specialize in neglect and rejection. She repeated the fate of being unwanted. Process #3 is introjection. As Figure 2 suggests, Mary introjected her mother's violence and degradation as well as the neglect. Copy processes can sometimes be seen in negative image, measured in terms of points 180 degrees apart on the SASB model. For example, Mary showed negative identification with her neglectful mother in that she had been very, perhaps too, protective of her own child.

This idea that patterns of disorder are replications of patterns learned long ago in relation to loved ones is startlingly simple. It is common for patients in IRT to say "I cant believe it, but it really is true: I am just like him!" Copying is universal, and, according to IRT, the difference between normality and pathology is simply in what is copied. Normal parents function from a baseline described by the SASB points **AFFIRM. ACTIVE LOVE**, and **PROTECT**, shown on the right-hand side of Figure 1. Normal children complement these behaviors with DISCLOSE, REACTIVE-LOVE, and TRUST. These baseline behaviors, described by SASB as friendly and moderately enmeshed and moderately differentiated, are called the attachment group (AG). Normal people internalize these benevolent ways of relating to themselves and others. Severely disturbed patients, like Mary, are more likely to have lived with baselines of **IGNORE**, **ATTACK**, and **BLAME**, called the disaffiliative attachment group (DAG) of behaviors. Like Mary, they internalize hatred of self and/or others.

The core issue in treatment planning in IRT therapy is to lock on to the motivation that is maintaining the copy processes that implement the problem patterns. Why are the copy processes sustained? For example, why does Mary continue her mother's norm of attacking herself? IRT's answer to the question is that it is for love. Every psychopathology is a gift of love. The "Gift of Love" hypothesis holds that behaving according to the "rules" of the internalized representation of the attachment figures, called important persons and their internalized representations (IPIRs), is an attempt to seek "psychic proximity." Doing things his or her way offers psychic security in the same way that the toddler is reassured by returning to the mother for a hug. This perspective is named the developmental learning and loving (DLL) theory of psychopathology. The fact that people will maintain patterns from childhood despite their enormous cost in adulthood is evidence of the stunning power of early figures in the development of the psyche.

It follows that if the problem patterns reflect early learning through copy process maintained by the gift of love, then the treatment plan must target that attachment. Somehow, the patient must give up the organizing wishes to rewrite history, or to wreak revenge (followed by reconciliation). The heart of reconstructive change will involve grieving what has been lost and what can never be. The patient must see and accept that childhood cannot be relived better and "righter." Letting go of those wishes is not easy. Tragically, the less secure and the more damaged the person, the more likely he or she is to cling to old fantasies of rescue or restitution. It takes good security and a solid psychological base to be able to let go of old patterns and move on to friendly independence.

IRT attempts to facilitate the development of new bases so that the patient can have the courage to let go and live differently and better. The therapy relationship is part, but not all, of the process of building a new base. Sometimes the parenting figure himself or herself can best serve this role.[2] The IRT therapist is quite active in helping the patient chose and maintain current relationships that are based in the normal (AG) range of behaviors. This is easier said than done, for there are powerful forces[3] that call the patient back to the familiar domain of DAG.

In the effort to transform the gift of love, every intervention in IRT is supposed to comply with three requirements: (1) It must conform to the case formulation, already discussed; (2) in addition, an intervention must implement one or more of five therapy steps; (3) finally, a good intervention implements the core algorithm.

The five therapy steps are (a) collaboration; (b) learning what your patterns are, where they are from, and what they are for; (c) blocking maladaptive patterns; (d) enabling the will to change; and (e) learning new patterns. Each of these five steps can be facilitated by any and all interventions known to the domain of psychotherapy. Therapy techniques are classified in two subgroups depending on whether they facilitate (a) experiencing or (b) self-management. In general, techniques from psychodynamic therapies encourage experiencing (e.g., discovery of ancient patterns and buried feelings through free association). Those from

[2] This requires that the parent is currently not defensive and, more important, that the therapist is not blaming. The assumption is that the pathology stems from the internalized representation, not the "reality."

[3] Complementarity with current figures is one such force for stasis. Most threatening, however, is the fact, that when people give up old patterns, they lose their identity. "I don't know who I am if I am not what I have been." This undefined state can be quite terrifying, and one resolution is to go back to the old ways.

behavioral therapies (e.g., learning and practicing skills in assertiveness) are more likely to invoke self-management techniques. Both domains of intervention are required in IRT: (1) The patient has to experience how it was and is to engage the will to change; (2) once he or she decides to change, learning better self-management can follow. According to IRT, the main difference between psychodynamic and behaviorally oriented therapies is in their relative emphases on (1) and (2).

When choosing an intervention, it often is helpful to think of the patient as, in effect, two people. The part that comes to therapy and hopes to change to function and feel better is called the growth collaborator (GC) or the "Green." The part of the person that wants to remain loyal to old ways is the regressive loyalist (RL), or the "Red." The conflict between the Green and the Red is everpresent and can be understood only after the case formulation is clear. In Mary's case, for example, the Red was often furious when someone showed signs of rejecting her; she was likely to react with self-destructive behavior. The Green, by contrast, would reflect carefully on why Mary was so panicked and angry about being left, and how her behaviors encouraged her husband to avoid her (step 2). For someone still in a problem relationship, these insights can help the patient contain the actions that alienate the spouse (step 3). Later, the patient can consider ways of relating to the spouse that might be more successful (step 5). Unfortunately, the Green cannot do much until the Red has had her say and the patient is truly sick of repeating the pattern. That decision to give up the ancient ways (step 4) is the most critical and most elusive part of therapy. It is facilitated if the therapist can minimize interventions that support the Red, and maximize those that encourage the Green. This can be altogether tricky. For example, after a fight with her husband, therapist efforts to encourage better patterns (help the Green) could easily be seen by Mary as blaming her (excite the Red). By using carefully chosen words informed by SASB codes of the therapy process and the case formulation, the therapist can make interventions that are perceived mostly as Green.

Finally, the core algorithm requires that the clinician extract from the therapy narrative a current episode that reflects the presenting problems. In Mary's case, for example, anything involving rejection, attack, or blame would be highly relevant. The clinician makes sure that each episode is fully explored in terms of (1) input, (2) response, and (3) Impact on self. A second feature of the core algorithm is to remember to attend to three domains, called the ABCs (affect, behavior, and cognition). The third feature of the core algorithm is that the clinician should try to enhance the Green and minimize the Red. For example, if Mary reports an episode of raging and crying when her date does not show up for lunch, it is appropriate to conduct a verbal walk through her morning up to the point where the rage erupted. This includes consideration of input (what set her off); response (rage and despair); and impact on self ("Nobody will ever love me"). The therapist encourages Mary to describe not only the situation and her behavior (B), but also her feelings (A) and her thoughts (C) about it. This could take most of a session. It would be excellent if the discussion also could contribute to her program of learning about how her repetition of patterns of rejection and abuse is related to the residuals of her attachment to her mother. (Her sexually abusive father also is an important part of Mary's story, but cannot be developed here.) After substantial repetition and lots of support, Mary eventually can "get the picture" emotionally and behaviorally as well as cognitively. That, of course, is the most difficult and challenging step for both patients and therapists. Various additional specific procedures to facilitate that realization and enhance the decision to let go are discussed in Benjamin. When the old wishes are given up, Mary and other IRT patients can give up the quest and the associated repetitions of the family scenario.

II. THEORETICAL BASES (CONCEPTUAL UNDERPINNING)

Bowlby argued that having reliable access to a supportive primary caregiver provides basic security required for independence. He emphasized that security is not the direct result of receiving food or the satisfaction of other needs. Harlow confirmed Bowlby's view of attachment by showing that baby monkeys gained more security and willingness to explore from having a huggable terry cloth laboratory mother that did not provide milk, than from a bare wire mother that did. Harlow suggested that contact comfort is a key component of attachment. Bowlby further proposed that children organize their behavior around internal working models derived from experience with their attachment persons. Copy process theory draws directly on Bowlby's concept of internal working models. Describing an individual's patterns in terms of the SASB model simply makes more explicit the nature of the internal models and their connection to the problem behaviors. Bowlby's work with attachment as a primary drive was revolutionary. Today's burgeoning literature continues to show that early attachment has a profound impact on mental and physical health.

IRT combines the fundamental principles from attachment theory with behavior theory. From behavior theory comes the idea that what works is likely to be repeated. Therapy must therefore identify and change the rewards. Attachment theory provides the definition of what "works." In other words, psychic proximity is the main "reward." IRT's focus on attachment demotes traditional "drivers" such as anger, rage, power, superiority, and the like. These human traits are very much a part of IRT, but they are not considered to be the primary targets of intervention. IRT centers instead on love for an important person and his or her internalized representation (IPIR). Once the loyalty to that internal representation is transformed,[4] the patient is free to learn and implement an entirely new and better way of living.

III. EMPIRICAL STUDIES

There have been many published studies of the methodological and clinical validity of the SASB model. There have been no formal published studies on the validity of IRT. However, IRT has repeatedly been successfully applied in a difficult-to-treat population, illustrated by Mary. The main measures have been in "testimonials" and in dramatic reductions in numbers of hospitalizations and suicide attempts. Scattered sets of before and after measures using Intrex questionnaires and symptom scales also are encouraging. However, with these severely disordered individuals, treatment may have to last for 2 or more years to achieve definitive and stable remission. The present hope is to conduct formal clinical trials at the University of Utah Neuropsychiatric Institute and possibly with colleagues at the University of Pittsburgh.[5]

IV. SUMMARY

IRT seeks to treat "nonresponders" by directly identifying and transforming the underlying motivations for the interpersonal and intrapsychic problems. The presenting problems are linked specifically to relationships with early caregivers in the form of three types of copy process: be like him or her; act as if he or she is still there and in control; treat yourself as did he or she. The motivation for copy process is to implement the rules or values of the persons being copied in order to provide testimony to their beliefs and to achieve reconciliation with them. The treatment implication of this "Gift of Love" hypothesis is that these now impossible wishes must be recognized, grieved, and given up. Then, personality reconstruction can begin. To reach that goal, IRT draws from any and every school of therapy as long as an intervention can achieve one of five therapy steps, use the core algorithm, and fit the case formulation. Assessment of patterns, copy links, therapy process, therapy content, and the effectiveness of therapy steps are greatly facilitated by clarity and explicitness provided by the SASB model and its associated technology.

[4] It is assumed that the neurologically based templates that have been implementing the problem patterns must be transformed by the new learning.

[5] Paul Pilkonis and Jennifer Skeem have teams of clinicians engaged in preliminary trials to gather pilot data preparatory to applying for grant support.

Acknowledgments

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This chapter derives from and summarizes portions of Benjamin, *Interpersonal Reconstructive Therapy,* currently in press with Guilford Publications.

See Also the Following Articles

Configurational Analysis ■ Formulation ■ Sullivan's Interpersonal Psychotherapy

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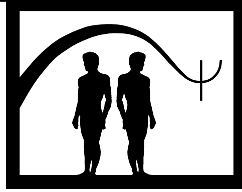

Structural Theory

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I. Limitation of the Topographic Model
II. Structural Theory
III. The Id
IV. The Ego
V. The Superego
VI. Structural Conflict
VII. Technical Implications
Further Reading

GLOSSARY

autonomous ego functions *Primary:* Inborn functions that follow a development timetable that unfold sequentially, so long as the environment does not interfere. Includes processes such as cognition, perception, and language. *Conflict free:* Refers to primary autonomous ego functions that arise without precondition of conflict. *Secondary autonomy:* Ego functions that arise out of conflict but become independent of such conflict.

compromise formations The balance of superego injunctions and id demands created by the ego and manifested in fantasies, symptoms, dreams, character traits, etc.

condensation A process whereby a sole idea represents several associative changes and is part of the functioning of the id.

displacement The process employed by the id in which an idea's emphasis, interest, or intensity is detached and passed onto other ideas.

drive derivatives The surface and conscious representation of id drives.

drives Psychic representation of instinctual and biological needs and urges.

ego The psychic structure posited by the structural theory developing out of the id, which functions as a synthesizing agency between the demands of the superego and the pressure for expression in the id. Functions include self preservation, perception, motility, learning, memory, cognition, language, reality testing, and the synthetic function.

ego psychology An offshoot of structural theory developed by Heinz Hartman and David Rapaport emphasizing the role of the ego in mental life.

id Identical to the earlier concept of the System Unconsious. The id is, in the structural theory, the reservoir for psychic representation of the two instinctual drives of libido and aggression.

infantile sexuality The idea that infants and children have sexual intentions, aims, and motivations.

intrapsychic conflicts Conflicts between intentions of the person, both conscious and unconsious, in conflict with the demands of external prohibitions.

libido The instinctual drive oriented towards merging, and is generally thought to be the basis of sexuality.

pleasure principle The economic concept of the organization of the mind under the structural theory that posits the motivating drive as the discharge of excitations, experiences, pleasure.

primary process A type of logic employed by the id in which the pleasure principle guides the direction of behavior. It is a timeless process that modifies distinctions in order to create representations and opportunities for pleasurable discharge.

reality principle The manner in which the ego carries out its work based on a perception and measurement of social reality demands.

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resistance A defense aimed towards keeping the unconscious material activated by analysis or psychotherapy from reaching consciousness.

secondary process thinking The mode used by the ego that is based on logic, linear thinking, and time orientation.

structure A group of psychological functions or processes that are organized hierarchically and have a slow rate of change.

superego The psychological structure that represents the internalization of the parents' values and prohibitions and consequently those of the larger social cultural world.

topographical model An early model of psychoanalytic theory developed by Sigmund Freud which characterized mental phenomenon as being unconscious or conscious in postulated functions in a relationship to these qualities of mental life. This thinking included the ideas of systems unconscious, preconscious, and conscious.

I. LIMITATION OF THE TOPOGRAPHIC MODEL

Structural theory, sometimes referred to as the structural model or the tripartite model, refers to Freud's final and ultimate model of the mind that he first introduced with his book, *The Ego and the Id* in 1923, and elaborated in *Inhibitions, Symptoms, and Anxiety* in 1926. This shift in conceptualizing the workings of the mind away from the topographic model that had organized his thinking for over 20 years was prompted by Freud's realization that his topographic theory had too many theoretical inconsistencies to remain viable, and that it could not account adequately for a variety of clinical phenomena, most notably unconscious guilt. Freud came to see that understanding the workings of the mind, particularly the intrapsychic conflicts that give rise to most mental phenomena, needed to be based on something other than the relationship of mental contents and functions to consciousness. Thus, he changed his metaphors for understanding the mind away from the notion that mental contents moved from the depths to the surface. To accomplish this goal and to ensure that his new model more adequately explained the complexity of the psyche necessitated the relinquishing of his constructs of the systems Unconscious, Preconscious, and Conscious.

II. STRUCTURAL THEORY

These layers or stratas of the mind were replaced by what he first called agencies and later called structures—the id, the ego, and the superego. The term structure is an ambiguous one in psychoanalysis, although most analysts adhere to the definition of David Rapaport that the term refers to a group of psychological functions or processes that are organized hierarchically and have a slow rate of change. The id, ego, and superego are certainly not the only mental structures that comprise the mind. But they are thought to be its superordinate structures, leading Merton Gill to refer to them as macrostructures. It is assumed by most psychoanalysts that the mind is composed completely of these three superordinate structures, each of which can have substructures. The interrelationships within and between these three structures, particularly intrapsychic conflict, are what give rise to most mental phenomena and all psychologically mediated behavior.

Freud did not abandon all of the key concepts that he had developed during his topographic era of model building when he replaced it with the structural theory, however. His important concepts of infantile sexuality, libidinal and aggressive drives, unconscious mental functioning, and internal conflict remained as did more dubious concepts such as psychic energy. But these concepts were modified and integrated into structural theory with varying degrees of conceptual clarity and success. For example, the concepts of unconscious, preconscious, and consciousness were retained. But these concepts now became adjectives, used merely to describe whether any particular mental content or process was within the individual's conscious awareness or not. The terms no longer retained any structural or systemic implications. Despite this fundamental reconceptualization, it is not uncommon, even today, to hear psychoanalysts speak of the Unconscious as though it were a structure, to imply that unconscious mental phenomena are somehow deeper and more primitive than conscious mental phenomena, or to talk about the technical need to make the Unconscious conscious. Such analysts seem not to realize that such ways of thinking about analytic matters are outdated and at odds with how we have come to understand the workings of the mind.

III. THE ID

Nonetheless, conceptual overlap between the earlier topographic model and the later structural one remains important in understanding the intricacies as well as the necessity for utilizing structural theory in clinical situations. Perhaps the clearest overlap between the two models involves how Freud formulated the id. The id is virtually identical with the earlier concept of the system

Unconscious. Thus, it is the reservoir for psychic representations of the two instinctual drives, libido and aggression. As such its contents revolve around the basic, pleasure-seeking urges of mankind. It operates according to the pleasure principle and is organized according to the logic (or lack thereof) of the primary process. Freud retained his concept of psychic energy when he developed the structural model and he used differences in the nature of psychic energy to explain differences between structures of the mind. Psychic energy was thought to be mobile and its discharge rapid in the id, allowing for the clinical manifestations of primary process thinking—condensation and displacement. Drives were thought to be relatively unfused in this structure. Freud was drawn to the analogy of the id as a wild, untamed horse that had to be broken by the rider, the ego. Thus, he saw the ego as developing out of the id so that the individual could adapt to reality rather than run amok as the id's drives were given free rein. Freud viewed the contents of the id as dynamically unconscious; that is, they were defended against so as not to reach conscious awareness and cause unpleasure. He thought that they could only be known through their surface manifestations—what came to be called drive derivatives. More recent theorists such as Charles Brenner have questioned this dichotomy, arguing that the concept of drives is a purely theoretical and abstract one. To the degree that drive derivatives are the real clinical phenomena encountered, their availability to consciousness is a graded one. It is simply at odds with clinical experience to speak of completely unconscious drives.

IV. THE EGO

The ego is generally accepted as the most important structure of the mind in understanding the ability of humans to adapt and to survive in the world. In fact, it is so important that psychoanalytic thinkers such as Heinz Hartmann and David Rapaport developed an offshoot of structural theory, called ego psychology, between the late 1940s and the early 1960s. Their ideas are generally subsumed under the rubric, structural theory, today. But their wish to highlight the importance or even preeminence of the ego among the structures of the mind is worth noting. As will be described later, it has major implications for the clinical practice of psychoanalysis. Freud described the ego as developing out of the id because of the necessity to mediate between the drive wishes of the id and the demands and restrictions of external reality. As development proceeds, the ego comes to balance superego injunctions along with these other pressures. Thus, it is the source of compromise formations manifested in fantasies, symptoms, dreams, character traits, and so on. The ego accomplishes this complex task of mediating between the id, superego, and external reality according to the reality principle and through the use of secondary process thinking. The ego psychologists emphasized that the ego's structure was so complex and its mode of organization so substantially different than that of the id that it seemed more likely that both structures evolved out of an originally undifferentiated psychic matrix. This model of the mind developing through progressive differentiation is far more in keeping with modern concepts of developmental psychology than is Freud's metaphor of the rider ego.

Regardless of how one understands its origins, the ego remains understood as the "coherent organization of mental processes" that Freud described. Its most important clinical function is that of defense. That is, the ego monitors the conscious awareness and/or expression of id impulses and uses a wide array of defense mechanisms to keep them from arousing excessive unpleasure or causing danger to the individual. The ego does not just defend against the id, however. Defenses are just as readily deployed against the superego or against perceptions of external reality.

Defense is also not the only ego function. In *An Outline of Psychoanalysis* Freud discussed other ego functions including self-preservation, perception, motility, and learning. Later memory, cognition, language, reality testing, and the synthetic function of the ego were described by psychoanalysts including Anna Freud, Hartmann, Kris, and Loewenstein, Bellak, Arlow, and Brenner. All agree that it is impossible to develop a comprehensive list of ego functions because the mind is so complex. Nonetheless a particularly useful delineation of 12 ego functions that can be empirically measured has been developed by Leopold Bellak and his collaborators. These 12 functions include reality testing; judgment; sense of reality of the world and of the self; regulation of drives, affects, and impulses; object relations; thought processes; adaptive regression in the service of the ego; defensive functioning; stimulus barrier; autonomous functioning; synthetic-integrative functioning; and mastery–competence. This list is neither exhaustive nor theoretically consistent. But it does demonstrate the complexity of the ego and does offer a method of quantitative research.

Many of these functions also help to clarify another reason that the ego psychologists objected to Freud's idea that the ego developed out of the id. Freud's idea carried with it the notion that all ego functions arise

out of intrapsychic conflict and are influenced by the id. Reality testing, for example, was thought to arise out of hallucinatory wish fulfillment conflicting with external reality. In contrast Heinz Hartmann argued that many ego functions are primarily autonomous. That is, they are inborn and follow a developmental time table that will unfold sequentially as long as the environment does not interfere. Processes such as cognition, perception, and language, for example, are conflict-free. Conflict was not necessary for their genesis or development. Other ego functions achieve what Hartmann called secondary autonomy. That is, certain functions or personality traits may originally develop out of conflict but over the course of development become functionally autonomous. Thus, conflict-related behaviors can become independent of their roots. This concept helps to explain the imperviousness of certain fantasies or character traits to interpretation, despite the therapist's ability to analyze and interpret all the various conflicts that gave rise to it.

V. THE SUPEREGO

The superego was the third structure of the mind in Freud's structural theory. In large part it is this structure and the clinical phenomena that it elucidates that caused Freud to develop his structural model in the first place. Prior to giving up the topographic model, Freud struggled to understand the phenomenon of unconscious guilt and its clinical manifestations, particularly the negative therapeutic reaction and issues pertaining to masochism. To explain these phenomena, he offered the concept of the superego as the internalization of the parents' values and prohibitions. He described it as developing out of the ego and becoming a full-fledged structure in its own right as part of the child's oedipal resolution. This latter point continues to be debated in the literature. Some contemporary structural theorists such as Paul Gray argue that the superego is just a specialized ego function and not a structure in its own right. In contrast some child psychoanalysts have noted the presence of a fully functioning superego far earlier than oedipal resolution and have argued that its function as a separate mental structure needs to be kept conceptually separate from the developmental level of the drives against which it is pitted. Despite these subtleties of theory, most psychoanalysts see the superego as crucial in understanding behavior. In essence it functions both as a conscience and as an internalized set of ideals, both of which are significant motivators of behavior.

VI. STRUCTURAL CONFLICT

These three structures of the mind—id, ego, and superego—function both on their own and interact in ways that determine every aspect of human behavior. But it is important to realize that calling structural theory a tripartite model is somewhat misleading. This is because external reality plays a far more prominent role in structural theory than it did in the earlier topographic model. Because the structural model stresses the importance of adaptation to an external environment, external reality is viewed as placing demands on the ego's mediating abilities just as much as the id and the superego. Thus, the compromise formations that the ego organizes to balance these sources of pressure must take into account reality's demands also.

The clinical implications of this model generally involve its role in intrapsychic conflict. Conflict between any of the structures can occur as can intrastructural conflicts wherein subprocesses or functions of each structure conflict with each other. Examples of the former include an ego defense arrayed against an id drive or a superego injunction deployed against an id drive or an ego function. An intrastructural conflict might involve competing ideals within the superego, for example. The fantasies, symptoms, behaviors, or character traits for which patients seek therapy are understood as compromise formations involving the ego's attempt to mediate the conflicts between these structures and external reality.

VII. TECHNICAL IMPLICATIONS

Only recently have psychoanalysts delineated a manner of working with patients that follows logically from this structural model. Fred Busch and Paul Gray are the two psychoanalysts most closely associated with a contemporary structural approach to technique. In essence, this way of working with patients emphasizes the need to expand the patient's autonomous ego functioning by teaching him or her to observe intrapsychic conflict as it becomes manifest in sessions. The patient is taught to closely observe his or her associations with a particular lookout for evidence of resistance. Resistance is monitored carefully with the analyst listening to and teaching the patient to listen for moments in the analytic process when resistance to the direct and unfettered expression of thoughts or feelings occurs. The patient learns to oscillate between being in analysis and observing the free associations that characterize the psychoanalytic process.

The goal of an analysis shifts from the topographic emphasis on making the unconscious conscious so that core unconscious fantasies can be changed to gaining mastery over them by thinking about them. Resistance analysis gains center stage in analytic technique guided by structural theory rather than being a means to an end with the end being making unconscious mental contents conscious. Self-analysis becomes a key criterion for termination, as patients master the analytic way of thinking and apply it to their own associations, particularly noticing unconscious defensive activity aimed at keeping thoughts out of awareness.

This approach to analytic technique is based on the realization that the way in which the ego handles its task of mediating the other structures and reality determines psychological health. Thus, the way in which a person thinks, and the amenability of that thinking to analytic interventions, are more important than the contents of that thinking. Oedipal, preoedipal, narcissistic, and so on refer to mental content. But structural theory, in contrast to earlier analytic models, focuses on mental structure. Analysts now try to help the patient to reestablish mental connections that have been disrupted by defense rather than to recover memories or fantasies. Structural theorists such as Busch or Gray take the ego's synthetic function seriously. Thus, insight becomes directed at understanding the workings of the patient's mind instead of at deep, hidden, mental content. New solutions to conflict emerge as a result of bringing the conflict between unconscious wishes and defenses or superego under the scrutiny of the autonomous ego.

Toward this end, vicissitudes of conflict are addressed by the analyst as they appear in sessions. Busch points out that the ego is regressed when in the midst of conflict so that thinking becomes preoperational and concrete. Thus, interventions by the analyst must be concrete and immediate in order to be grasped by the patient's regressed ego. Conflict, as it occurs in the associational processes, can be seen more readily by the patient than unconscious content, which is more abstract, and less immediately visible. Furthermore, interpretations of deep unconscious content as practiced under the topographic model risk analytic change occurring on the basis of identifying with the analyst's authority rather than on any expansion of the ego's ability to perceive and master conflict. Finally, the structural model postulates that the ego defends against unconscious id contents because they would stimulate excessive anxiety or guilt if they became conscious. To address these contents directly without first exploring and modifying the anxieties that motivate the defense will only increase the patient's anxiety and resistance.

Although such technical implications may seem obvious, they have only been elucidated over the past 15 years. Until then psychoanalysts practiced according to an implicitly topographic perspective despite their belief that they were operating from a structural orientation. This state of affairs was due primarily to Freud's writings on technique having been published during his topographic era of theorizing. He never returned to the theory of technique after formulating his structural model. Thus, too many psychoanalysts clung to outdated ways of working or of formulating their work because of their wish to remain true to Freudian technique. Even today it is not uncommon to hear analysts interpret unconscious anger, for example, before they have interpreted and understood the patient's reluctance to be aware of his or her anger. Furthermore, psychoanalysts of orientations other than Freudian have continued to misunderstand structural theory so that their critiques of so-called Freudian technique seem appropriate to technical concepts of the topographic era and not relevant to a truly structural approach to psychoanalytic practice. Modern day or contemporary structural theory offers a model and way of working with patients that is the most comprehensive and integrative of psychoanalytic approaches today. It is capable of integrating the clinical findings of self-psychology or object relations theory while retaining all of Freud's brilliant insights into the organization of the mind and the way in which this organization affects behavior.

See Also the Following Articles

Intrapsychic Conflict ■ Oedipus Complex ■ Structural Analysis of Social Behavior ■ Topographic Theory ■ Transference Neurosis ■ Unconscious, The

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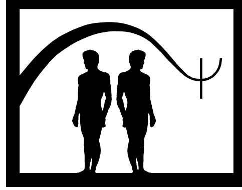

Substance Dependence: Psychotherapy

Kathlene Tracy, Bruce Rounsaville, and Kathleen Carroll

Yale University

I. Description of Treatment
II. Theoretical Bases
III. Empirical Studies
IV. Summary
Further Reading

GLOSSARY

community reinforcement approach Interventions based on learning theory that are designed to rearrange significant aspects of local communities, such as vocational, family, and social activities, to differentially support a non-substance-using lifestyle.

disease model approach Interventions that help the individual who abuses substances accept that they have an illness or disease and surrender by acknowledging that there is hope for sobriety through accepting the need for help from others and a higher power. A major goal is fostering active participation in self-help groups (e.g., AA, NA, CA).

methadone maintenance A pharmacological approach to the treatment of opioid dependence in which the individual who abuses opioids is maintained on an agonist, methadone, that has action similar to that of the abused drug but is considered to be less harmful.

substance abuse (*DSM–IV* criteria) A maladaptive pattern of substance use not due to dependence leading to significant impairment or distress that is characterized by one or more of the following occurring at any time in a 12-month period: recurrent substance use resulting in failure to fulfill major role obligations at home, work, or school; recurrent substance use in physically hazardous situations; recurrent substance-related legal problems; continued use despite having persistent or recurrent interpersonal or social problems exacerbated or caused by the effects of using.

substance dependence (*DSM–IV* criteria) A maladaptive pattern of substance use leading to significant impairment or distress that is characterized by three or more of the following occurring at any time in a 12-month period: tolerance; withdrawal; taking the substance in larger amounts or for longer periods than intended; expressing a desire to cut down on use or unsuccessful efforts to cut down or stop using; spending large amounts of time obtaining the substance, using, or recovering from the substance's effects; important social, occupational, or recreational activities have been given up or reduced because of the substance use; and continued use despite recurrent physical or psychological problems that is made worse or caused by the use.

therapeutic community An intervention that supports the individual's submission to group ideology of abstinence from substances. Every aspect of the individual's daily life is regimented often through confinement, structure, and daily work assignments.

Given the place of this article in a volume describing a variety of psychotherapeutic approaches, this article focuses on those aspects of individual and group therapy that are unique to the treatment of substance dependence. This article presents guidelines on therapy applicable to those both dependent on alcohol as well as those dependent on other drugs.

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I. DESCRIPTION OF TREATMENT

Some form of psychotherapy or behavioral therapy is usually considered as a treatment option for virtually all patients seeking treatment for substance use disorders. Treatment seekers typically represent the more severe end of the spectrum of community members who meet criteria for current substance use disorders. Most of those who seek treatment do so only after numerous unsuccessful attempts to stop or reduce substance use on their own. The alternatives to psychotherapy are either pharmacological or structural limitations from access to drugs and alcohol such as in residential setting. Both these alternatives have limited effectiveness if not combined with psychotherapy or counseling. Removal from the substance-using setting is a useful and, sometimes, necessary part of substance treatment but is seldom sufficient, as is shown by the high relapse rates typically seen from residential detoxification programs or incarceration during the year following the patient's return to the community.

The major strategy that is now common to all currently practiced psychotherapies for individuals who abuse substances is to place primary emphasis on controlling or reducing substance use, while pursuing other goals only after substance use has been at least partly controlled. This means that either (a) the therapist employs techniques designed to help the patient stop substance use as a central part of the treatment, or (b) the therapy is practiced in the context of a comprehensive treatment program in which other aspects of the treatment curtail the patient's use of substances (e.g., methadone maintenance, disulfiram for alcoholics, residential treatment). Because people who abuse substances frequently react to increased anxiety or other dysphoric affects by resuming substance use, anxiety-arousing aspects of treatment are typically introduced only after a strong therapeutic alliance has been developed or within the context of other supportive structures (e.g., inpatient unit, strong social support network, methadone maintenance) that guard against relapse to substance use when the patient experiences heightened anxiety and dysphoria in the context of therapeutic exploration.

Psychotherapy to treat substance abuse can occur in a variety of settings. For example, individuals who are severely dependent remain unsuccessful at achieving abstinence may become inpatients or be admitted to a detoxification program. While in the detoxification program, the individual may receive brief directed psychotherapy that focuses mainly on controlling the impulse to use. In partial hospitalization or residential treatment programs, psychotherapy offered is typically longer in duration, and not only focuses on the impulse to use, but also includes a greater representation of managing and changing behavioral aspects that contribute to or maintain the person's substance use. In outpatient treatment settings, psychotherapeutic treatments often include all the components previously mentioned as well as an opportunity to engage in longer-term treatment that can address broader issues in the patient's life that may indirectly play a role in the individual's ability to remain abstinent.

Beyond setting differences, psychotherapy for substance use disorder may be delivered in a range of different modalities, such as group or individual. Major advantages to group substance treatment are: (a) cost savings, (b) given the social stigma attached to having lost control of substance use, having group members who acknowledge similar problems can provide comfort, (c) group members who have longer periods of abstinence can model that attempting to stop using is not a futile effort, (d) group members can act as social supports, and (e) the public nature of the group can provide powerful incentive to avoid relapse. Principal advantages to individual substance treatment are: (a) privacy for members whose careers or reputations may be damaged from more widespread knowledge of their substance use, (b) increased flexibility to address problems that are uniquely relevant to that patient, (c) easier resolution of logistics surrounding therapist caseloads where often there are not enough substance abuse clients to form a group or determent from individuals having to wait to engage in treatment until the group is formed, and (d) therapists may use the one-to-one relationship to explore relational elements not possible in group treatment.

II. THEORETICAL BASES

The history of individual psychotherapy for substance abusers has been one of importation of methods first developed to treat other conditions. Thus, when psychoanalytic and psychodynamic therapies were the predominant modality for treating most mental disorders, published descriptions of dynamics of substance abuse or of therapeutic strategies arose from using this established general modality to treat the special population of individuals who abuse substances. Likewise, with the development of behavioral techniques, client-centered therapies, and cognitive-behavioral treatments, earlier descriptions based on other types of patients were followed by discussions of the special modifications needed to treat substance abuse.

Although always present as a treatment option, individual psychotherapy has not been the predominant treatment modality for substance abusers since the 1960s, when inpatient 12-step informed milieu therapy, group treatments, methadone maintenance, and therapeutic community approaches came to be the fixtures of substance abuse treatment programs. In fact, these newer modalities derived their popularity from the limitations of dynamically informed ambulatory individual psychotherapy when it was used as the sole treatment for substance abusers. Many reported problems with dynamic treatment. Some of the difficulties reported for this form of treatment were premature termination, reaction to anxiety-arousing interpretations with resumption of substance use, erratic attendance at sessions, difficulties posed by attending sessions while intoxicated, and failure to pay fees because money was spent on drugs and alcohol.

Most schools of therapy, with widely varying rationales and strategies, have been adapted for potential use to treat substance abuse. Rather than focus on specific techniques associated with the different approaches, this article focuses on two topics that can guide substance abuse therapy within a variety of different schools: (a) specialized knowledge needed to apply psychotherapy to treat substance abuse, and (b) common goals and strategies that must be addressed by psychotherapists.

A. Areas of Specialized Knowledge to Treat Substance Abuse

1. Understanding the Effects of Using

The principal areas of knowledge to be mastered by the beginning therapist are the pharmacology, use patterns, consequences, and course of addiction for the major types of abused substances. For therapy to be effective, it is useful not only to obtain the academic knowledge about frequently abused substances, but also to become familiar with street knowledge about drugs (e.g., slang names, favored routes of administration, prices, availability) and the clinical presentation of individuals when they are intoxicated or experiencing withdrawal from the different abused substances. This knowledge has many important uses in the course of individual therapy with individuals who abuse substances.

First, it fosters a therapeutic alliance by allowing the therapist to convey an understanding of the addicted person's problems and the world in which he or she lives. This is an especially important issue when the therapist is of a different background from the patient who abuses substances. In engaging the patient, it is important to emphasize that the patient's primary presenting complaint is likely to be substance abuse, even if many other issues are also likely to be amenable to psychotherapeutic interventions. Hence, if the therapist is not comfortable and familiar with the nuances of problematic drug and alcohol use, it may be difficult to forge an initial working alliance. Moreover, by knowing the natural history of substance abuse and the course of drug and alcohol effects, the clinician can be guided in helping the patient anticipate problems that will arise in the course of initiating abstinence. For example, knowing the typical type and duration of withdrawal symptoms can help the individual recognize their transient nature and to develop a plan for successfully completing an ambulatory detoxification.

Second, knowledge of substance actions and withdrawal states is crucial for diagnosing comorbid psychopathology and for helping the person who is addicted to understand and manage dysphoric affects. Most abused substances such as opioids or cocaine are capable of producing constellations of symptoms that mimic psychiatric syndromes such as depression, mania, anxiety disorders, or paranoia. Many of these symptomatic states are completely substance induced and resolve spontaneously when substance abuse is stopped. It is frequently the therapist's job to determine whether or not presenting symptoms are part of an enduring, underlying psychiatric condition or a transient, substance-induced state. If the former, then simultaneous treatment of the psychiatric disorder is appropriate; if the latter, reassurance and encouragement to maintain abstinence are usually the better course. Over the last decade, co-occurrence of psychoactive substance use disorders with other psychiatric disorders have become much more widely recognized and are of common occurrence in most treatment facilities.

Third, learning about drug and alcohol effects is important for detecting when patients have relapsed or have come to sessions intoxicated. It is seldom useful to conduct psychotherapy sessions when the patient is intoxicated, and when this happens the session should be rescheduled for a time when the patient can participate while sober.

2. Understanding Treatment Philosophies

A second area of knowledge to be mastered by the psychotherapist is an overview of treatment philosophies and techniques for the other treatments and self-help groups that are available to patients who abuse substances. As noted earlier, the early experience of attempting individual psychotherapy as the sole treatment of the more severe types of substance abuse was

marked by failure of an early dropout. Hence, for many individuals who abuse substances, individual psychotherapy is best conceived of as a component in a multifaceted program of treatment to help them overcome a chronic, relapsing condition.

Another major function of knowing about the major alternative treatment modalities for substance abusers is to be alert to the possibility that different treatments may provide contradictory recommendations that may confuse the patient or foster the patient's attempts to sabotage treatment. Unlike a practitioner whose treatment is likely to be sufficient, the individual psychotherapist does not have the option of simply instructing the patient to curtail other treatments or self-help groups while the treatment is taking place. Rather, it is vital that the therapist attempt to adjust his or her own work to bring the psychotherapy in line with the other treatments. It is also important to note that many treatments with high levels of empirical support are not the treatments most widely used clinically.

B. Common Goals and Strategies for Substance Abuse Psychotherapy

This section reviews issues presented by persons who abuse substances that should be addressed, if not emphasized, by any type of individual or group psychotherapy that is likely to be effective. As noted in reviewing the difficulties encountered by early psychodynamic practitioners, the central modification that is required of psychotherapists is always to be aware that the patient being treated is a substance abuser. Hence, even when attempting to explore other issues in depth, the therapist should devote at least a small part of every session to monitoring the patient's most recent successes and failures at controlling or curtailing substance use and being willing to interrupt other work to address slips and relapses when and if they occur.

Implicit in the need to remain focused on the patient's substance use is the requirement that psychotherapy with these patients entails a more active therapist stance than does treatment of patients with other psychiatric disorders such as depression or anxiety disorders. This is related to the fact that the principal symptom of substance abuse, compulsive use, is at least initially gratifying, and it is the long-term consequences of substance use that induce pain and the desire to stop. In contrast, the principal symptoms of depression or anxiety disorders are inherently painful and alien. Because of this key difference, substance abuse psychotherapy typically requires both empathy and structured limit setting, whereas the need for limit setting is less marked in psychotherapy with patients who are depressed or anxious.

Beyond these key elements, this section also elaborates on key tasks that are common to most approaches to psychotherapy for substance use: enhancing motivation to stop substance use, teaching coping skills, changing reinforcement contingencies, fostering management of painful affects, and improving interpersonal functioning. Although different schools of thought about therapeutic action and behavior change may vary in the degree to which emphasis is placed on these different tasks, some attention to these areas is likely to be involved in any successful treatment.

1. Enhancing Motivation to Stop Substance Use

Even at the time of treatment seeking, which usually occurs only after substance-related problems have become severe, patients usually can identify many ways in which they want or feel the need for drugs or alcohol and have difficulty developing a clear picture of what life without substances might be like. To be able to achieve and maintain abstinence or controlled use, individuals who abuse substances need a clear conception of their treatment goals. Several investigators have postulated stages in the development of ones' thinking about stopping use, beginning with precontemplation, moving through contemplation, and culminating with determination as the ideal cognitive set with which to get the most out of treatment.

Regardless of the treatment type, an early task for psychotherapists is to gauge the patient's level of motivation to stop substance use by exploring the treatment goals. In doing this, it is important to challenge overly quick or glib assertions that the patient's goal is to stop using substances altogether. One way to approach the patient's likely ambivalence about treatment goals is to attempt an exploration of the patient's perceived benefits from abused substances or perceived needs for them. To obtain a clear report of the patient's positive attitudes toward substance use, it may be necessary to elicit details of the patient's early involvement with drugs and alcohol. When the therapist has obtained a clear picture of the patient's perceived needs and desires for abused substances, it is important to counter these exploring advantages of a substance-free life.

As noted earlier although virtually all types of substance abuse psychotherapies address the issue of motivation and goal setting to some extent, motivational therapy or interviewing makes this the sole initial focus of treatment. Motivational approaches, which are usually quite brief, are based on principles of motivational

psychology and are designed to produce rapid, internally motivated change by seeking to maximize patients' motivational resources and commitment to abstinence.

2. Teaching Coping Skills

One enduring challenge of treating substance abuse is to help the patient avoid relapse after achieving an initial period of abstinence. A general tactic for avoiding relapse is to identify sets of circumstances that increase an individual's likelihood of resuming substance use and to help the patient anticipate and practice strategies (e.g., refusal skills, recognizing and avoiding cues for craving) for coping with these high-risk situations. Examples of approaches that emphasize the development of coping skills include cognitive-behavioral approaches such as relapse prevention, in which systematic effort is made to identify high-risk situations and master alternative behaviors and coping skills intended to help the patient avoid substance use when these situations arise.

3. Changing Reinforcement Contingencies

As substance abuse worsens, it can take precedence over concerns about work, family, friends, possessions, and health. As compulsive substance use becomes a part of every day, previously valued relationships or activities may be given up so that the rewards available in daily life are narrowed progressively to those derived from substance use. When substance use is brought to a halt, its absence may leave the patient with the need to fill the time that had been spent using drugs or alcohol and to find rewards that can substitute for those derived from use.

An example of an approach that actively changes reinforcement contingencies is the approach developed by Steve Higgins and colleagues that incorporates positive incentives for abstinence into a community reinforcement approach (CRA). This strategy has four organizing features that are grounded in principles of behavioral pharmacology: (a) substance use and abstinence must be swiftly and accurately detected, (b) abstinence is positively reinforced, (c) substance use results in loss of reinforcement, and (d) emphasis on the development of competing reinforcers to substance use.

4. Fostering Management of Painful Affects

Dysphoric affects are the most commonly cited precipitant for relapse, and many psychodynamic clinicians have suggested that failure of affect regulation is a central dynamic underlying the development of compulsive substance use. To foster the development of mastery over dysphoric affects, most psychotherapies include techniques for eliciting strong affects within a protected therapeutic setting and then enhancing the patient's ability to identify, tolerate, and respond appropriately to them.

5. Improving Interpersonal Functioning and Enhancing Social Supports

A consistent finding in the literature on relapse to substance abuse is the protective influence of an adequate network of social supports. Gratifying friendships and intimate relationships provide a powerful source of rewards to replace those obtained by drug and alcohol use, and the threat of losing these relationships can furnish a strong incentive to maintain abstinence. Typical issues presented by individuals who abuse substances are: (a) loss of or damage to valued relationships occurring when using substances was the principal priority, (b) failure to have achieved satisfactory relationships even prior to having initiated substance abuse, and (c) inability to identify friends or intimates who are not, themselves, abusing substances. For some types of psychotherapy, working on relationship issues is the central focus of the work (e.g., interpersonal therapy, supportive-expressive treatment), whereas for others, this aspect is implied as a part of other therapeutic activities such as identifying risky and protective situations.

Again, although most approaches address these issues to some degree in the course of treatment, an approach that strongly emphasizes the development of social supports are traditional counseling approaches, 12-step facilitation, and other approaches that underline the importance of involvement in self-help groups. Self-help groups offer a fully developed social network of welcoming individuals who are understanding and, themselves, committed to leading a substance-free life. Moreover, in most urban and suburban settings, self-help meetings are held daily or several times weekly, and a sponsor system is available to provide the person in recovery with individual guidance and support on a 24-hour basis, if necessary. For psychotherapists working with substance abuse, encouraging the patient to become involved in a self-help group can provide a powerful source of social support that can protect the patient from relapse while the work of therapy progresses.

III. EMPIRICAL STUDIES

In general, the existing literature on behavioral treatment for substance dependence suggests the following:

1. To date, most studies suggest that psychotherapy is superior to control conditions as treatment for substance

abuse. This is consistent with the bulk of findings from psychotherapy efficacy research in areas other than substance use, which suggests that the effects of many psychotherapies are clinically and statistically significant and are superior to no treatment and placebo conditions.

2. No specific type of behavioral treatment has been shown consistently to be superior as a treatment for substance abuse or for other types of disorders as well. However, behavioral and cognitive-behavioral therapies may show particular promise.

3. The studies examining the differential impact of effectiveness of psychotherapy on those who abuse substances with and without coexistent psychopathology indicate with some consistency that those therapies shown to be generally effective were differentially more effective with patients who presented with high levels of general psychopathology or depression.

4. The effects of even comparatively brief psychotherapies appear to be durable among substance users as they are among other populations.

A. Specific Psychotherapy Approaches

In the following section we briefly describe some of the most promising behavioral therapies for substance use that have at least a minimal level of empirical support from randomized clinical trials. Although this is not exhaustive, many of these approaches are making their way into the field.

B. Contingency Management Approaches

Perhaps the most exciting findings pertaining to the effectiveness of behavioral treatments for cocaine dependence have been the recent reports by Higgins and colleagues discussed briefly earlier in the article. In this approach, urine specimens are required three times weekly to systematically detect all episodes of drug use. Abstinence, verified through drug-free urine screens, is reinforced through a voucher system in which patients receive points redeemable for items consistent with a drug-free lifestyle that are intended to help the patient develop alternate reinforcers to drug use (e.g., movie tickets, sporting goods). Patients never receive money directly. To encourage longer periods of consecutive abstinence, the value of the points earned by the patients increases with each successive clean urine specimen, and the value of the points is reset when the patient produces a drug-positive urine screen.

A series of well-controlled clinical trials demonstrated (a) high acceptance, retention, and rates of abstinence for patients receiving this approach relative to standard 12-step-oriented substance abuse counseling, (b) rates of abstinence do not decline substantially when less valuable incentives are substituted for the voucher system, (c) the value of the voucher system itself (as opposed to other program elements) in producing good outcomes by comparing the behavioral system with and without the vouchers, and (d) although the strong effects of this treatment decline somewhat after the contingencies are terminated, the voucher system has been demonstrated to have durable effects.

Moreover, the efficacy of a variety of contingency management procedures (i.e., including vouchers, direct payments, and free housing) has been replicated in other settings and samples, including cocaine-dependent individuals within methadone maintenance, homeless substance abusers, and freebase cocaine users. The use of contingency management procedures has also been effective in reducing substance use in individuals with schizophrenia and substance disorders in addition to individuals who may be homeless.

These findings are of great importance because contingency management procedures are potentially applicable to a wide range of target behaviors and problems including treatment retention and compliance with pharmacotherapy (i.e., including retroviral therapies for individuals with HIV). For example, in 1996, contingency management may be used effectively to reinforce desired treatment goals (e.g., looking for a job) in addition to abstinence.

However, despite the very compelling evidence of the effectiveness of these procedures in promoting retention in treatment and reducing cocaine use, these procedures are rarely implemented in clinical treatment programs. One major impediment to broader use is the expense associated with the voucher program; where average earnings for patients are about $600.

Recently developed low-cost contingency management (CM) procedures may be a promising approach to bring these effective approaches into general clinical practice. For example, Nancy Petry and colleagues have demonstrated that a variable ratio schedule of reinforcement that provides access to large reinforcers, but at low probabilities, is effective in retaining participants in treatment and reducing substance use. Rather than earning vouchers, participants earn the chance to draw from a bowl and win prizes of varying magnitudes. In a study of 42 alcohol-dependent veterans randomly assigned standard treatment or standard treatment plus CM, 84% of CM participants were retained in treatment throughout

an 8-week period compared to 22% of standard treatment participants. By the end of the treatment period, 69% of those receiving CM had not experienced a lapse to alcohol use, but only 39% of those receiving standard treatment were abstinent. A controlled evaluation of this promising approach for the treatment of cocaine dependence is ongoing.

C. Cognitive Behavioral/Relapse Prevention Therapy

Another behavioral approach that has been shown to be effective is cognitive-behavioral treatment (CBT). This approach is based on social learning theories on the acquisition and maintenance of substance use disorders. Its goal is to foster abstinence through helping the patient master an individualized set of coping strategies as effective alternatives to substance use. Typical skills taught include: (a) fostering resolution to stop drug use through exploring positive and negative consequences of continued use, (b) functional analysis of substance use, that is, understanding substance use in relationship to its antecedents and consequences, (c) development of strategies for coping with craving, (d) identification of seemingly irrelevant decisions that could culminate in high-risk situations, (e) preparation for emergencies and coping with a relapse to substance use, and (f) identifying and confronting thoughts about substance use.

A number of randomized clinical trials over the last decade with several diverse cocaine-dependent populations have demonstrated: (a) compared with other commonly used psychotherapies for cocaine dependence, CBT appears to be particularly more effective with more severe cocaine users or those with comorbid disorders, (b) CBT is significantly more effective than less intensive approaches that have been evaluated as control conditions, and (c) CBT is as or more effective than manualized disease model approaches. Moreover, CBT appears to be a particularly durable approach, with patients continuing to reduce their cocaine use even after they leave treatment.

D. Motivational Approaches

For individuals with severe dependence who deny the seriousness of their involvement, a course of individual therapy in which the patient is guided to a clear recognition of the problem may be an essential first step toward more intensive approaches. Motivation enhancement treatment (MET) sets out to accomplish this in a brief therapy approach (i.e., 2–4 sessions). Included in these sessions are typically emphasis on personal responsibility for change with advice and change options, objective feedback of impairment, therapist empathy, and facilitation of patient self-efficacy.

MET has been used to treat a variety of substance disorders, including marijuana dependence. although marijuana is the most commonly used illicit substance, treatment of marijuana abuse and dependence is a comparatively understudied area to date, in part because comparatively few individuals present for treatment with a primary complaint of marijuana abuse or dependence. Currently, no effective pharmacotherapies for marijuana dependence exist, and only a few controlled trials of psychosocial approaches have been completed. In 2000, Robert Stephens and associates compared a delayed treatment control, a 2-session motivational approach, and the more intensive (14-session) relapse prevention approach and found better outcomes for the two active treatments compared with the delayed-treatment control group, but no significant differences between the brief and the more intensive treatment.

E. Family Therapy

Early intervention with individuals who abuse alcohol has historically been approached in some settings by addressing past crisis caused by the alcohol abuse into one dramatic confrontation by family and friends. This therapeutic approach is designed to combat denial by having family and individual close to the person present the negative effects of the individual's use in attempts to move the individual to agree to get treatment.

Moving beyond initial confrontation, others have included family in ongoing aspects of treatment. Edward Kaufman has identified three basic phases of family involvement in treatment: (a) developing a system for establishing and maintaining a drug-free state, (b) establishing a workable method of family therapy, and (c) dealing with the family's readjustment after the cessation of drug abuse. Where these three stages may vary is based on the substances abused, stage of the addiction, family reactivity, and gender of the individual.

M. Duncan Stanton and William Shadish in 1997 conducted a meta-analysis across 1,571 cases reviewing drug abuse outcome studies that included family couples therapy. Family therapy was seen as more beneficial than individual counseling, peer group therapy, and family psychoeducation. In addition, family therapy had higher retention rates than nonfamily therapies and was seen as a cost-effective adjunct to methadone maintenance.

F. Manualized Disease Model Approaches

Until very recently, treatment approaches based on disease models were widely practiced in the United States, but virtually no well-controlled randomized clinical trials had been done evaluating their efficacy alone or in comparison with other approaches. Thus, another important finding emerging from recent randomized clinical trials that has great significance for the clinical community, is the effectiveness of manualized disease model approaches. One such approach is 12-step facilitation (TSF). It is a manual-guided, individual approach that is intended to be similar to widely used approaches that emphasize principles associated with disease models of addiction and has been adapted for use with cocaine-dependent individuals. Although this treatment has no official relationship with Alcoholics Anonymous (AA) or Cocaine Anonymous (CA), its content is intended to be consistent with the 12 steps of AA, with primary emphasis given to Steps 1 through 5 and the concepts of acceptance (e.g., to help the patient accept that they have the illness, or disease, of addiction) and surrender (e.g., to help the patient acknowledge that there is hope for sobriety through accepting the need for help from others and a "higher power"). In addition to abstinence from all psychoactive substances, a major goal of the treatment is to foster active participation in self-help groups. Patients are actively encouraged to attend AA or CA meetings, become involved in traditional fellowship activities, and maintain journals of their self-help group attendance and participation.

Within Project MATCH, TSF was found to be comparable to CBT and motivational enhancement therapy in reducing alcohol use among 1,726 individuals with alcohol dependence; the findings from these studies offer compelling support for the efficacy of manual-guided disease model approaches. However, it is critical to recognize that the evidence supporting disease model approaches has emerged from well-conducted clinical trials in which therapists were selected based on their expertise in this approach and were trained and closely supervised to foster high levels of adherence and competence in delivering these treatments, and it remains to be seen whether these approaches will be as effective when applied under less-than-ideal conditions.

G. Combined Treatment Approaches

1. Combining Psychotherapies

At times it can be useful to combine different psychotherapies to treat patients who have ongoing specialized needs such as in the case of co-occurring disorders or if they are at a point in their treatment where they can benefit from combined approaches that address specific areas of concern. An example of the latter would be individuals in the initial stages of treatment receiving MET in conjunction with relapse prevention to address early treatment issues of decreased motivation to stop using that often occurs initially due to the uncertainty of how life would be without substances.

An example of the former would be combined treatments for posttraumatic stress disorder (PTSD) and substance dependence. Many women receiving substance treatment also meet the criteria for current PTSD. This may often cause the individual to experience a greater severity in the course of their illness than those who have only one of these. Other examples of combined treatments for patients who have co-occurring diagnoses include relapse prevention and exposure therapy for individuals who also have obsessive–compulsive disorder and relapse prevention and motivational long-term approaches for individuals who also have psychotic disorders.

2. Combining Psychotherapy with Pharmacotherapies

At times psychotherapy may be combined with pharmacotherapies to enhance adherence to the pharmacotherapy or synergistically enhance the effects of both treatments. Even when medications have been proven to be effective, dropout from treatment and compliance have still been a problem. Moreover, there has been no study that has demonstrated that the addition of psychotherapy did not help the medication effect.

The most powerful and commonly used pharmacologic approaches to substance abuse are maintenance on an agonist that has an action similar to that of the abused substance (e.g., methadone for opioid addicts, nicotine gum for cigarette smokers), use of an antagonist that blocks the effect of the abused substance (e.g., naltrexone for opioid addicts), the use of an aversive agent that provides a powerful negative reinforcement if the substance is used (e.g., disulfiram for alcoholics) and use of agents that reduce the desire to use the abused substance (e.g. naltrexone and acamprosate for alcoholics). Although all of these agents are widely used, they are seldom used without the provision of adjunctive psychotherapy, because, for example, naltrexone maintenance alone for opioid dependence is plagued by high rates of premature dropout and disulfiram use without adjunctive psychotherapy has not been shown to be superior to placebo.

Several studies have evaluated the use of contingency management to reduce the use of illicit drugs in addicts who are maintained on methadone. In these studies, a reinforcer (reward) is provided to patients who demonstrate specified target behaviors such as providing drug-free urine specimens, accomplishing specific treatment goals, or attending treatment sessions. For example, methadone take-home privileges contingent on reduced drug use is an approach that capitalizes on an inexpensive reinforcer that is potentially available in all methadone maintenance programs. Maxine Stitzer and George Bigelow, in 1978 and 1986, did extensive work in evaluating methadone take-home privileges as a reward for decreased illicit drug use. In a series of well-controlled trials, this group of researchers has demonstrated (a) the relative benefits of positive (e.g. rewarding desired behaviors such as abstinence) compared with negative (e.g., punishing undesired behaviors such as continued drug use through discharges or dose reductions) contingencies, (b) the attractiveness of take-home privileges over other incentives available within methadone maintenance clinics, and (c) the relative effectiveness of rewarding drug-free urine screens compared with other target behaviors. More recently in 1998, Andrew Saxon and colleagues further demonstrated that take-home doses of methadone serve as a reinforcer for abstinence among methadone maintenance program participants by showing fewer restrictions on their availability make them even more effective.

In 1996 and 1998, Kenneth Silverman and colleagues, evaluated a voucher-based CM system to address concurrent illicit drug use, typically cocaine, among methadone-maintained opioid addicts. In this approach, urine specimens are required three times weekly to systematically detect all episodes of drug use. Abstinence, verified through drug-free urine screens, is reinforced through a voucher system in which patients receive points redeemable for items consistent with a drug-free lifestyle that are intended to help the patient develop alternate reinforcers to drug use (e.g., movie tickets, sporting goods). In a very elegant series of studies, the investigators have demonstrated the efficacy of this approach in reducing illicit opioid and cocaine use and producing a number of treatment benefits among this very difficult population.

IV. SUMMARY

Psychosocial treatments should be considered as a treatment option for all patients seeking treatment for substance use disorders. The treatment itself can take place in a variety of settings including inpatient, residential, partial hospitalization, or outpatient treatment. In more controlled settings the frequency and duration of sessions increases.

Through our review of the literature, it becomes evident that individuals who abuse substances are a heterogeneous group reflecting much diversity. To address this diversity in treatment, it is useful to consider multidimensional outcomes. Consequently, no one form of treatment or psychotherapy is typically seen as universally effective across all substance disorders. However, one major strategy common to all currently practiced psychotherapies is to place primary emphasis on reducing substance use, while pursuing other goals only after substance use has been at least somewhat controlled.

The history of individual psychotherapy to treat substance abuse arose from using already established therapeutic strategies adapted for use to treat a special population of individuals who abuse substances. Most schools of therapy that have been adapted to address substance-related problems share common knowledge and common goals or strategies that must be addressed to provide successful treatment to substance-using populations.

The main areas of knowledge to mastered by the beginning therapist are pharmacology, use patterns, consequences, and the course of addiction for the major types of abused substances. It is important to go beyond textbook knowledge to street knowledge of frequently abused drugs as well as understand the clinical presentation of intoxicated individuals or withdrawal from different substances to fully understand the clinical picture and to aid alliance.

Common goals and strategies related to substance abuse psychotherapeutic treatment include enhancing motivation to stop using, teaching coping skills, changing reinforcement contingencies, fostering management of painful affects, and improving interpersonal functioning and social supports. The therapist needs to take a more active stance than in the treatment of other disorders such as depression of anxiety disorders due to the principal symptom, compulsive use, being initially gratifying until the long-term consequences of use induce pain and desire to stop.

Our review of rigorously conducted efficacy research on psychotherapies for substance abuse provides support for the use of a number of innovative approaches: individual substance counseling, and cognitive behavioral treatment for cocaine dependence; community reinforcement treatment with contingency management for cocaine dependence; and contingency

management approaches combined with methadone maintenance in the treatment of opioid dependence as well as use with a wide range of other substance use disorders including alcohol dependence. Manualized disease model approaches have been as effective to other forms of psychotherapeutic substance abuse treatments. Substance psychotherapies have been combined with pharmacotherapies to enhance adherence to pharmacotherapies or synergistically enhance the effects of both treatments. Future studies are needed to evaluate the usefulness of combined psychotherapy approaches and further investigate less rigorously studied treatments.

See Also the Following Articles

Addictions in Special Populations: Treatment ■ Adjunctive/Conjoint Therapies ■ Comorbidity ■ Controlled Drinking ■ Gambling: Behavior and Cognitive Approaches ■ Matching Patients to Alcoholism Treatment ■ Psychopharmacology: Combined Treatment

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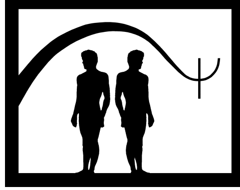

Successive Approximations

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I. Description of Use
II. Theoretical Bases
III. Empirical Studies
IV. Summary
Further Reading

GLOSSARY

operant conditioning The process of increasing or decreasing the frequency of a behavior by altering the consequences that follow the performance of that behavior.

reinforcement Consequences that increase the likelihood that a behavior will increase.

systematic desensitization A therapeutic technique for anxiety reduction in which anxious clients are relaxed and exposed to an incremental, graded series of anxiety-provoking elements that approximate the ultimate event feared by the clients.

Successive approximations are responses that gradually increase in resemblance to the final behavior that is being shaped as part of a therapeutic program to develop new behavior. Shaping is the process of reinforcing responses that successively approximate the final desired behavior. Responses are reinforced that either resemble the final behavior or that include components of the final behavior. As new approximations are reached successfully and reinforced, the earlier ones in the sequence are allowed to extinguish.

I. DESCRIPTION OF USE

Before using successive approximations, a shaping program must be established. The shaping program consists of the following sequence: (1) a determination of the goal behavior and the criteria for successful performance; (2) a determination of the elements that resemble the goal behavior in gradually increasing steps (successive approximations) and a decision about the size of the intervals between steps; (3) a determination of the reinforcers to be given contingently as the incremental behavior is produced; (4) the application of the program. The goal behavior may be anything that the organism is physically capable of producing. It should be clearly specified in ways that may be unambiguously measured. In determining the elements that approximate the goal behavior, it is important to find a beginning point that has some resemblance to the final behavior. The beginning point may be as elementary as raising a hand, turning a head in a particular direction, or making a mark on paper. Progressive sequences of responses leading to the goal behavior and the intervals between the responses must also be determined. These are the successive approximations. The intervals between responses must be small enough so that the organism is able to succeed more often than not, for reinforcement is not given for failed responses. The interval must not be so small, however, that the organism becomes bored or inattentive. The organism may be reinforced at the same step for a short period of time in

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order to practice the response, but the demands for performance must be gradually increased sequentially so that the organism does not stop altogether at one step before reaching the goal.

II. THEORETICAL BASES

The procedure of response shaping by successive approximations was developed in the laboratories of Charles Ferster and B.F. Skinner in 1957, where pigeons were trained to peck at a response key. The birds were reinforced at first when their heads moved forward and ignored for all other behaviors. Once the forward movements occurred at a high rate, additional movements in the desired direction of the final goal of key pecking were reinforced. Reinforcements were withheld until the birds moved their heads in gradually increasing distances. Finally, the birds were reinforced for moving their heads in a position directly across from the response key. The pecking response could not fail to occur and the birds were reinforced only for pecking the key, the final desired behavior.

This technique is derived from the operant conditioning theoretical perspective, which holds that when rewarding consequences immediately follow the performance of a particular behavior, that behavior will increase in frequency. The principles of operant conditioning describe the relationship between behavior and environmental events, called antecedents and consequences, that influence behavior. This relationship is called a contingency. Antecedent events are those stimuli that occur before a behavior is exhibited, such as instructions, sounds, and gestures. Behaviors include actions made by an organism in response to the antecedent events. Consequences are those events that follow the performance of the behavior. For a consequence to affect behavior it must be contingent or dependent on the occurrence of that behavior.

In 1958 Joseph Wolpe reported on his work in the development of methods to reduce the laboratory-created experimental neurosis (anxiety) of cats. Wolpe gradually exposed the animals to a series of rooms that successively approximated the features of the room in which the anxiety had originally occurred. When the animals displayed a slight reduction in anxiety in the other rooms, Wolpe encouraged them to eat, reasoning that if the animals could engage in responses that competed with the anxiety response, the anxiety would be overcome. This systematically applied procedure was successful.

Using this information from the laboratory, Wolpe conceptualized the effects of the procedure from the viewpoint of classical conditioning in which environmental cues are said to elicit anxiety or fear responses. Anxiety may then be eliminated by conditioning an alternative response that is incompatible with it. For humans Wolpe used deep muscle relaxation as the competing response to anxiety. While relaxed, anxious clients were exposed to anxiety- producing stimuli, either in imagination or in real life. The stimuli were presented in gradually increasing intensity and resemblance to the original anxiety stimuli (i.e., successive approximations to the original event). As relaxation becomes associated with the anxiety events, the anxiety is reduced. Wolpe called this procedure "systematic desensitization."

III. EMPIRICAL STUDIES

Successive approximations is not a clinical technique per se, but a way of presenting material within a number of procedures. There has been no research on successive approximations independent of the clinical techniques in which it is embedded. The procedures of shaping and systematic desensitization have, however, been extensively reviewed and are presented elsewhere in this book.

IV. SUMMARY

Successive approximations are responses that gradually increase in resemblance to the final behavior that is being shaped as part of a therapeutic program. They are an element in the operant conditioning procedure of shaping and in the classical conditioning procedure of systematic desensitization.

See Also the Following Articles

Convert Reinforcer Sampling ■ Negative Reinforcement ■ Operant Conditioning ■ Positive Reinforcement ■ Progressive Relaxation ■ Reinforcer Sampling ■ Systematic Desensitization

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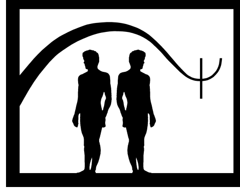

Sullivan's Interpersonal Psychotherapy

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I. Introduction
II. Theoretical Bases
III. Therapeutic Range
IV. Technique
V. Summary
Further Reading

GLOSSARY

counter-transference The personal reaction of the therapist to the patient including distortions that the therapeutic training helps him or her restrain.

field of awareness The content of the therapist's conscious attention to the interaction with the patient.

modifying the introject The therapist uses insight to modify by understanding the specific content he or she is experiencing directly from the patient.

object relations theory Within the traditional psychoanalytic framework W.R.D. Fairbairn introduced object relations to refer to the relations between the patient and a significant other person.

preverbalization Thoughts and feelings that give rise to specific language.

schizophrenia A term introduced by Bleuler to replace the term dementia praecox, referring to cognitive and emotional disturbances of a severe degree. Now a term designating a set of syndromes characterized by severe disturbances in thinking and reality perception.

security operations Verbal and nonverbal efforts of many kinds to prevent or ward off anxiety.

selective inattention Perceptions not attended to because they might arouse anxiety.

self-system The envelope of all the security operations.

transference The distortion of present experience by past experience as reflected in the patient toward the therapist.

I. INTRODUCTION

Harry Stack Sullivan's technique of psychotherapy was strongly influenced by his exquisite sensitivity to any sign of a patient's distress or discomfort in interaction with a therapist—himself or other. His theory of interpersonal psychiatry was the foundation for his practice of psychotherapy. He called his method of psychotherapy participant observation because the significant data included the psychiatrist's thoughts and feelings as well as those of the patient. Although Sullivan expressed an appreciation of Freud's work, it had little influence on his own thinking, which was firmly based on the philosophy of experience.

Sullivan was first and foremost an American psychiatrist, as Helen Swick Perry has brilliantly documented in her book *Psychiatrist of America.* However respectful and sensitive, he was firm, vigorous, and well-disciplined in his approach—contrary to the opinion of his critics who accused him of being too protective of his patients.

Sullivan had an extensive correspondence with Alfred Korzybski who, together with Kurt Lewin, organized their observations to a theoretical field in which many vectors of different force operated simultaneously with their counterparts in interpersonal transactions. Therefore, some part of a personality would

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enhance parts of another personality while other parts might diminish or suppress aspects of the other person. This could be elaborated with topological diagrams to clarify the ideas.

II. THEORETICAL BASES

Early in his career, Sullivan published a paper in his journal *Psychiatry* authored by Albert Dunham describing the important work of the American philosopher Charles S. Pierce and comparing it to the European philosophers on the nature of human responses. Pierce's three categories of experience, firstness, secondness, and thirdness, are logically parallel to Sullivan's prototoxic, parataxic, and syntaxic modes of experience.

The prototaxic mode of Sullivan is more or less equivalent to the Firstness of Pierce—that is, immediate, instant, forever, here and everywhere, with no differentiation before or after—"unione mystica." With differentiation and past, present, or future, here and there, we have the category of Secondness and the early part of the Parataxic mode, which includes myth, superstition, dreaming, and metaphor. Thirdness includes the logical, consensually validated, or scientific—which is the Syntaxic mode of Sullivan.

Sullivan introduced the term interpersonal for the first time in psychiatry in order to emphasize that the treatment, the work that was being done, was something that was done between two people, the patient and the psychiatrist, and not something that was being done to the patient by the psychiatrist. This was also emphasized in his term participant observation, which refers to the psychiatrist and the patient working together on the patient's difficulties in living in order to clarify them and to help the patient develop insight and better ways of coping more effectively.

The purpose of psychiatric treatment is to enhance the development of the syntaxic mode of experience, including the range of communication by word, gesture, and movement, between persons—interpersonal processes. In that way the problems of living that are contributing to the patient's distress and/or disablement can be clarified and addressed. Sullivan avoided the terms unconscious, preconscious, and conscious for their lack of precision and consistent meaning. He preferred to use the field of awareness, which ranged in content from unavailable to marginal to focal in its spectrum. This field spectrum can become wider or narrower with specific interactions, verbal or otherwise, blocked or opened up, as the interpersonal area changes, including the illusory or projected personification of "good me," and "bad me," "not me," as well as those of "good other," "bad other," and "non-other." In this context the psychiatrist or other mental health expert must manifest a precise sensitivity to nuances of speech and subtlety of movement. In this way the psychiatrist could avoid provoking anxiety that interfered with communication while eliciting information that was associated or accompanied by some anxiety. This has been described by others in the literature as coping with the mechanisms of defense. It is described later by Anna Freud in her well-known work *The Ego and Mechanisms of Defense.* Although Sullivan advocated various measures to minimize anxiety he vigorously opposed fraudulent reassurance or falsehood in any form. In his work with the severely mentally ill, he would sometimes use alcohol or mild sedation to help open up channels of communication.

III. THERAPEUTIC RANGE

Sullivan used the term parataxic for the phenomenon of transference and counter-transference—that is, generalizations from past experience that may not be appropriate to the present encounter, and may contribute to distressing interactions with others. As a participant observer, the therapist may reinforce some projections and diminish others. The content of this field of interaction was called the social geography or social landscape by Leston Havens. Sullivan insisted on obtaining detailed and precise descriptions of feelings and context—in one instance having a patient describe the New York subway system.

Sullivan also liked to set some distance by referring to a third party. He said that it is much easier for patients to tell the therapist what is important and unimportant, even about the therapist, if they talk about a third party. Sullivan objected to the patient lying on a couch with the therapist sitting behind the patient. Sullivan preferred to sit alongside the patient at an angle, which is the way I practiced analysis for 25 years, as did Clara Thompson, my training analyst. Sullivan referred to the content of transferences carried by the patient as false expectations, projections, and misconceptions.

For example, Sullivan said:

> If a patient says to me "You must think I'm terrible" and I don't feel that is just hysterical drama, but means something, I am apt to say, quite passively "about what?" as if I had not heard anything about such a

> notion. Quite frequently, just because my reaction seemed so astonished and annoyed, they tell me, and to that extent I have gotten somewhere.

Thereby he reduces the transference.

Sullivan was more interested in therapeutic change than he was in cognitive insight. This could be seen as deconditioning or in object-relations theory as modifying the introject. In some ways Sullivan's method is analogous to play therapy, with the transference projected onto the narrative or the world "out there."

In addition to correcting the transferences in a profoundly collaborative way, he used what can be called counterprojective statements. These statements talk about the important figure in the patient's life, which draws attention and projection to them. Sullivan may then join the patient in expressing appropriate feelings toward these persons such as desperation and rage. Sullivan was remarkably and dramatically effective with paranoid patients. The first step was establishing empathy with the paranoid person's rage and expressing it. At the same time Sullivan would avoid a direct face-to-face confrontation but would sit alongside the patient, joining the patient in a collaborative effort to look at the world from the patient's side. Third, he would cite some experiences of his own at distressing institutional behavior. However, this must be authoritative and not susceptible to being experienced by the patient as patronizing or false.

Sullivan examined and treated a variety of patients, but his central focus was always on schizophrenia and, to a lesser degree, obsessive–compulsive disorder. He saw conversion hysteria as a substitutive disorder wherein physical symptoms substituted for achievement in promoting an enfeebled self-esteem, and preventing anxiety, that is, the type of anxiety caused by a threat to one's sense of being a worthwhile human being.

Sullivan described the three most basic requirements for the effective psychotherapy of persons with schizophrenia. First, the therapist must review with the patient a survey of his or her conflicted growth and adaptation as skillfully as possible. Second, the therapist must provide some type of healthy "corrective" experiences in the patient's living of his or her life. Lastly, there is collaboration of the patient with an enlightened physician skilled in penetrating self-deceptions with the goal of improving the patient's self-esteem and social competence.

In assessing Sullivan's remarkable success at Sheppard Pratt Hospital it is important to note the linkage to the type of onset: Out of 100 patients who had slow insidious onset only two went on to a full recovery. Of 78 who had an acute onset, 48 showed marked improvement with most others experiencing a full recovery, according to (Sullivan in 1962.) In the Sheppard Pratt program Sullivan did very little psychotherapy directly with the patients but worked through a staff that he carefully selected, personally trained, and closely supervised.

Sullivan became interested in the criminal mind, the psychopath or sociopath, that had no empathy for fellow human beings, and no concern for anyone's welfare except their own. He expressed an opinion that they were not quite human, and that they should be studied by a method of studying animal behavior. However, he never developed this idea any further.

IV. TECHNIQUE

In his own psychotherapy practice Sullivan preferred to work indirectly with as much collaborative style as could be achieved. By sitting alongside or at an angle to the patient the two together could look at the "social geography" of the patient's life, examining the important relationships therein. In Sullivan's language this would "loosen or attenuate" the parataxes, or in object-relations theory modify the introjects. A corollary of this would be the counterprojective statements that would move the transference (parataxes, distortions) back to the original figures from the patient's past. In doing so Sullivan might not only refer to the significant figure (parent, sibling, etc.) and point it out, but also supply the appropriate feeling of hurt, anger, or rage in a corrective emotional experience.

Sullivan's verbal psychotherapeutic interventions could be described in four categories: interrogative, imperative, rhetorical, and declarative. Although the interrogative direct questions are obviously necessary, the imperative is only subtly apparent in the fundamental rule of free association—the verbal expression of empathy is rhetorical as it communicates the imaginative projection of one's own consciousness into the consciousness of another person. Declarative statements usually are made to clarify or interpret, but Sullivan used them also to direct attention elsewhere, away from the patient and therapist to the social field of other people. This is similar to doing play therapy with children. Thus these counterprojective statements move attention away from the patient; they point to the critical figures, and express appropriate feelings by the therapist toward those critical figures, setting an example for the patient. These counterprojective statements are

especially useful in treating a paranoid patient or a psychotic transference. Again this is analogous to using play objects in treating children. Sullivan, in speaking of reconstructing the past, said, "What I would have seen if I had been there." The advantages gained are a clearer perspective on the past, differentiation of the structure (family, teacher, friend) internalized from the past, and best of all, freedom from the past.

In the beginning of this work, and in fact throughout the course of therapy or participant observation, the emphasis and direction were always on the concrete sharing of feelings and experiences in which the feelings and thoughts of the therapist were as important to share when appropriate as were the patient's. However, the therapist's only gratification from this experience was exercise of their competence and the pay that was received. He or she would not pursue friendship, gratitude, prestige, or anything else.

Sullivan never accepted general, vague, or speculative statements at face value. He would always try to pin down specifically and concretely what the patient was referring to, and that way the patient might become more aware of something that previously he or she had not paid attention to. Naturally, this required a very intense concentration on the part of the therapist, and a very disciplined approach to paying attention to what the patient meant by what was said. Therefore, theoretical hypotheses, structures, and jargon are completely avoided in accumulating very accurate and precise information. Therefore, Sullivan advocated questions that would be more productive than the interpretations. He also recommended attention to nonverbal communication of feelings such as a facial expression, tilting of the head, or a raising of the eyebrows that would communicate something to the patient that would be helpful in bringing out more useful data. In confronting delusional ideas that were communicated by the patient the therapist can show his or her puzzlement or questioning but should never flatly contradict or show a nonacceptance of this. The therapist should never pretend that he or she understands something when he or she does not. It is much better to say frankly that he or she does not understand and to ask for clarification or further explanation. In asking such questions the therapist might prefer indirect questions as they are less likely to be anxiety provoking, and they may yield more information than a direct question does. Indirect questions might also bring more attention to the interpersonal aspects of what was going on in the interaction between the two people referred to, rather than an attribute of somebody. Of course, at all times with either direct or indirect inquiry such questions for seeking more useful information and helping the patient should not in any way undermine the patient's self-esteem.

Sullivan was also very active as a therapist. He was opposed to the more traditional psychoanalytic position of passively listening to whatever the patient brings out. Instead, the therapist pursues data, striving for more details and more precise information until the issue is very clear and the patient understands it, and can go on to the next thing. Sullivan not only tended to avoid interpretations but he even objected to the word interpretation, which has an authoritarian aspect to it. Instead of using the word interpret he would employ words like comment, inquire, point out, indicate, and so on. There is a difference of viewpoint. He also recommended when pointing out particular aspects or data to a patient that the therapist should not try to do too much all at once but rather pace oneself properly so the patient has time to assimilate it, and express his or her own reaction to it. The therapist thus allows the interaction between the two of them to be productive, rather than to cut it short by overloading the patient with too much information at one time.

The thrust of the patient's work with the therapist is to become more aware of what goes on between himself or herself and other people, particularly the ones who are most significant in their life. To the extent that he or she can formulate this in words and share it with another person, namely the therapist, he or she is able to be in better health, and to be more effective in dealing with his or her problems in living. Therefore the work of therapy very often consists of paying attention to many small details that help the patient become more aware and to be able to use this awareness more effectively.

Sullivan believed very strongly that there was an innate movement toward health in the person and this thrust toward mental health would be more active as the barriers to it were removed in the collaboration between the therapist and the patient. Therefore, the therapist was never seen as curing the patient or making the illness go away; the therapist was seen as helping the patient be healthier and more competent in handling the emotional and personal problems of their life.

Sullivan uses the term anxiety in a way that is different from its general use in medicine and everyday life. He uses it as a category of all kinds of emotional anguish such as fearfulness, tenseness, guilt, inferiority feelings, shame, self-loathing, eerie feelings of personality change, and all other forms of emotional distress. Anxiety can vary in degree from a scarcely noticeable fear to incapacitating panic. There has to be some anxiety in order to know that you are getting somewhere, doing something useful; therefore, it is important for the therapist to (as it were) keep the

finger on the pulse of anxiety to keep it manageable and constructive rather than interfering.

Sullivan was very skeptical about the value of direct reassurance. He saw that many schizoid and obsessional patients were able to respond to direct reassurance by having no response whatsoever and not allowing it to have any impact on them. Therefore indirect assurance was the only kind of assurance that would be effective. Sullivan was also very skeptical about the expression of admiration, gratitude, and affection from the patient. He did not believe that patients had enough feelings for themselves to be able to afford to appreciate him much. He believed patients may feel worthwhile only because this wonderful person is interested in them, but that is not very clinically useful and is not going to do them much good in their lives. It is much better that they discover how more effective and competent they are than they thought; and if that means disappointment in the therapist, that is beneficial. Being disappointed in themselves and feeling more inadequate is not of benefit, and indicates that their therapy is not going too well.

Sometimes the therapist can pick up anxiety that is blocking the patient by listening carefully to the pauses, missing data, and distortions in an account that the patient is giving them. The anxiety tends to block out an awareness of events, and things happening in the event, so by paying close attention, one may pick up on what is missing, and then find out what the anxiety was, and what it was all about. Rather than giving empty reassurance to the patient's anxiety, it is better for the therapist to specify the nature of the anxiety and the context in which it arose. For example, if the patient is feeling very angry with his parents it may make him feel guilty to point that out. It might be helpful for the person to be oriented to where he is emotionally because the anxiety interferes with the process. It may seem like stating the obvious, but when a person is in the midst of a breakup of a relationship, it may be useful to simply spell out the distress that the person is experiencing in the context of the breakup and how natural and normal it is to suffer such distress. Some people feel ashamed and embarrassed that they are a patient seeking help from a mental-health expert for their problems. This can be spelled out with the patient and put into its proper context. In doing such explorations with a patient, Sullivan was particular in adhering to objective data taking place in real time and a real place, and to not encourage the patient to go off into descriptions of fantasies. This is something he did not encourage and did not think was valuable. He believed it might even encourage unrealistic thinking; daydreaming might be present at times but it does not solve any problems.

Sullivan used the term security in a much broader sense to mean the opposite of anxiety: a sense of personal adequacy, or personal worth, personal value, or strong self-esteem and a complete lack of the negative feelings of worthlessness and other emotional distress. He saw the polar opposites of anxiety and security as being in a continual state of movement, trying to balance against each other like opposite ends of a see-saw. The ways of enhancing security and avoiding anxiety were called security operations by Sullivan and they could be either healthy or unhealthy. A healthy security operation increased a person's effectiveness and emotional health, and an unhealthy one could impair the interpersonal relationship. They are different from the Freudian notion of defense because the notions of defense occur in a hypothetical mind-structure and are not observable, whereas the security operations of Sullivan are behavioral.

Sullivan's whole system might be called a cognitive behavioral system. One of the unhealthy or sometimes healthy security operations is selective inattention. This occurs when individuals observe only a part of what is happening in their environment between them and authorities so that they pay attention to some things and avoid paying attention to others. This is analogous to Freud's concept of repression. Selective inattention is always an ongoing activity between two or more people whereas repression can be something between a person and himself in his mind. Sullivan was a fairly rigorous taskmaster in keeping the patient focused on the matter at hand, and not letting the patient go off into empty discussions of trivial subjects that were not particularly relevant to the basic problems for which help is being sought. Sullivan also discouraged pseudo-compliance wherein a patient becomes very eager to please and agrees with everything the therapist says without really confronting his or her issues. It is a way of dismissing the whole investigation with faint praise. Another way of avoiding confronting something that is painful or distressing is to get angry about something that is not to the point, and in the angry exchange the therapist may be put on the defensive unless he or she realizes what is happening.

The self-system is not exactly the same thing as the ego of psychoanalytic theories. The self-system that Sullivan refers to is what is characteristic of the individual and what defines that individual as a person that is known. Thereby the self-system protects patients against distress and enables them to live as comfortably as possible so that they can feel (that is, identify) who they are, and that they are worthwhile and recognized as such. The self-system is not something that exists as a thing in

time and space. The self-system is simply a verbal convenience, a phrase to refer to an envelope of protective movements and ethics that the patient makes to avoid distress. The therapist must therefore use his or her skill to enable the patient to feel more worthwhile, and safer, and with more self-esteem while exploring relationships and experiences that might provoke embarrassment, shame, or other kinds of distress.

Sullivan paid great attention to this aspect of giving a kind of reassurance that was not sentimental, false, or difficult for the patient to assimilate. He would indirectly always provide a way for patients to see themselves with greater dignity and self-respect. Nonetheless, as Sullivan rigorously pursued the details of the patients' experiences with the important other persons in their life, it would provoke some distress. Sullivan was very careful to note this distress and to try to be helpful with it. Sometimes he would suggest a healthier, more constructive, way of dealing with a problem situation that the patient had never considered. When the patient is presented with the novel approach it must be something reasonable and practicable for the patient to follow.

Behavior and feeling patterns that recurrently characterize interpersonal relations—the functional interplay of persons and personifications, personal signs, personal abstractions, and personal attributions—make up the distinctively human sort of being. Sullivan characterized the manifestations in the interpersonal relations of activities as integrating, disjunctive, or isolative. He sometimes referred to the zones of interaction in which behavior takes place in interpersonal relationships, such as the oral zone, genital zone, anal zone, muscular activity zone, and so on. But he rarely referred to these zones.

In the course of treating very seriously ill persons Sullivan noticed that they sometimes manifested what he called a malevolent transformation. This occurs when the therapist or another person has shown a greater manifestation of tenderness and expression of a caring closeness to the patient than the patient is able to bear in his own experience of himself. Therefore the patient manifests a sense, or a feeling of hatred and hostility, and may even attack the person who is being tender and loving to him.

Sullivan did pay some attention to dreams but he never referred to it as dream interpretation. He would pick out salient features of the dream and then present them to the patient to ask the patient what the patient thought of it. For example, there was a dream of a Dutch windmill that the patient had in which everything was rack and ruin and when the patient finished reporting the dream Sullivan picked out two details, that the windmill was beautiful, active on the outside but utterly dead and decayed within, and the patient responded, "My God, my mother." Although this might be seen by others as interpretation it actually was presenting some details to the patient in such a way that the patient was able to use the dream, and use these details to get some insight into the relationship with his mother that he had not seen before. Sullivan not only showed a great respect for dreams and their content but he also showed much respect for the fantasies a patient might present. He objected strongly to the dismissal of these fantasies as mere wish-fulfilling fantasies. He insisted that they might actually provide some creative foresight and planning for the future.

The therapist needs to be aware of what he or she is communicating nonverbally to the patient as well as what the patient is communicating to him or her consciously or otherwise. Sullivan was against the idea of the therapist sitting behind the patient where he or she could not be seen, which reduces nonverbal communication to some extent, but of course it did not eliminate it. Sullivan was very much aware of the particular meanings that vary from one language or culture pattern to another. When therapists are not familiar with the language, or the cultural context of the patient, they may be misled by words or gestures from the patient. Because of Sullivan's experience with anthropology he was able to bring a much more sensitive cross-cultural awareness to his work.

In a case seminar with Dr. Kvarnes, an associate at Chestnut Lodge, Sullivan brought out the importance of looking at the apparent devotion and love of the patient's parents for him and seeing what there was in it that could be constructive for the patient. It could also be harmful in being overprotective. Sullivan was exquisitely sensitive not only to overprotective movements and gestures by significant people in the patient's life but also to overindulgence, which can be equally sabotaging of the patient's self-esteem.

A personified self is the whole fabric of how the patient presents himself and sees himself in relation to other people. He may mean that when important people around him are upset he retires and withdraws. If they upset him, also, that may mean that he cannot stand stress very well. However, he might mean that he has much inner emotional calm and secure self-respect that will enable him to cope with stress in a very effective manner.

Another area that is useful to explore is what the patient imagines about his future. It is good to encourage the patient to speculate about what he will be doing 3 years or 5 years or 10 years from now. However, if this arouses undue feelings of despair and hopelessness, one

should not permit that to go on. In every case, in all categories of illness and types of patients, Sullivan was rigorously pursuing the precise and exact data of the patient's experience: What did occur, when did it occur, where did it occur, who was there, what did they say, what did they do, and so on. Sometimes the patient gets upset without the therapist knowing what the upset was triggered by, and what it is all about; one cannot let that pass. The therapist must investigate it and find out what has upset him, and what can be done about it.

Sullivan sometimes used what he called preverbalization when things were not going well with a patient; this is not the same thing as Freudian free association. Free association is usually employed as a method of therapy over a period of months or a year, whereas Sullivan used preverbalization as a tool for alleviating a block or a difficulty in communication. When there has been stagnation, he asked the patient to tell him everything that came to his mind about this particular aspect of his life. In the course of the interview in clarifying and straightening out misunderstandings, and the events and experiences of the patient's life, it was important for him to not only avoid any jargon himself but also to discourage the patient from using technical terms such as psychosis, complex, and so on. That way he could get down to the "nitty-gritty" and not be bogged down in terms of which neither person knew exactly the meaning.

Sullivan felt very strongly that the patient should get a summary of the important content of the interview or the course of treatment at some point. This could be done just before saying goodbye. The course of treatment could be summarized after each session. The therapist could give a summary of what was noteworthy in the session, and an anticipation of what will be looked for in the next meeting. In the course of such summaries the therapist may repeat the fact that he or she is a skilled person who has special training and knowledge; that the therapist is there to help clarify the problems that the patient has, and to help resolve them. This helps to keep the therapist/patient relationship on a professional level and reminds the patient of what he or she is about, and not to get lost in various distortions of what the therapist would like or fears or other anticipations that are not grounded.

Sometimes a patient who is grateful toward the therapist may experience a sexual urge to show his gratitude by submitting to a sexual experience, to giving the therapist sexual pleasure. In such cases the therapist needs to simply express an appreciation, and point to the fact that such an experience would be destructive to the therapeutic relationship. The professional nature of their relationship must be preserved so that work can go on, and the patient can get the most benefit from the relationship.

Sullivan was very familiar with the phenomenon of loneliness and stressed the important and powerful role it could play, referring to it as a driving force.

Sullivan had considerable experience of loneliness in his childhood and adolescence. He emphasized very strongly the importance of intimacy, and the devastating character of its lack from infancy throughout development to early adult life. He called loneliness or the need for intimacy one of the major integrating tendencies of life. He carefully separated it from other needs such as the need for satisfaction of lust.

Sullivan was very interested in the subtle and sometimes minute consequences of personal statements made to a patient. For instance, when a nurse told him some information about a patient, he was careful not to invade the patient's privacy by frankly communicating this to him. Instead he would do it indirectly so that the patient did not feel that people were spying on him. He did not want to undermine the patient's sense of confidence in the nurse's interest and her communication with him. He expected that their privacy would be fully respected. For example, the patient might confide something to the nurse that Sullivan felt was important to investigate and so Sullivan might say to the patient that he did not know how the nurse got this idea but he was glad that she was interested enough to speak to him about it. He would then ask the patient what he thought about it and what it was all about. In that way he got into it without violating the confidentiality of the nurse/patient relationship and at the same time he was able to explore this important information.

V. SUMMARY

In conclusion, it must be emphasized that Sullivan avoided jargon, theoretical systems, and language pertaining to such. He was very compassionate and at the same time very vigorous in collecting significant data from the patient that would be useful and helpful to the patient in living his or her life. Sullivan said that growth is still possible for the fortunate ones: If they are fortunate the growth goes on and on, they observe, formulate, and validate more and more; at the same time foresight continues to expand so that they can foresee their career line, not as it inevitably will be, but in terms of expectation and probability, perhaps with provisions for disappointment. Sullivan viewed a human as an enduring pattern of human relationships and also as a whole person, unique and alone. To him

the structure of our human being and the core of our self-esteem is one with the continuity of specific kinds of relationships. The integrity of the self is one with the integrity of relating to others; reality of the self is one with the reality of the relationship, the "I am" of identity with the "you are" of identity—the enduring patterns of relatedness, with the whole person, alone in his uniqueness, related in his humanness.

See Also the Following Articles

Cognitive Behavior Therapy ■ Countertransference ■ History of Psychotherapy ■ Interpersonal Psychotherapy ■ Object Relations Psychotherapy ■ Rational Emotive Behavior Therapy ■ Schizophrenia and Other Psychotic Disorders ■ Transference

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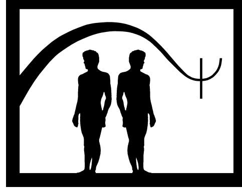

Supervision in Psychotherapy

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I. Conduct of Supervision
II. Termination
III. Evaluation
IV. Characteristics of Therapists
V. Learning to Be a Supervisor
VI. Outcome of Supervision
Further Reading

GLOSSARY

evaluation Feedback in supervision allows the therapist to take distance from the therapy and is a form of ongoing evaluation.

parallel process The therapist re-creates the therapy in the supervision. This parallel process provides a guide to understanding the therapy.

supervision A relationship between a supervisor and a therapist to help the therapist more effectively engage in a purposeful relationship with a patient.

supervisor An individual experienced in psychotherapy and teaching.

therapist An individual engaging in helping patients with psychological problems.

Supervision is best viewed in the context of a relationship between supervisor and therapist. The supervisor, an experienced colleague and a teacher, helps the student therapist, a novice, to more effectively engage in a purposeful relationship with a patient. This is an apprenticeship to learn the craft of psychotherapy. A hermeneutic model provides an understanding of this process. The model holds that supervision is concerned with the meaning found in the supervisor–student interaction about patient-related issues. This is craft learning that as Alan R. Tom notes implies "an inexhaustible rule structure" because the "application of routinized skill sequences often fail to bring about desired results." The skilled therapist has the ability to analyze situations and has a broad range of therapy strategies that are then applied to a specific situation. In supervision, the student provides data about what occurred, and new knowledge is constructed in the supervisory interaction. Issues cluster around problems, which are analyzed by supervisor and student who then revise strategies for dealing with them. Over time there is an increasing understanding of problems, and the focus is on new concerns. The supervisory interaction provides new ways of framing problems and strategies to deal with them. The supervision process allows for the resident to take distance from psychotherapy and provides a method of ongoing evaluation of the psychotherapy.

I. CONDUCT OF SUPERVISION

A basic task of the supervisor is to provide a trusting relationship in which the student therapist can openly discuss work with the patient. An accepting and nonjudgmental attitude provides the context for the therapist

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to share unique concerns raised by the patient in an atmosphere of safety. Indeed, the alliance with the supervisor is at the center of supervision experience. So valued is this relationship that many former trainees view supervision as one of the most important elements of training. The supervisor allows the therapist's story about the therapeutic encounter to develop. Indeed, the identification and the tracking of the therapist's central and affectively charged concerns about the patient are essential elements of supervision. Different terms describe the therapist's concerns: blind spots, conflicts, difficulties, dilemmas, impasses, issues, lack of mastery, lead or main themes, problems, troubles, worries, and from the educational literature, messes.

A focus on the therapist's immediate experiences and an orientation to the specifics of the material are also essential to supervision. Indeed, therapist's concerns should be dealt with in the context of the material. Inquiry should be kept within the parameters described by therapist staying close to the understanding of the moment. For example, recommendations for interventions should be linked to issues presented by the therapist. Seemingly general questions should be reframed to focus on specific issues raised in the session. Similarly, each session is taken on its own understanding. Themes from previous sessions should be acknowledged in the changing context of current material. This is disciplined behavior on the part of the supervisor.

An accurate view of the patient using data provided by the therapist has the effect of affirming the therapist's observational and reporting skills. Even what is not discussed is perceived as an affirmation that the therapist's conduct with the patient is adequate.

Early, the novice therapist has to learn how to handle the data of the psychotherapeutic interaction and to maximize the production of new information. They learn over time how to discern problems and be able to share them with the supervisor. The task of the supervisor is to facilitate such discussion. In addition, a language of discourse develops between teacher and student about the patient interaction. The student's language and conceptual framework best guide this development.

Technical comments and jargon terms are used sparingly and in the context of the therapist's data. In addition, theoretical discussions are generally infrequent. This is in keeping with an early report by Joan Fleming and Theresa Benedict of the supervision of psychoanalytic candidates who called these discussions "surplus learning." Although scientific data and theory enhance reflection, such discussion should be also tied to the specifics of the material presented by the therapist.

The downside of not being in touch with the student therapist's concerns and not exploring underlying issues as well as interfering with the development of the therapists' story is to leave the novice therapist without direction or insight into the care of the patient. This leads to the therapist feeling discounted, devalued, and resentful.

Different methods of presentation of material from therapy sessions yield different information and are suitable for different tasks. Videotapes as well as audiotapes of actual sessions minimize distortion of what goes on in the therapy session. Videotapes have particular value early on in the supervisory experience. Discussion of videotaped data can alert the student therapist to the complexities of the interaction and are useful in group supervision. Audiotapes and detailed notes of the therapy (called process notes because they are filtered through the therapist) are more commonly used in supervision. In part, the use of each is a matter of personal preference. Audiotapes require a review of the tape by the therapist before the supervisory session. This allows the therapist to be an active participant. A downside of audiotapes as well as videotapes is that they are inefficient. For instance, observation of supervision using audiotapes reveals that considerable time is spent listening to the tape with minimal interaction between supervisor and therapist. Here, both supervisor and therapist are observed looking at the tape recorder as if it were the patient. Some supervisors base their discussion on the therapist's free-flowing summary of the session. Although this method addresses the therapist's understanding of the therapy it may be more suited to supervision of experienced therapists who have learned the complexities of therapeutic interaction. Notes drawn from an actual session force the therapist to capture the interaction and focus on problems raised in the interaction.

A. Focus of Comments: Parallel Process

The therapist recreates his or her view of the therapy in the supervision. In this sense, the therapist's data parallels what goes on in the therapy. An awareness of this parallel process provides a guide for the supervisor to help the therapist understand the therapy and is at the heart of supervision. The various levels of feedback implicitly use the parallel process strategy.

In terms of frequency, comments made by supervisors are directed at four levels:

1. Understanding the patient
2. Relationship of patient to therapist

3. Relationship of the therapist to patient
4. Relationship of therapist to supervisor in the context of understanding the patient

1. Understanding the Patient

The bulk of supervisory comments are directed to helping the therapist further understand the patient's actions, thoughts, and feelings. This is done through reframing the therapist's understanding of the patient. Questions about the meaning of a patient's comments should have continuity with the material and be asked in an open-ended manner. This leads the therapist to develop a broader understanding of the patient and the interaction.

Special attention is necessary for highly charged clinical dilemmas. These often involve the therapist's concerns about safety for themselves or for patients who are self-destructive, suicidal, angry, or violent. Guidance about dealing with these situations helps defuse the therapist's sense of helplessness. However, supervision based solely on management of difficult patients is better suited for supervision of more structured clinical experiences such as patients who are seen in an emergency center.

2. Relationship of Patient to Therapist

The most frequent relationship comments are directed to helping the therapist understand the patient's view of therapy or that relationship to the therapist.

3. Relationship of Therapist to Patient

Less frequent, although highly valued by therapists, are comments directed to deepening the therapist's understanding of concerns about his or her role in the interaction. The supervisor can reframe the interaction to help the therapist understand the role in the interaction. The highest praise is for the supervisor who uses a strategy of helping the therapist understand responses to the patient. This is a strategy for deepening the therapist's understanding that is particularly useful when the therapist feels immobilized. This level of discussion catches deeper levels of vulnerabilities and encourages the therapist to be more appropriately direct and active. Moreover, such concerns are highly personal. They can take many years to fully professionalize and can remain active for a considerable period of time after training.

Supervisors of developing professionals often acknowledge therapist's concerns about the impact of personal life experiences on the care of their patient. These concerns can involve poignant and emotionally intense experiences. Some are coincident with similar experiences in the patient's life. These include the impact on treatment of their own depression, transition to chief residency, impending marriage, divorce, pregnancy, and adoption of a child, or grief over the death of a loved one. Former therapists remain thankful for such discussions years after the supervisory experience and rate these supervisors as among the best of their training.

An adult developmental perspective is useful for understanding therapists' interest in discussing personal issues that affect their work. For therapists, the domain of work and caring for patients is at forefront of their lives. Usually, one other domain, perhaps two, are also operative in therapists' lives. The other domains include intimate relationships, family, religion, and community. Activity in these domains allows for the expression and gratification of deep values and needs. An important element in the professional developmental process involves integrating work with the other domains. This is a highly personal process that can involve considerable emotional conflict.

4. Relationship of Therapist to Supervisor

A discussion of the therapist–patient relationship in the context of the supervisory relationship can highlight issues in the therapy but has to be easily integrated with the therapist's data. This level of discussion is used infrequently but can be quite helpful in dealing with therapist's issues.

II. TERMINATION

Novice therapists worry about how well they are doing with their patients and how their patients will do after termination. Many worry that they have failed their patients and feel guilt over possible inappropriate termination plans. Some have unrealistic expectations of outcome and what can reasonably be accomplished. Discussion of expectations of outcome should be ongoing rather than just at termination. In addition, discussion of termination should focus both on clarification of the therapists' expectations of outcome as well as patient outcome.

III. EVALUATION

The feedback provided by the supervisor is a form of ongoing evaluation. This is called formative evaluation and is in contrast to the evaluation given at the end of a teaching period called summative evaluation. Here the

supervisor summarizes what has occurred over the course of the supervision and provides recommendations for ongoing learning.

IV. CHARACTERISTICS OF THERAPISTS

The novice therapist's lack of experience in the conduct of psychotherapy can result in considerable emotional intensities. Indeed, the intensity of concerns about competence is easy to underestimate. Such concerns involve a sense of inadequacy to the task, feeling at a loss of how to conduct oneself with patients, and that others can do better. These underlying concerns can be acknowledged but do not need to be a major focus of discussion. Rather, the value of a sympathetic supervisor who acknowledges personal concerns provides a framework for helping the therapist achieve a sense of mastery. Indeed, development into a mature therapist takes years after training. With time, the student develops a personal style.

The ability among therapists to discuss and deal with problems varies considerably and guides the supervisor in the level of discussion. Indeed, supervisors adapt to the pace of the therapist's learning and adjust their discussion to the level of the therapist. Indeed, once a supervisory relationship is established, because of the variation in therapist abilities, it is difficult to discern the year of training by the level of sophistication of the presentation or the discussion. The range of therapist abilities mitigates against stage theories of learning supervision. Such theories posit stages of development as a psychotherapist based on year of training. These theories do not emphasize the personal development of the therapist.

V. LEARNING TO BE A SUPERVISOR

Discussing supervisory dilemmas with experienced colleagues is useful. This can be done in an ongoing group and is helpful for supervisors at all levels of experience. This discussion can aid the supervisor in understanding whether the problem is specific to the interaction, or a general problem that the therapist has with other supervisors. For instance the therapist may not be able to be open about discussing concerns about the patient. Such discussion can empower the supervisor to make appropriate interventions and also replicates the supervision process. Reading papers and texts on supervision is useful in orienting the supervisor to the conduct of supervision. However, they are often general and need to be applied to a specific situation.

Learning to be a supervisor is a matter of experience with a number of different therapists. Most supervisors initially model their behavior on their supervisory experiences during their training. They draw from these relationships until they develop a distinct supervisory style of their own. This also takes years to develop. Interestingly, supervisory behaviors become relatively stable even with different therapists.

VI. OUTCOME OF SUPERVISION

The intended outcome of the supervisory interaction is the transfer of new understanding to the patient encounter along with the transfer of patterns of interaction to other psychotherapeutic encounters.

See Also the Following Articles

Bioethics ■ Documentation ■ Economic and Policy Issues ■ Education: Curriculum for Psychotherapy ■ Informed Consent ■ Legal Dimensions of Psychiatry ■ Working Alliance

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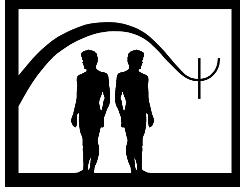

Supportive-Expressive Dynamic Psychotherapy

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I. Description of Treatment
II. Theoretical Bases
III. Applications and Exclusions
IV. Empirical Studies
V. Case Illustrations
VI. Summary
Further Reading

GLOSSARY

alliance The concept of the therapeutic alliance, which refers to the positive bond that develops between patient and therapist.

blinding The use of controls on human judgments where the judges are restricted from access to information that could contaminate them.

cognitive-behavioral therapy A well-known form of psychotherapy that is built on the concepts of belief systems and consequent dysfunctional attitudes.

core conflictual relationship theme (CCRT) A method of formulating the essence of the relationship pattern between patient and other people, including the therapist. It is derived from the repetitions of the themes across the narratives in the sessions.

correlation A statistic in which the level of association of one item with another is computed.

dynamic A well-known theory of psychotherapy based on Sigmund Freud. It involves an assessment of both conscious and unconscious aspects of behavior and the concept of conflicts among the patient's wishes and other behaviors.

empirical As used here, it refers to the inclusion of a reliance on quantitative methods for data analysis.

empirically validated treatments Treatments that are designated as effective because of their relative performance in comparative treatment studies.

meta-analysis A collection of data across many studies that is summarized quantitatively.

researcher's allegiance The belief of a researcher in a treatment's efficacy—the bond between researcher and treatment.

I. DESCRIPTION OF TREATMENT

Supportive-expressive (SE) dynamic psychotherapy is now a standard form of psychotherapy. It was developed in the early 1940s at the Menninger Foundation and it has continued to be practiced there and in many other places around the world. In 1984, I published a book on supportive-expressive dynamic psychotherapy explaining the principles, procedures, and empirical supports for doing that psychotherapy.

The attractions to therapists for practicing this form of psychotherapy are multiply based: (1) it is a dynamic psychotherapy, (2) it is adaptable in terms of treatment length and applicability to patients with a wide range of severity and wide spectrum of diagnoses, and (3) it has the convenient capacity to be able to mix supportiveness and expressiveness so that the more severely sick patients are treated by greater supportiveness and lesser expressiveness and vice versa for less severely ill patients.

My books describe the two main formats of SE: time open-ended and time-limited psychotherapy. In 1998, Howard Book dealt with time-limited treatment and gave

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an unusual example: a verbatim complete case as treated by SE short-term psychotherapy. For most treatments the decision about the use of short-term versus open-ended treatment can be made even before the treatment starts, or sometimes in the early sessions. Most commonly, the time open-ended treatment is the preferred choice because with that the length of treatment tends to be a function of the patient's needs and wishes. When time-limited psychotherapy is the option chosen, it tends to be based on considerations of the limited time available, or considerations of the needs of a research protocol or of the preferred practice in a particular treatment setting.

A. How to Begin a Supportive-Expressive Psychotherapy

1. Treatment Arrangements

In the opening phase of psychotherapy, usually in the first session, treatment arrangements must explicitly be made. They include the frequency of sessions (usually one or two per week), the cost of each session, the method of payment, the handling of missed sessions, and a guide for the patient's style of speaking—the patient should speak about whatever is on the patient's mind, as well as the patient can.

2. Setting Goals

In the early phase of treatment, the setting of goals is essential. In the early sessions, and throughout the treatment, the patient should specify what it is that he or she wishes to change. That is a crucial first step because it can lead to achievement of the goals and to changes in the patient's goals. Both the patient and the therapist should be working toward the achievement of the same goals, and progress is gauged in terms of the achievement of these goals.

3. Development of the Therapeutic Alliance

The hope of both patient and therapist is that in the early sessions, and certainly as the treatment goes on, a relationship will be formed between patient and therapist of greater trust, rapport, and alliance. As examined by Safran, Muran, and Samstag in 1994 at times there is an oscillation between movement toward a rupture in the alliance that is usually followed by a movement toward reestablishing a positive relationship.

4. Focusing Interpretations around the Core Conflictual Relationship Theme

Starting early in the treatment, the therapist, and then the patient, will be able to understand and respond more effectively to the patient's problems. The therapist, by following the Core Conflictual Relationship Theme (CCRT) method described in 1998 in Luborsky and Crits-Christoph, will be able to formulate the central relationship problem. It is this pattern that will help the therapist to focus interpretive responses on aspects of the central relationship pattern and it is this focus that helps the therapist to shape the treatment into a focal treatment. The word "focal" means that the treatment is based on the gradually greater understanding of the main relationship pattern, which continues throughout the treatment and thereafter. There are likely to be major changes in understanding and behavior in the course of the treatment, but mostly there is a broadening, deepening, working through, and a mastering of the central theme.

B. Supportive Procedures and Principles

According to the dynamic theory of psychotherapy, a supportive relationship is vital.

1. Sigmund Freud in 1913 advised that the therapist's basic attitude should be as a sympathetic listener. Most comparative studies of psychotherapies actually have similar amounts of supportiveness, as shown in 1983 in Luborsky, Crits-Christoph, Alexander, Margolis, and Cohen. The most necessary supportive component, of course, is that the therapist is there to be helpful and to help the patient achieve the patient's goals and that the patient recognizes this.
2. In most psychotherapies a rapport with the patient is developed, which, in turn, develops into a therapeutic alliance. The alliance tends to improve when progress has been made and is recognized; in turn, the alternative sequence can also be that when progress has been made the alliance tends to improve, as shown by Tony Tang and colleagues in 2000.
3. A variety of measures of the alliance have been developed. These measures include two main types: self-report measures (for example, for self-ratings of the helping alliance), and the observer-judged alliance measures as developed by Luborsky in 1976 and 2000.
4. Paradoxically, the joint search for understanding can be classified under supportiveness as well as under expressiveness, for it can be both—the giving of interpretations can be experienced by the patient as supportive and the giving of interpretations also provides the patient with understanding.

C. Expressive Procedures and Principles

The other broad category of technique besides supportiveness is expressiveness. Expressiveness refers to the state of the patient that permits the patient to express his or her thoughts and feelings as fully as possible. The therapist then uses what is expressed by the patient to frame interpretations of the main relationship themes that are drawn from aspects of the CCRT as described by Luborsky, a theme that is reevaluated by the therapist in each session. The patients then use the therapist's responses, as well as their own knowledge of themselves to advance in mastery of their relationship conflicts. This sequence is essentially what is done in dynamic psychotherapies and in psychoanalysis.

The therapist tries to help patients to be free enough to share thoughts about themselves and their main problems in several ways:

1. Within each session, the therapist often responds to the patient by offering facets of the CCRT. The therapist should not try to encompass the entire CCRT in each of the few interpretations given, but instead, presents the separate components from time to time, so that the patient has a chance to build up a concept of the broader pattern of the relationship themes.
2. In the course of each treatment, there will be times in the sessions in which the patient's alliance moves toward a near-rupture, as noted earlier. These alliance shifts tend to occur when the patient experiences the relationship with the therapist in terms of a major negative pattern in the patient's CCRT.
3. Some expressions of the components of the CCRT can be thought of as a test of the relationship with the therapist. It has been shown in Weiss and Sampson and their research group in 1986 by examination of patients' responses that it is helpful for the treatment that the therapist pass the test.
4. The movements toward mastery are an important aim in psychotherapy. In the course of the sessions, most patients will succeed in achieving improved mastery of the relationship conflicts as shown by Brin Grenyer in 1996.

D. Ending Treatment

Both in time open-ended and in time-limited treatment, as the treatment ending approaches, the patient and therapist remind each other of when the termination will take place, so that they will be prepared. If a reference to termination does not happen spontaneously from the patient's side, the therapist will often bring it up.

Treatment endings tend to correspond to the achievement of the patient's goals; patients tend to complete treatment when they have achieved at least some of their goals, and even in a time-limited treatment some of the goals tend to be achieved.

A common event toward the end of treatment is the resurgence or reemergence of the initial symptoms. This event typically implies that the patient experiences the anticipation of not seeing the therapist at a time when the patient does not recognize that he or she has enough of a reliable internalized image of the therapist and the treatment. Usually, even a brief review by the therapist of the meaning of such recurrence of initial symptoms tends to bring back the patient's level of control.

II. THEORETICAL BASES

My 1984 book on the principles of psychotherapy explained and exemplified the principles for doing supportive-expressive psychotherapy. These principles were mostly based on Sigmund Freud's 1912 and 1913 writings on dynamic psychotherapy and on SE adaptations of Freud by Robert Knight in 1945 and other collaborators, including Karl Menninger.

III. APPLICATIONS AND EXCLUSIONS

One of the attractions of SE psychotherapy is its broad applications in terms of degrees of severity and varieties of diagnoses. Even the most severely ill patients can be treated through modifications of the method in terms of increased supportiveness and decreased expressiveness of SE psychotherapy, whereas the reverse is feasible for less severely ill patients.

IV. EMPIRICAL STUDIES

There are about 50 studies dealing with the uses and the effectiveness of supportive-expressive psychotherapy. Some representative studies are given in the Further Reading section of this article and in the books by Luborsky.

These are two typical examples of empirical studies: (1) Supportive-expressive psychotherapy for depression has been frequently studied, as reviewed in the 1984 book, the SE patients performed well. One of these studies is a comparison of patients diagnosed with major depression versus with chronic depression; there were no significant differences in outcomes in these two groups; (2) in the National Institute for Drug Abuse study of cocaine addiction four treatments were compared: supportive-expressive psychotherapy, cognitive-behavioral psychotherapy, drug counseling, and group psychotherapy. The results were that the supportive-expressive and cognitive-behavioral groups were not significantly different in their outcomes, but the most effective of the four in this study was the drug counseling.

It is also worth noting that the comparisons of one form of psychotherapy with another form of psychotherapy tend to show nonsignificant differences between them. This was true for supportive-expressive psychotherapy as well as for other psychotherapies. To cite some examples: In 1983, Woody, Luborsky, McLellan, and colleagues found nonsignificant differences between supportive-expressive psychotherapy and cognitive-behavioral psychotherapy for opiate addicts. In the psychotherapy for cocaine abuse, supportive-expressive and cognitive-behavioral therapies were not significantly different in their outcomes and also were not as effective as drug counseling, as reported by Crits-Christoph, Siqueland, and colleagues in 1999.

A meta-analysis summarizing the results of comparisons of different psychotherapies, such as Paul Crits-Christoph's in 1992, showed nonsignificant differences were most common. In 1993 analysis by Lester Luborsky and Louis Diguer showed a similar nonsignificant tendency.

In conclusion, there is not a lot of reliable consistent evidence for the special advantages of any one psychotherapy over another. In fact, the major positive evidence from comparative treatment studies is marred by a major limitation, that is, treatment comparisons are not done blindly by the researchers and perhaps cannot even be done blindly. The probable effect of this is that the differences in researcher's allegiance to forms of psychotherapy correlates very highly with the differences in outcomes of the treatments—the correlation is .85, according to a study by Luborsky, Diguer, and Seligman in 1999! Until such findings have appeared, the research field has been involved in a highly enthusiastic search for what are called "empirically validated treatments." The outcomes of these treatment comparisons have, in fact, even become part of advertisements as the "winners" of these comparisons. Unfortunately, the facts are that the field has to recognize the ambiguity of comparative treatment results, as just stated.

In summary, in practice it has become clear that the "empirically validated treatment comparisons" are ambiguous in their implications. The combination of the ambiguity introduced by the researcher's allegiance effect, as well as of the older problem of nonsignificant differences among the treatments compared, means that the field has a distance to go in terms of generating a trustworthy set of comparisons of one form of psychotherapy with another.

V. CASE ILLUSTRATIONS

Howard Book in 1998 offered a vivid, complete, and highly instructive book including a case illustration of a supportive-expressive psychotherapy in a generally well-functioning patient who developed a very positive alliance with her therapist.

Another example explains in greater detail the operation of the CCRT. Mr. EH, age 18, was a college student with problems of guilt, anxiety, sporadic pain in his penis, difficulty in dealing with a new girlfriend, and resentment of his parents. As a youngster he had never felt close to his father but had felt very close to his mother. He often felt he could not experience closeness from others. The seriousness of his conflicts were difficult to evaluate. They seemed either a worsening of normal adolescent development with intense guilt over sex or there was a thought disorder involved with his wishing to be an exaulted spiritual leader. The start of his treatment also showed that he had difficulties in being assertive and becoming separate from his family.

The relationship episodes in his session 3 contained six condensed examples. These six relationship episodes are followed here by a CCRT formulation in which the most frequent components are summarized: He wishes to be close, the other person rejects him, and he feels rejected, ashamed, and upset. What follows below are brief summaries of the six relationship episodes that he told during session 3 of his psychotherapy and the CCRT scoring of each one. This CCRT, as is usual, formed the basis for the interpretations given by the therapist:

CCRT Scoring	Precis of First Six Relationship Episodes
W: To get info about sex (W1): To get closeness RO1: Rejection RS1: Feel rejected RS2: Shame RS3: Upset	*Mother* #1 This might have been a dream. Mother says it didn't happen. Up until we moved, when I had questions about sex, mother would explain to me. One day I asked and she said, "Sorry E. we can't talk about that anymore. You're getting to that age." Bothered me 'cause my young sister went into fits of laughter.
W: Get in bed with parents (W1): To get closeness RO1: Rejection RS1: (Rejected)	*Mother* #2 Mother said this never happened: we, brother and I—before sister was born—when it was really cold, would sleep with parents. Parents took my brother in bed with them and they wouldn't take me.
W: To get rapport (W1): To get closeness RO1: Rejection RS1: Feel blank (empty)	*Therapist* #3 T: What's happening now? P: I feel generally unresponsive. I'm getting a headache, tense, been thinking all week about relating all this stuff to what I was 10 years ago (sigh) and not getting any—I mean, nothing comes out … like groups of guys who have embarrassing silences. It proves no perfect rapport exists. I feel blank.
W: To kiss mother RO1: M. criticizes him RO1: Rejection, kissing stopped RS1: Rejected, out in the cold	*Mother* #4 Before I went to school I always used to kiss mother. I'm not sure it was a big thing, but it was a big thing when it stopped. She made a big thing about how I didn't want to kiss her anymore. I was suddenly out in the cold again.
(W1): Closeness to girlfriend RO: Doesn't like me RO1: Rejection, broke off RS2: Self-blame RS1: Rejected ("severed") RS3: Upset	*E* (girlfriend) #5 I'm beginning to feel a lot of resentment to E (girlfriend). I went with her for a couple of years. It's just been severed. I'm fearful of seeing her and feeling something for her. She just doesn't give a dame Bothers me I used to be so screwed up about her.
(W1): To get a response RO1: Rejection RS: Resentment RS1: Rejected	*Mother* #6 One thing that started my resentment against my parents. I told her about E (girlfriend) that everything was cut off. I said E's not writing and it upsets me. She said, "Well, I'm sure about you and you aren't sure about her." That really cut me up because she … she … a … assumes between us is like between E and me.

N	*Total CCRT Formulation*
6 Wish 1	W1: To be close
6 Response from other 1	RO1: Rejection
6 Response from self 1	RS1: Feel rejected
2 Response from self 2	RS2: Shame
2 Response from self 3	RS3: Upset, anxious

VI. SUMMARY

Supportive-expressive psychotherapy is a common form of dynamic psychotherapy. Its main principles are basically derived from Sigmund Freud's as these were shaped by clinicians at the Menninger Foundation, starting around 1940. In each session the therapist allows the patients to express themselves in their own way and to choose their own goals. A main technique for helping the patient is provided by the therapist who formulates the patient's main conflictual pattern of relationships in terms of the Core Conflictual Relationship Theme. It is the patient's main pattern of relationships, especially those that are conflictual; this pattern of relationships is derived from narratives about relationships that the patient tells during each session. The treatment is called

supportive-expressive because supportiveness and expressiveness are the two main techniques that the therapist uses. When the treatment conditions are more supportive, the therapist provides support when needed; when the help is more expressive, the therapist provides help with understanding by using what the patient expresses in interpretations. The length of the treatment is either time open-ended or time-limited. The treatment comes to a close when the main goals have been achieved and there has been sufficient occasion to work through the meanings of termination in order to optimize the retention of the gains.

See Also the Following Articles

Cognitive Behavior Therapy ■ Psychodynamic Couples Therapy ■ Psychodynamic Group Psychotherapy ■ Time-Limited Dynamic Psychotherapy

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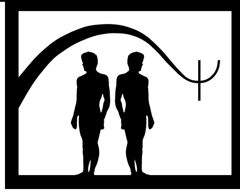

Symbolic Modeling

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I. Description
II. Theoretical Basis
III. Empirical Findings
IV. Summary
Further Reading

GLOSSARY

imitation The behavior of an observer that is similar to that of a model and that occurs subsequent to the observation of modeling.

model The individual or character who is observed and demonstrates the behavior that is to be imitated.

modeling (1) The act of demonstrating the behavior that is to be imitated and (2) the general term describing the treatment procedure.

observer The individual who observes and imitates the behavior of the model.

Symbolic modeling is one of two general forms of modeling: live and symbolic. In live modeling, the model is actually present and models behavior "live." In symbolic modeling, the model is not actually present but instead is pre-recorded, drawn, or described. Symbolically modeled behavior is typically presented on videotape or film; in animated or still cartoons; and in narratives read aloud by another, listened to on audiotape, or read silently to one's self from printed handouts, instruction manuals, and books. Silent reading, as well as imagining a model or one's self engaging in behavior, are considered covert forms of symbolic modeling.

I. DESCRIPTION

In its most basic form, symbolic modeling is a process in which one individual sees, hears, or reads a depiction of the behavior of a real or fictional individual or character and then engages in behavior that is similar to the behavior that was observed. Although the initial research on modeling focused on overt motoric behavior, more recent research has also explored the effects of modeling on covert affective and cognitive behaviors. The results of that research confirmed that modeling is indeed an important contributor to the acquisition and modification of both overt and covert behaviors, and that the manner in which modeling produces its effects is generally the same for both overt and covert behavior.

Although symbolic modeling alone can have powerful effects, it is often a part of multicomponent programs designed to teach social skills, such as assertiveness, anger management, and self-control. It is also often a component of programs designed to treat anxiety disorders, such a social phobias, agoraphobia, and animal phobias. Symbolic modeling can serve five general functions: It can teach a new behavior or skill that is demonstrated by a model; it can reduce anxiety by depicting a model

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engaging in a feared activity or making contact with a feared situation with no untoward consequences; it can encourage or disinhibit behavior by depicting positive consequences following modeled behavior; it can discourage or inhibit behavior by depicting negative consequences following behavior; and it can elicit or facilitate behavior by serving as a prompt to engage in the behavior at a particular time or place.

II. THEORETICAL BASIS

Since first recognized and studied by psychology, what is now typically referred to as modeling has been known by a variety of other terms, including observational learning, vicarious learning, identification, copying, matching-to-sample, and contagion. In their efforts to understand the modeling process, researchers have examined several theoretical issues raised by modeling and imitation, four of which will be discussed here. The first issue is whether the ability to imitate is innate or acquired. The general consensus among scientists in the field now is that the ability to imitate a broad range of behaviors modeled by a variety of both live and symbolic models is primarily an acquired skill.

The second issue involves the role of operant conditioning in modeling and imitation. Researchers have concluded that operant conditioning plays an important role in the acquisition and modification of overt, motoric behavior, as when a mother reinforces an infant when the infant produces a vocal sound similar to that the mother has made and as a result is more likely to imitate that and other vocalizations, or a child observes other children behaving aggressively and then does so as well.

The third issue involves the role of respondent conditioning. Again, researchers have concluded that respondent conditioning is primarily involved in the acquisition and modification of covert, emotional behavior, as when a child is terrified by a filmed depiction of a traumatic event happening in a dark room and as a result is fearful of dark rooms. Conversely, symbolic exposure to fear-producing stimuli can contribute to the deconditioning or extinction of anxiety responses in the treatment of anxiety disorders.

The fourth issue involves the adequacy of operant and respondent conditioning in the explanation of the full range of modeling and imitation phenomena. Cognitive theorists claim that conditioning theories ignore central processes. The cognitivists in general, and advocates of a social learning theory explanation in particular, postulate that a consideration of the action of a variety of intervening variables, such as anticipation, symbolic coding, and cognitive organization is necessary for an adequate understanding of the effects of modeling.

III. EMPIRICAL FINDINGS

Both live and symbolic modeling have long been accepted as an important contributor to the acquisition and modification of behavior. The major advantages of live modeling are that it typically allows more participatory learning and greater individualization of the content, pacing, and repetition of the modeled material to maximize its impact on the observer than does symbolic modeling. The major advantages of symbolic modeling are that it typically allows the modeling of behavior in situations that cannot be either practically or safely created live, it permits the widescale dissemination and cost-effective utilization of the modeling materials in a variety of settings, and it enables the assignment of homework or "self-study" modeling experiences as part of the course of treatment.

Several guidelines for the effective use of modeling have been identified. They address the characteristics of the observer, the characteristics of the model, and how modeling is conducted. The findings most relevant to the design of modeling programs will be noted here. The observer must have an adequate repertoire of imitation skills. If an assessment of the strengths and weaknesses of the observer indicates that the observer has not mastered the ability to imitate, imitative behavior must be taught.

The observer must attend to both the model and to the relevant aspects of the modeled behavior. Again, if assessment indicates that the observer does not have these skills, they must be taught; if the observer has these skills but does not use them, prompts must be provided and/or contingencies must be arranged to foster their utilization. Finally, the observer must imitate the modeled behavior. If the observer does not, impediments must be identified and eliminated and/or contingencies must be analyzed and altered to foster imitation.

To maximize the effects of modeling, the model should be similar to the observer and/or have high status or prestige for the observer. The modeled behavior should be expected to result in naturally occurring positive consequences for the model, such as the granting

of a request, rather than arranged consequences, such as the award of a token. Modeling should portray a naturally occurring positive outcome for the model as a result of the modeled behavior. Models should be portrayed as coping successfully with the problems or tasks confronting them rather than achieving complete mastery and/or exhibiting flawless performance. To the degree possible, a variety of models using a number of variations of the skills being taught should be shown dealing with a range of problems or tasks in an array of settings appropriate to the observer.

The difficulty or complexity of the modeled behavior should be matched to the characteristics and abilities of the observer. More difficult or complex behavior should be broken down into components or approximations and taught in sequence. Self-instructions should be taught in order to assist observers to guide themselves through expected performances and deal with impediments to successful outcomes if they arise. Observers should be taught to evaluate their behavior, identify the strengths and weaknesses of their performances, and then self-reinforce for the strengths and determine how the weaknesses may be remediated. The modeled behavior should be actively practiced by the observer after it is modeled, and the practice should include feedback, reinforcement, and correction. Finally, arranged prompts and reinforcement that have been used to foster acquisition and performance of the modeled behavior should be faded out during the course of training to maximize the likelihood that the behavior will occur and maintained under natural conditions.

IV. SUMMARY

Symbolic modeling consists of a recording, depiction, description, or imaginal portrayal of behavior. The person demonstrating the behavior is termed the model; the actions of the model are termed modeling; the person observing the model is termed the observer; and the subsequent behavior of the observer that is similar to the modeled behavior is termed imitation. Explanations of symbolic modeling and imitation rely on operant conditioning, respondent conditioning, and cognitive social learning processes. Modeling has been shown to be effective in the teaching of overt behavior, such as social skills and anger management, and in the treatment of covert behaviors, such as fear and anxiety.

Successful modeling programs should include an assessment of the observers' strengths, weaknesses, and natural environment. The program should then be matched to observers' strengths, weaknesses, and the characteristics of their natural environment. Factors to be considered include the attributes of models, and the complexity and natural consequences of the modeled behavior. A variety of models, situations, and behaviors resulting in successful outcomes should be presented. Coping rather than mastery should be emphasized, and ample opportunities to practice and refine imitative performance should be provided. Prompts and reinforcement should be used as necessary to facilitate learning and performance and then faded out to foster success in the natural environment.

See Also the Following Articles

Behavior Rehearsal ■ Coverant Control ■ Heterosocial Skills Training ■ Modeling ■ Role-Playing ■ Self-Statement Modification

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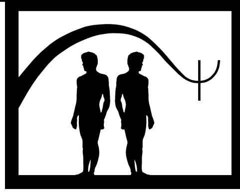

Systematic Desensitization

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I. Description of Treatment
II. Theoretical Bases
III. Applications and Exclusions
IV. Empirical Studies
V. Case Illustration
VI. Summary
Further Reading

GLOSSARY

conditioned inhibition In the learning theory of Clark L. Hull the repetition of a learned response is accompanied by the buildup of a fatigue-like tendency to not respond called reactive inhibition. Stimuli present at the time of reactive inhibition become conditioned stimuli for inhibition or conditioned inhibitors.

counterconditioning An approach to learning associated with the theory of Edwin R. Guthrie; a relevant stimulus is maintained intact while a substitute response is practiced in its presence.

exposure technology Associated with Isaac Marks; refers to a therapeutic orientation according to which prolonged exposure to fear cues is the sole requirement for treatment success, and no interest is shown in how or why exposure produces beneficial outcomes.

extinction Associated with Ivan P. Pavlov's learning theory; denotes the repeated presentation of a conditioned stimulus in the absence of any unconditioned stimulus. Sometime refers to the response decrement that follows from repeated presentations of a conditioned stimulus alone.

habituation The decrement in a response due to repeated, predictable presentations of a stimulus. Sometimes habituation is said to be limited to unconditioned responses. Usually habituation refers to decrements in the neural substrate of behavior.

hierarchy As used in behavior therapy; a listing of verbal scenarios that describes situations in which a fearful person gradually confronts fearsome objects and/or events.

progressive relaxation training An approach to learning how to relax developed by Edmund Jacobson. Different groups of muscles are repeatedly tensed and relaxed in sequential order "up" or "down" the body while the different feedback from tense versus relaxed muscles is contemplated and deeper relaxation is suggested.

reciprocal inhibition The physiologist C. S. Sherrington's term that denotes the inhibition of neuronal activity by the activation of other, reciprocally inhibiting, neuronal activity. As used by Joseph Wolpe reciprocal inhibition refers to the inhibition of sympathetic activation by parasympathetic dominance.

spatiotemporal hierarchy A hierarchy for systematic desensitization in which increasing the fearsomeness of successive scenarios is accomplished by reducing the times and/or distances separating the patient from the frightening encounter.

SUD scaling The patient is taught to assign numbers from 0 (calm) to 100 (terrified) that reflect the level of fear or subjective units of discomfort (SUDs) associated with targeted activities or objects.

thematic hierarchy A hierarchy for systematic desensitization in which increasing the fearsomeness of successive scenarios is accomplished by increasing the clarity or poignancy of focal themes such as "being watched," "being criticized," "suffocating," "being confined."

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Systematic desensitization is a venerable behavior therapy technique developed by Joseph Wolpe for the treatment of fear- and anxiety-related disorders. Systematic desensitization includes three basic procedural elements. The patient is taught to relax his or her voluntary musculature using a procedure known as progressive relaxation training. Concurrently the patient and therapist develop detailed descriptions of realistic encounters with the objects and/or events that provoke fear or anxiety, and arrange those descriptions in order of fearsomeness. Finally the patient is guided to visualize the scene descriptions in increasingly fearsome order while taking care to maintain a relaxed muscular state. In addition, treatment based on systematic desensitization often entails encouragement to rehearse the targeted encounters in real life after they have been visualized calmly. Systematic desensitization helped launch the behavior therapy movement and was the first psychological treatment that produced behavioral improvement reliably.

I. DESCRIPTION OF TREATMENT

A. Relaxation Training

As noted above one basic procedure in the use of systematic desensitization is training the patient to relax the voluntary musculature. Usually the training is done according to the "progressive relaxation" techniques that were developed by Edmund Jacobson during the 1930s. Ideally relaxation training is done using a procedural guide and detailed transcripts such as those in the manual provided by Douglas A. Bernstein and Thomas D. Borkovec in 1973 and in the book provided by Marvin R. Goldfried and Gerald C. Davison in 1976. Ordinarily the available transcripts for relaxation training provide the following: (1) a subdivision of the skeletal musculature into a number of muscle groups, usually 16; (2) a set of instructions that will produce tension in each of the muscle groups; and (3) another set of instructions that focus attention on the different sensations that arise from tense versus relaxed muscles. In the widely used manual of Bernstein and Borkovec there are transcripts also that subdivide the muscles into eight and four separate groups.

The 1976 book by Goldfried and Davison contains valuable information about how to set the stage for relaxation training, including information about such things as the purpose of relaxation training and how being deeply relaxed will feel. After the stage is set according to those or similar guidelines the therapist is ready to begin. The first step in relaxation proper is to demonstrate various exercises that will be used, exercises that create discernible tension in several groups of muscles. The second step is to encourage the patient to seek clarification about the exercises and, as needed, to repeat one or more of the demonstrations. In the third step the therapist reads the relaxation transcript with a few points in mind: (1) A training "trial" for a muscle group is a tension-relaxation cycle. After instructions for tensing a specific muscle group have been read, 10 seconds or so are allowed for maintaining the tension. At that time instructions for relaxing or "letting go" are read, after which another 20 seconds or so are allowed for relaxing and for attending to feedback differences from tense versus relaxed muscles. (2) Each muscle group is used for at least two consecutive trials. (3) The muscle tension should be easily discernible but not extreme. (4) The muscle groups will be relaxed in some progression (i.e., from the feet to the head-neck).

Some therapists provide patients with tape-recorded relaxation instructions and encourage them to practice relaxing at home. There is evidence that "live" relaxation is better than taped relaxation. Hence, taped relaxation is best viewed as an adjunctive procedure. If home practice of relaxation is important, then the patient should be instructed to record and submit regularly a diary of when, where, and how well he or she relaxed on each occasion.

B. Hierarchy Construction

Relaxation training usually takes from five to seven sessions. During this time the therapist and patient can construct what is known as a "desensitization hierarchy" provided that care is taken to construct the hierarchy when the patient is not relaxing. Behavioral assessment will have provided the information necessary to begin hierarchy construction. The information will include a complete and detailed listing of the various cue-stimuli for fear as well as a tentative arrangement of the fear stimuli according to groups. Each group of fears that has a common thread will ultimately be arranged into a single hierarchy or increasingly fearsome listing of targeted scenarios.

The most common types of desensitization hierarchies are spatiotemporal hierarchies and thematic hierarchies. In spatiotemporal hierarchies, increasing the fearsomeness of successive scenarios is accomplished by decreasing the times and/or distances that separate the patient from targeted encounters. For example, the

times and distances separating a socially phobic student from a dreaded classroom speech can be reduced systematically from days, to hours, to minutes. In thematic hierarchies, increasing the fearsomeness of successive scenarios is accomplished by increasing the clarity or poignancy with which the scenario captures the fearsome theme. Given the same socially phobic student, for example, the successive scenarios in a public-speaking hierarchy could entail increasing scrutiny and/or increasing likelihood of failure. Choosing between spatiotemporal and thematic hierarchies is not always straightforward, nor is grouping disparate fears to form thematic hierarchies. The most common approach to the problem of grouping is to use traditional phobia categories. Wolpe, for example, arranged 14 "different" fears into four hierarchies: acrophobia, agoraphobia, claustrophobia, and fears related to illness.

The most common procedure for constructing desensitization hierarchies was developed by Wolpe and is called SUDs scaling. In this procedure, the patient is first taught to assign a numerical value of 0 subjective units of discomfort (SUDs) to reflect absolute calmness, and to assign a numerical value of 100 SUDs to reflect the most extreme fear imaginable. Each potentially useful scenario in a given hierarchy is then assigned a SUDs rating and the scenarios are ordered in terms of increasing fearsomeness. Then scenarios are dropped and new ones added until the first scenario (hierarchy item) is rated near 0 SUDs, and the zenithal scenario is rated near 100 SUDs. As is described later, each hierarchy of fearsome scenarios provides for systematic "exposure in imagination" to attenuated, then intermediate, than maximally fearsome forms of the cue stimuli for fear. Each successive scenario should be more fearsome than the last but the difference should not be over 10 SUDs at any point in the hierarchy and should be quite small toward the upper end of the hierarchy. The scenarios incorporated into the hierarchy should sample comprehensively the objects, events, situations, or themes that cue fear responses. Each scenario should be relatively complete and, where possible, relatively concrete. Initial hierarchies can be modified as desensitization proceeds and response to treatment can be monitored.

C. Systematic Desensitization

Systematic desensitization proper typically is performed in one of two ways. In the "orthodox" procedure the patient is first exposed to abbreviated relaxation training. (Abbreviated relaxation training is accomplished, after thorough training, by using fewer than 16 muscle groups, for example 8 or 4 groups as described by Bernstein and Borkovec.) Next the therapist instructs the patient to visualize for 10 to 15 seconds the least aversive hierarchy scenario and to signal by elevating an index finger if the visualization is accompanied by discomfort or fear. If the patient does not signal the presence of fear, then he or she is instructed to relax and, later, to visualize the scenario again. If the visualization occasions no fear on this second trial, then a 30 to 60 second period for relaxing follows and the next scenario on the hierarchy is presented for visualization. This process is repeated again and again as progressively more fearsome scenarios are visualized. Should the patient signal that fear is present, he or she is instructed to stop visualizing and relax. After time for relaxation the scenario is visualized again. If the fear signal recurs, then the therapist repeats the previously desensitized scenario and, after relaxation, repeats the troublesome scene. If the patient still signals the presence of fear, then the therapist and patient construct, on the spot, a new scenario that stands between the troublesome scenario and the last one that was successfully negotiated. Orthodox imaginal desensitization is complete when the most fearsome scenarios are visualized without fear signals.

Joseph Wolpe introduced the "improved" procedure for systematic desensitization in 1973. Here again treatment begins with abbreviated relaxation practice. Then the patient is instructed to visualize the appropriate scenario and to signal, by raising an index finger, when the imagery is clear. The therapist allows 10 to 15 seconds after a signal for the patient to continue visualizing fearsome material, then instructs the patient to drop the images and report orally a SUDs rating of the fear experienced during visualization. In this procedure visualization of each fearsome scenario is repeated until the patient reports 0 SUDs. "Improved" desensitization in imagination is complete when the patient visualizes the zenithal scenario(s) and reports that no fear was experienced.

Beyond the basic techniques discussed earlier there are a number of important considerations at the level of procedure. Discussions of specific procedures are available in Wolpe's various books and in the book by Goldfried and Davison. The following subset of those recommendations shows the flexibility of the approach.

1. The therapist should view any hierarchy as tentative and should be prepared to add, modify, or delete exact scenario descriptions as needed.

2. Multiple hierarchies should be dealt with simultaneously; no more than three or four scenarios in any given hierarchy should be dealt with during a given session.

3. Desensitization proper should last 20 to 30 minutes per session; sessions should occur at daily to weekly intervals.

4. Once a particularly troublesome scenario has been visualized calmly, it should be visualized repeatedly before the next one is attempted.

5. Throughout desensitization the patient should be reminded to include himself or herself as a participant in the scenarios. He or she is not merely visualizing fearsome situations, but is visualizing himself or herself behaving within the fearsome scenarios.

6. The patient should be encouraged to participate in the targeted real life scenarios after they have been imaginally desensitized; such participation should lag somewhat behind progress in imaginal desensitization.

II. THEORETICAL BASES

There are a dozen or so theories that explain how or why systematic desensitization brings about fear reduction. Many of them are only partial theories, nearly all are *post hoc* in nature. Theorizing about the causal efficacy of desensitization represents in microcosm many of the ills that have plagued general and clinical psychology for the past half century.

A. The Legacy of Learning Theory

The psychology of learning during the 1930s and 1940s incorporated several competing theoretical systems (e.g., the systems of Edwin R. Guthrie, Clark L. Hull, and Edward C. Tolman). There was not much disagreement about experimental data. The major facts of acquisition, extinction, generalization, discrimination, and the like were, for the most part, consensually endorsed. Nonetheless there was spirited argument at the seemingly basic levels of "what" was being learned, "what" was being unlearned, and so forth. Hull spoke of "habits." Tolman spoke of "expectancies." Guthrie spoke of S-R bonds.

Joseph Wolpe chose to articulate his explanation of desensitization effects using the language of Hull (see below). When he did so he invited rejoinders in the languages of Guthrie and Tolman. Once Joseph Wolpe's ideas gained some notoriety, these rejoinders did not take long to appear. Guthrie's language was used in the assertion that systematic desensitization embodies "counterconditioning." Tolman's language was used in the argument that desensitization works, in part, by engendering optimistic "expectancies."

B. The Psychotherapy Environment

The field of psychotherapy during the 1950s and 1960s also incorporated competing theoretical systems. Arnold Lazarus, for example, listed 36 psychotherapy systems in evidence as of 1967, adding that his list was incomplete. There was not much disagreement at the level of data in the psychotherapy field either. With the noteworthy exception of Carl Rogers and his followers, data did not play an important role in system development. From such a variegated and uncritical psychotherapy environment, it was inevitable that some would seize on opportunities to explain Joseph Wolpe's impressive results by recourse to their own preferred explanatory constructs. Thus, the beneficial effects of desensitization were said to depend on "the therapeutic alliance," on fortuitous psychodynamic accompaniments of desensitization treatment, and the like.

C. Empirical Problems

During the late 1960s and early 1970s scores of articles appeared that were intended to provide experimental answers to the theoretical questions made outstanding by the legacies of learning theory and the environment of psychotherapy. For one example, the outcomes of experiments on systematic desensitization with and without muscular relaxation were styled as evaluating "counterconditioning" versus "extinction" as explanatory vehicles. Unfortunately, the substantive yield from the many papers was confusing and contradictory; theorists remained free to "pick and choose" experimental support for the various explanations afforded by learning and psychotherapy theories.

D. Theories of Fear Reduction from Systematic Desensitization

By and large theories of the active mechanism(s) of systematic desensitization have not been theories at all. Rather, they have been uniformly *post hoc* (and often vacuous) claims that desensitization effects represent something else such as extinction, habituation, counterconditioning, deconditioning, and the like. Furthermore, these and similar concepts have been used

uncritically, even interchangeably, as if the early behavior therapist acquired the lexicon of animal learning but little else.

1. Reciprocal Inhibition and Habituation

According to the reciprocal inhibition theory, systematic desensitization reduces anxiety by causing the cues for the anxiety to become cues for anxiety inhibition. Anxiety is composed of conditioned sympathetic responses. The occurrence of sympathetic responsivity during aversive imaging can be reciprocally inhibited by the parasympathetic underpinnings of concurrent muscular relaxation, provided that the imaging is graduated in fearsomeness. When reciprocal inhibition of the sympathetic response occurs during aversive imaging, the act of imaging acquires an anxiety-inhibiting function. This happens via a mechanism known as conditioned inhibition. Hence systematic desensitization reduces anxiety via conditioned inhibition based on reciprocal inhibition.

According to the habituation theory, systematic desensitization reduces anxiety due to habituation of sympathetic responses to clinically targeted stimuli. Sympathetic responsivity during aversive imaging is made to habituate over repeated imaging trials in much the same way that an orienting reflex habituates over the course of exposure to repeated novel stimuli. Theoretical accounts of habituation differ in minor ways and these differences appear in different renditions of how habituation is produced by systematic desensitization. Muscular relaxation plays a significant role by hastening or facilitating the rate of sympathetic response habituation.

2. Counterconditioning and Extinction

According to a theory based on counterconditioning, systematic desensitization reduces anxiety by causing the cues for anxiety-related behaviors to become cues for other behaviors. The display of emotional behaviors during conditioned aversive stimulation is prevented by rehearsing competing behaviors. (Relaxation is customary but any nonanxious behavior would suffice in principle.) In due course the conditioned aversive stimuli call forth the competing behaviors instead of the anxiety-related behaviors. Muscular relaxation plays a role by providing the substitute behaviors.

Throughout much of the early behavior therapy literature, clinically focal fears were regarded as conditioned emotional (Pavlovian) respondents. Accordingly, systematic desensitization was said to work by promoting respondent extinction. The role of muscular relaxation, in tandem with graduated exposures, was that of arranging for presentations of fear signals to be unreinforced.

3. A Variant of Exposure Technology

Beginning with Isaac Marks in the mid 1970s, most contemporary writers describe systematic desensitization as a variant of exposure technology. On the surface that characterization is not unreasonable because imaginal exposure is a prominent aspect of the procedure, and *in vivo* exposure is recommended adjunctively. However, characterizing systematic desensitization as a variety of exposure flies in the face of well-known history and does nothing to explain how systematic desensitization works.

4. Cognitive and Social Reinforcement Theories

Albert Bandura and Wallace Wilkins have both offered theories that explain the beneficial effects of systematic desensitization. Initially during the 1970s Albert Bandura developed his broadly applicable idea that "a sense of self-efficacy" is fundamental to success in psychological therapy. Relatively high self-efficacy influences successful outcomes by promoting persistent and vigorous self-change efforts. According to Albert Bandura systematic desensitization operates by increasing self-efficacy; the stronger self-efficacy promotes continued self-change efforts, and so forth.

In 1971 Wilkins offered a fairly elaborate theory explaining the beneficial effects of systematic desensitization. Among Wilkins' assertions are that systematic desensitization works because the therapist fosters an expectation of therapeutic success; because feedback during treatment affords information that the patient is improving; and because systematic desensitization teaches one how to control the onset and offset of fearsome imagery.

5. Other Theoretical Approaches

The notions that systematic desensitization effects arise from the therapeutic alliance and from fortuitous psychodynamic processes were alluded to earlier. Others have argued that systematic desensitization effects might rest on covert modeling of fearless behavior, or on social reinforcement of motoric approach responses, or on reinterpretations of the meanings of fearsome images. There is also the plausible notion, based on the contemporary work of Peter J. Lang, that systematic desensitization works by modifying the bioinformational import of fearsome imaging.

III. APPLICATIONS AND EXCLUSIONS

Over the past three decades creative clinicians have found numerous applications for relaxation-based fear treatments such as systematic desensitization and its variants. The most common applications have involved various specific phobias and social phobia. But applications to other anxiety-related disorders are not rare. Among the specific phobias with which systematic desensitization has been used are those related to death, injury, disaster, illness, water, storms, animals, birds, reptiles, airplanes, automobiles, injections, ambulances, sanitary napkins, and childbirth. Applications related to social phobia have included "social situations," heterosexual interactions, and authority figures. Among the other anxiety-related disorders treated heretofore with systematic desensitization are asthma, recurring nightmares, repetitive cleansing, chronic diarrhea, and urinary urgency.

For the past two decades clinicians have been opting for *in vivo* treatments that, in the aggregate, are called exposure technology. Hence, the first choice point in deciding to use systematic desensitization for any phobia or anxiety-related disorder is to establish that *in vivo* techniques are not feasible.

After a decision is made to consider using systematic desensitization there must be a relatively thorough assessment of the controlling stimuli for fear and the details of fearful responsivity. (Assessment of the sort used for diagnosis and for exposure treatment is rarely adequate.) Such specific assessment will afford answers to four important questions. (1) Can the cue-stimuli for fear be described in fairly concrete terms? (2) Does the patient show four or fewer different sets of fears? (3) Does the patient report clear imagery related to the fear cues? (4) Does the patient report or manifest fear, arousal, or discomfort while visualizing the relevant fear scenes? Affirmative answers to these questions prompt consideration of treatment via systematic desensitization.

Wolpe has written extensively on complications that arise from attempting systematic desensitization with inappropriate patients. Some patients simply cannot learn to relax. Others display what might be called a fear of relaxing or of "letting go." Still other patients do not seem to be able to conjure up the requisite imagery or to picture themselves as part of the targeted scenarios. Problems at these levels should prompt reconsideration of whether it is possible to use some sort of *in vivo* exposure procedure.

IV. EMPIRICAL STUDIES

Early reports about the successes of systematic desensitization did much to promote behavior therapy and the conditioning formulation of psychopathology on which behavior therapy was based. However, the tenor of those early reports was influenced by the Protestantism of that era; the subsequent four decades have witnessed some moderation of those early claims and no small amount of controversy.

A. Early Clinical Reports

The first reports of clinical success with systematic desensitization were reported by Joseph Wolpe via a series of papers published from 1952 to 1962. These papers were shadowed by a series of similar reports provided by Arnold Lazarus from 1957 to 1965. An extraordinarily thorough review of these and other early reports was prepared by Gordon L. Paul and published in 1969.

1. Joseph Wolpe

In his influential 1958 book, *Psychotherapy by Reciprocal Inhibition,* Joseph Wolpe reported that nearly 90% of 210 patients were either improved or much improved following treatment with his new methods. Gordon Paul pointed out later that some of those 210 patients were treated with methods other than systematic desensitization. He reanalyzed Wolpe's original reports, identified 85 patients who had been treated with systematic desensitization alone, and reported success in 78 (92%) of those 85 cases. He reported also that follow-up contacts with 21 patients after periods of 6 to 48 months yielded no report of relapse. In some cases the effects of systematic desensitization were gauged by direct observation and by reports from unbiased others. By and large, however, "success" was defined as self-reports of improved responses in the presence of previously anxiety-eliciting stimuli encountered in the natural environment.

2. Arnold Lazarus

In 1957 Arnold Lazarus and Stanley Rachman provided the first report of success when systematic desensitization was used by a therapist other than Joseph Wolpe. Through the first half of the 1960s Lazarus provided very careful case reports and summaries about a total of 220 patients with whom systematic desensitization had been used. The presenting problems were quite diverse; they included social anxieties, generalized

anxiety, panic, and numerous phobias including agoraphobia. Of these 220 diverse cases Lazarus counted 190 as successes based on therapists' Likert-type ratings of patients' functioning in several adaptively significant arenas. He also acquired corroborative reports from referral sources in 70% of his cases.

3. Other Early Reports

The successes reported by Joseph Wolpe and Arnold Lazarus prompted numerous other reports about treating anxiety-related conditions with systematic desensitization. By 1969, Gordon L. Paul was able to locate 51 separate reports of individual cases or clinic series and several reports of systematic desensitization applied in groups. Successful outcomes were not universal in these reports, but there were relatively few failures.

B. The First "Controlled" Experiments

The earliest behavior therapists sought scientific support for the efficacy of their treatments. Thus when early experimental work done by Peter J. Lang and by Gordon L. Paul provided that support it received unprecedented attention.

1. Peter J. Lang

In 1963 and again in 1965 Peter J. Lang and his colleagues reported early experiments in which snake-fearful college students were exposed to standardized forms of systematic desensitization. In the aggregate the experiments achieved impressive control over sources of unwanted variance in the dependent-variable measures; they succeeded in supporting the argument that temporal pairing of muscular relaxation and graded imaging of snake-related scenarios was specifically responsible for observed reductions in avoidance and reported reductions in fear of snakes. They also provided 6-month follow-up data supporting the specific effect of systematic desensitization. Overall, 15 participants who nearly completed the standard course of systematic desensitization improved significantly by contrast with 10 participants who did not complete the standard course of desensitization, with 10 participants exposed to a procedural control for experimental demand/placebo influences, and with 11 participants who served as untreated controls.

2. Gordon L. Paul

In 1966 Gordon L. Paul reported an experiment that remains a methodological reference point three decades later, and that still affords the most convincing evidence available of the specific effectiveness of systematic desensitization. The participants were 96 college students most of whom would now be diagnosed as having generalized social phobia with particular problems in the domain of public speaking. After extensive assessment each of 74 participants was assigned to one of four experimental conditions that, taken together, served to compare the effects of systematic desensitization with those of insight-oriented psychotherapy under conditions that controlled for influence from experimenter (therapist) bias and from major extratherapeutic sources of variance. Fear during a standardized public speaking task was assessed by self-reports, by demonstrably reliable behavioral observation, and by pulse-rate and palmar sweat measures. The group treated with systematic desensitization improved significantly more than did any other group on fear measures in all three domains. Posttreatment differences were maintained as judged by self-reports acquired 2 years later from carefully selected respondents.

C. Analogue Experiments

The behavior therapy movement was up and running by 1970 complete with several new books, three new journals, and two new societies. In this context the early experiments reported by Peter J. Lang and his colleagues spawned scores of experiments in which pretreatment and posttreatment measures of fear of snakes among college students were used to evaluate the effects of systematic desensitization. Some of the experiments compared the effects of systematic desensitization with the effects of competing behavior-influence packages, notably implosive therapy and imaginal flooding. Most of the experiments compared the effects of systematic desensitization with those procedural variations that were germane for one reason or another. Many questions were asked. Is muscular relaxation training necessary for fear reduction with systematic desensitization? Must the imaging instructions proceed along a graded, increasingly fearsome hierarchy of scenarios? Must the participant be permitted to govern his or her own rate of progress along the scenario hierarchy?

Notwithstanding the effort and ingenuity that went into the so-called "snake desensitization studies" they afford very little by way of characterizing the clinical efficacy of systematic desensitization. This is true for at least two reasons. First, in the intellectual climate of the day the efficacy of systematic desensitization was virtually axiomatic; therefore most of the research was intended

to answer other questions, such as questions about the "active ingredients" or causal mechanism(s) that explain the success of the approach. Second, the quality of systematic desensitization research with snake-fearful participants fell off sharply very soon after Lang's original reports; since 1972 the external validity of empirical generalizations based on orthodox "snake desensitization studies" has been very much in doubt.

D. Current Status

Throughout most of the decade of the 1960s systematic desensitization was clearly the treatment of choice for phobias and for other anxiety-related conditions. That popularity was based on the reports of clinical cases and series noted earlier and, in part, on the zeitgeist in which Joseph Wolpe's formulations appeared. Toward the end of the decade the work of Albert Bandura and his students began to receive attention also; phobia treatments such as graduated participant modeling began to compete with systematic desensitization. During the middle 1970s Isaac Marks began arguing persuasively that exposure to fear signals is the common element of the successful phobia treatments and that *in vivo* or real-life exposure is all that is needed for clinical success. Thus was born the approach known as "exposure technology."

One outcome of the competing efforts of Albert Bandura and Isaac Marks was an abrupt decline of interest in systematic desensitization. Thus when reports of experiments on the systematic desensitization of snake-fearful (and test-anxious and shy) college students disappeared suddenly from the mainstream literature in 1972 there was nothing about systematic desensitization to take their place. For the past 28 years the empirical literature has contained only episodic case reports about unusual or otherwise interesting applications of the procedure.

Because of the dearth of new data for a quarter century and the widely suspect external validity of "analogue" studies, there are essentially two ways to attempt answering questions about the efficacy of systematic desensitization. One can study and evaluate polemic papers, including papers based on meta-analytic studies, that include statements about clinical outcomes and/or one can retreat to information found in the early clinical series and experiments reported by people such as Joseph Wolpe, Arnold Lazarus, Peter J. Lang, and Gordon L. Paul. The polemics have occurred mainly between Joseph Wolpe and Isaac Marks who have championed the causes of systematic desensitization and exposure technology, respectively. The early clinical series and experiments were, as noted earlier, reviewed in painstaking detail, by Gordon L. Paul in 1969.

V. CASE ILLUSTRATION

The narrative that follows describes the treatment of a 45-year-old, married, white female (Helen) who had severe dental phobia. Behavioral interviewing revealed a clear history of aversive conditioning that involved both pain and ridicule during her extremely rare dental visits. The patient's goal in seeking treatment was to tolerate many sessions of restorative dental treatment. (She could more easily have been a candidate for dentures than for full-mouth restoration; she resisted dentures citing the implication of old age.)

A. Assessment

Early on Helen flatly refused to try direct exposure to dental care under any conditions. Systematic desensitization was then considered as a preparation for subsequent real-life exposure, provided that assessment data supported the use of systematic desensitization.

Initially a suitable dentist was contacted and together Helen and I visited the dentist's office in order to promote concrete imagery during the upcoming assessment. (The visit required a promise that no interaction with the dentist other than a "hello" would be expected.) Time was taken for Helen to get sufficient information for detailed mental pictures of the sights and sounds of that specific environment, and to tell that dentist about her fear.

A widely used structured interview produced diagnoses of claustrophobia and social phobia. (Usually fear of pain or of other oral discomfort plays a central role in dental fear and avoidance; the picture for Helen was surprising, especially given an apparent history of pain-related aversive conditioning.) Questionnaires, role-plays, and imaginal rehearsals were used to pinpoint the kinds of events that made Helen anxious and to describe her fear in three-channel terms. (For example, a questionnaire about the details of claustrophobia established that she was concerned with confinement but not with suffocation.) Helen was identified as a candidate for systematic desensitization in imagination based on the criteria in Joseph Wolpe's 1990 book. Importantly she reported clear imagery and considerable discomfort, including perceived heart-rate increase, during imaginal rehearsals of selected dental-visit scenarios. The kinds of events that made Helen anxious did, indeed, have more to do with confinement and with criticism than with pain.

B. Relaxation and Hierarchy Construction

An eight-session course of relaxation training was undertaken twice weekly using transcripts from the 1973 manual of Douglas A. Bernstein and Thomas D. Borkovec. During the last two sessions four muscle groups were used in order to set the stage for systematic desensitization. In general four repetitions of tension-relaxation cycles were used. Helen had no means of playing tape-recorded relaxation instructions. She was encouraged to relax at home when possible but no records were kept.

During several of the eight visits, at times when Helen was not relaxing, two initial hierarchies for systematic desensitization in imagination were prepared. The hierarchies were developed with an orthodox SUDs-scaling procedure based on scenarios initially provided by both of us. There was difficulty developing separate hierarchies for confinement and for devaluation/criticism that had the necessary gradations in SUDs. After considerable work we decided to begin with one hierarchy that contained scenarios related both to confinement and to devaluation/criticism. In addition we imbedded scenarios of both kinds in a spatiotemporal sequence that began 4 weeks before the first dental visit and that ended in the dental operatory. In the end the hierarchy included 21 scenarios that were at or near 5 SUDs apart from one another. Representative items include "Thinking about the dental visit one week away," "The assistant telephones to remind you two days before the appointment," "The dentist looks startled and asks you if you have ever brushed your teeth," "Reclining in the dental chair with tubes in your mouth so you cannot move."

C. Systematic Desensitization

Systematic desensitization occurred over 12 weekly visits. Each time it was preceded with 8 minutes of four muscle-group relaxation training. Then imaginal rehearsals of the hierarchical scenarios were begun. By and large the procedure involved "orthodox" systematic desensitization as described earlier. In general the actual desensitization trials lasted between 15 and 18 minutes. Each scenario was visualized calmly four times in succession before going to the next. No more than three scenarios were completed in any single session. Care was taken to end the trial on a successful item. On five occasions a scenario prompted repeated anxiety signals and a new, intervening scenario was used.

Beginning in the third week Helen was instructed to begin real-life practice of the spatiotemporal and behavioral aspects of the visualized scenarios. She was encouraged to not go too fast; to practice a week or so behind her progress along the imaginal gradient. As systematic desensitization progressed the dentist participated as an *in vivo* partner; various, long-duration *in vivo* exposure visits were added to the imagined scenarios.

VI. SUMMARY

Systematic desensitization is a venerable behavior therapy for fear and anxiety. Usually it entails remaining deeply relaxed while visualizing a series of increasingly fearsome scenes in which the patient confronts targeted events or situations. There are many theories about how systematic desensitization reduces fear; most "theories" are *post hoc* claims that systematic desensitization instantiates some other training regimen or process such as respondent extinction, habituation, counterconditioning, or self-efficacy augmentation. Joseph Wolpe's original theory of how systematic desensitization works appeals to learned inhibition of anxiety that is based on parasympathetic inhibition of sympathetic activation. Criteria have been developed to identify good candidates for systematic desensitization (e.g., there are four fears or fewer, there is evidence of a capacity for clear imagery, there is evidence of emotional discomfort while imaging frightening material). Scores of case studies and reports of clinical series attest to the efficacy of systematic desensitization. Several now classic experiments show the efficacy of systematic desensitization also. Much research on the outcomes of systematic desensitization was done in a way that renders it of little value. By and large research on the effects of systematic desensitization disappeared from the literature when exposure technology replaced systematic desensitization as the treatment of choice for phobic complaints. However, the earliest case studies and clinical series suffice to support the claim that systematic desensitization is effective and should be considered when *in vivo* exposure is not feasible or is initially refused. A case is described in which a 45-year-old female is treated for dental phobia that was based on claustrophobia and on social phobia.

See Also the Following Articles

Coverant Control ■ Emotive Imagery ■ Exposure ■ Eye Movement Desensitization and Reprocessing ■ Habit Reversal ■ Relaxation Training ■ Self-Control Desensitization ■ Successive Approximations

Further Reading

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Tele-Psychotherapy

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GLOSSARY

bandwidth Data transfer speed for telecommunication data.

cable The widest pipes and the fastest but speed will vary. Pipelines are shared with neighbors, and are not dedicated lines like DSL. The maximum theoretical download speed is 27 gigabits per second. Upload speed may be 128 to 384 kbps.

chat rooms Virtual containers for instant e-mail correspondences from disparate locations.

DSL A digital subscriber line has no standard speed. Speeds vary from 256 kbps to 1.5 Mbps and thus are considerably faster than ISDN.

e-mail Electronic mail sent via the Internet.

fixed wireless Requires an antenna on the roof; download speed 1 to 2 mbps, and upload 256 kbps.

ISDN Integrated services digital network begins with a guaranteed 64 kbps, or two lines at 128 kbps, or four lines at 256 kbps or higher Data can be compressed as well to speed transmission.

POTS Plain old standard telephone has the slowest speed. Data are transmitted in analogue wave form. A computer modem converts outgoing digital data to analogue and on the other end incoming analogue data are converted back to digital. Download speed, which is variable at best is 50 kbps, and upload is 33 kbps.

satellite Speeds are on par with DSL and cable. Requires a rooftop dish.

videoconferencing Long distance meetings occurring with both picture and sound transmitted between two or more locations. Ideally transmission occurs in real time and there is perfect synchronization of voice and sound.

I. INTRODUCTION

Tele is a prefix from the Greek *tele* meaning at a distance, or far off. Thus, tele-psychotherapy is simply a term for psychotherapy conducted at a distance instead of taking place in the usual office setting with all participants physically present in one room. Tele-treatment is usually assumed to include new technology, either videoconferencing or e-words.

Videoconferencing technology has advanced sufficiently to deploy psychotherapeutic services that can span the globe, or even transmit to a space vehicle. At the present time, researchers funded by NASA are planning the psychological and medical care for a Mars probe planned for the end of this decade. Treatment will soon be supported from one end of our solar system to another. Truly, psychotherapy has been liberated from the office!

There is nothing new in psychotherapy occurring long distance. Letters have always been sent by surface mail from patient to therapist and vice versa, and

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should be considered a valid part of treatment. The telephone, as well, has routinely been used for brief consultation or full scheduled visits. Certainly, the initial call that plans the first visit and introduces the participants to each other is a form of tele-psychotherapy, although rarely recognized as such.

Telephone psychological support services have a long history, and provide much needed round-the-clock services sometimes with a more user-friendly interface than traditional medical settings. While suicide hot lines may be staffed by nonprofessionals, the ready access to a sympathetic voice has often sustained the troubled through difficult times.

Students who go off to be educated at a distant locale frequently remain in telephone relationships that are well established and proven salutary. Face-to-face visits are held at vacation times. Many adult patients who are attached to their therapists move, and choose to remain in a well-known trusted helpful partnership, rather than start over again with someone new. These patients should, and often do, have an occasional live office visit.

A colleague in psychoanalysis explained that at the beginning of the week she traveled to a city 3 hours away for an evening session, stayed overnight in a hotel, and had a visit the following morning, and then participated in two more telephone visits before the weekend. While this is unusual, it is not unheard of. Other patients traveling for work or pleasure, or simply too busy to commute to the therapist in the midst of a day of activities, will opt to keep a therapy appointment by phone, if the therapist is agreeable. This is more likely in the west than in the east. There are numerous surreptitious stories of telephone treatments. However, until now, the practice of telephone psychotherapy has always been utilized within treatments that began in a traditional office setting.

Today our new technology allows for treatments to begin outside an office container. What should we make of this psychotherapeutic brave new world? This article will introduce you to tele-psychotherapy: good or bad, safe or risky.

There is much reason for optimism: As new standards for telecare are written, and new regulatory law is encoded, good treatments will prevail, not wild teletherapies, and new, effective and improved telepsychotherapies will be developed. We are at the point that quality care can be universal, if only we will share our resources.

II. TECHNOLOGY: VIDEO

Top-quality telephone or computer-driven videoconferencing has images that are similar to television or movies. The transmission of separate pictures is not detectible, and lip synchronization is perfect. Often there is little or no delay caused by distance, and communication flows easily. From the wide array of videoconferencing tools, equipment can be utilized with a guaranteed verisimilitude, the ideal, or for the most modest investment, inexpensive video that is unreliable, and/or so poorly reproduced that it is nearly useless. The quality of images relates to one factor: cost. The more money spent on equipment, software for computer applications, and transmission links, the better the result.

Videophones are now available that are simply telephones that can be plugged into a standard phone jack and produce excellent pictures. The image may appear on a lightweight portable phone screen that easily fits into an ample pocket or purse, or on a larger stationary telephone unit's screen, or displayed on a computer screen, or at the most lifelike projected on a television screen. These phones may have regular or plain old telephone system transmission links (POTS), or ISDN phones that utilize linkages two to four times as wide as POTS telephones. The best of them, often bought by the government to be used by the CIA, FBI, or military, cost well over a thousand dollars. The advantage of POTS videophones is ubiquity. The best videophones scramble information so privacy is almost guaranteed, hence their utility for the government.

Videoconferencing can also be conducted between computers with no telephones involved. When the widest pipe lines (known as broadband) are sending digital information, excellent images result. The cost of an individual long distance phone call is not incurred with every meeting, which is considerable when the videoconference lasts for a standard psychotherapeutic hour and crosses one or more oceans. The users pay a monthly fee for renting the broadband attachment (e.g., cable, ISDN, or DSL) to the local phone line. Such private stable computer linkages are often established between hospitals and satellite clinics. These networks may be set up by one of the large videoconferencing companies who sell their own connecting software or done more simply by downloading videoconferencing software off the web to go with a single PC.

Small clinics that cannot underwrite such expensive private networks can turn to the Internet for video transmission help. At least two companies will now permit downloading of videoconferencing software without charge into a PC/Windows based personal computer: CUSeeMe from White Pine and Microsoft's Netmeeting. With the addition of a 70 dollar videocamera on both ends, and an attachment to a high speed

link like cable or DSL, without the addition of special software of equipment sold by the top videoconferencing companies, reliable intermediate quality images will result. For a military clinic in Hawaii with patients on a tiny island thousands of miles away, some video is far better than none, and improves care well above that done with mere sound.

Lower cost computer-driven video and low end videophones are, of course, available for pure POTS transmission, although diminishing expense is unfortunately correlated with decreasing quality. This would occasionally allow a therapist to receive video alongside audio, but the images are most likely to be delayed, and are prone to breaking up or fragmenting into component data, and transmission most often cannot be guaranteed, as crowded Internet lines prevent the flow of data at peak times. Thus, when a subject moves, the image conveyed breaks up into tiny parts or fragments. This is a disconcerting experience to view. The intermittent distorted weird displays are unsettling, and are not conducive to serious psychotherapeutic work.

How does videoconferencing compare to a real office visit? Is it nearly as useful? How much evaluative data are lost when a therapy patient is seen in only two dimensions? What happens when scent/olfaction is lost as a sensory cue? How much do we rely on intuition, whatever that is, as an evaluative measure and how much is it dependent on the actual sharing of physical space? How long will it take a generation of computer savvy people to process the mysteries of each other with a virtual contact? We have much to learn, but this should not hold us back.

III. TECHNOLOGY: E-WORDS

In the beginning, the portal of entry to the web was a computer. Access today can be instantaneous with a mere handheld wireless device that can fit in one small palm, even a child's. Alternatively a modestly priced electronic gadget designed only to link to the Internet equipped with a keyboard and large screen will do. The Internet's transmission of words, pictures, and other data is astonishing; the effluent is rapidly changing our civilization. Information of serious or dubious value is readily available for global consumption. The latest news can be read almost as it happens with the flick of a switch on a tiny unit. Nearly anyone can search the most knowledgeable medical databases from nearly anywhere. Sophisticated patients may know as much or more than their doctors about their illnesses as chat groups or bulletin boards run by victims of illnesses often provide the best information for dealing with disease. The Internet world has spun us topsy-turvy, replaced some pomposity with humility, and occasional ignorance with knowledge, and allowed a cave in a wilderness to headquarter a global terrorist war. The facile flow has brought all of us closer together, for good and for evil.

Groups, sometimes patients, can meet in real time in chat rooms that include participants from all over our planet. At the present time, these virtual settings allow only verbal messages, but in the near future, when broadband and POTS are near equally priced, and information that creates images races along, these virtual rooms will have multiple video-streams, one from each source. A dyad, or therapy pair, can now talk via instant messaging and share live real time e-conversation, usually typed and sometimes spoken.

E-mail is ubiquitous: The good news is the telephone has not deleted the written word, indeed letter-writing has returned in spite of television usurping hours spent on reading; the bad news is that much e-mail, whether spoken or typed, like much surface mail, is junk.

Amidst the deluge of e-correspondences, however, are useful interactions between therapists and patients. E-mail contact has a bad reputation because of the exploitation of cyberspace for felonious "activities". However, imagine the gain for a fragile person who can send a letter (albeit an e-letter) to a therapist at any time of night or day. In the loneliest hours when most are asleep, this may make the difference between life and death.

Properly used, the Internet will alter psychotherapy practice for the benefit of patients. Today, cyberspace is the "wild west," anything goes. Rest assured, this will not last.

IV. TELE-PSYCHOTHERAPY TODAY

A spare room in a centrally located community building can quickly be converted into a satellite psychotherapy clinic with the simple addition of a videoconferencing system, a scheduling administrator, and the requisite broadband link to a clinic with available psychotherapy staff. The earliest utilization of tele-psychotherapy has been the most natural: The technology has enabled the development of satellite clinics providing care in communities that cannot support full mental health clinics themselves.

The psychiatric and psychological sections of meetings for telemedical professionals have nearly always included clinical presentations from countries and states

with large remote areas with low population density including Australia, Newfoundland, Norway, Alaska, Arizona, Michigan, and New Mexico, as well as other more exotic locales. These papers recount the benefit and efficacy of tele-treatments. The presentations are inspirational and usually have scenic photographs: one side of the videolink may be a well-known center of excellence, while the other is a few huts in the wilderness sometimes surrounded by reindeer and locked in by snow and ice. The patients, if depicted, are overwhelmingly grateful that care is available at long last for conditions that heretofore have gone neglected. The tele-psychotherapeutic visits are presumed to be almost as good as the real thing, and are justified as providing virtual care where real office care cannot exist.

A secondary proliferation of tele-psychotherapeutic services has been to prisons that are intentionally built far from population centers. A videoconferencing link allows for flexibility of delivery of services that could not be supported by importing mental health staff or exporting prisoner-patients with the requisite guard staff and a driver.

The United States Department of Health and Human Services Commission endorses long-distance treatment as the legitimate embrace of new technology by creating the first reimbursement codes for tele-psychotherapy, although in rural areas only. The preference for rural telemedicine and telepsychotherapy is echoed as well by the governmental agencies that fund telemedical programs: They are only willing to support programs in rural settings. Urban clinicians need not apply.

The military, of course, uses tele-treatments for troops and support staff who are stationed routinely in remote locations. The earliest implementation of the most sophisticated equipment would be allocated toward saving lives, hence tele-psychological services would be supported only when physical health needs are fully deployed. It is not yet widely accepted that providing adequate psychological support after the horror of battle and injury, if possible, speeds recovery from medical injuries.

Tele-treatments are slow in developing outside remote areas. There is little research on the potential exploitation of this new technology to improve delivery of care for patients who require the careful purview of a vigilant therapist with some exceptions. A project from Massachusetts General evaluates videoconferencing for OCD by Lee Baer and colleagues. A researcher from London, Paul McLaren, studies the use of videoconferencing in psychiatry in urban settings by inpatient units seeking specialty consultation at other hospitals.

Medical schools in and outside the United States show enormous zeal for developing consultation programs that bring in patients from distant locales. Many of these projects are developing to bring income into institutions facing funding cuts while they are simultaneously finding new and improved models of patient care. The comparative indifference to exploring the potential benefit of this new technology for local use seems shortsighted and overly cautious. In general, the prevailing opinion of tele-psychotherapy is that it is a second-rate alternative to in-the-flesh real care. Still, there is a surprising lack of creative effort for planning new techniques for conducting psychotherapy using this technology. Perhaps one explanation of this relative indifference is that grant money for pure clinical work is difficult to find. Much psychiatric research is drug company based, hence scientific research devoid of pharmaceuticals is more difficult to support. If this technology promises to bring relief of suffering to patients, and this opinion is popularized, scientific scrutiny is certain to ensue, although this seems not likely to occur soon. Today's adolescents have rich social lives in virtual settings sometimes all over the world, but the adult scientist generation is not yet ready to mine these virtual settings for clinical gain.

Psychotherapy in cyberspace or e-therapies are developing quickly. A web search will find a variety of dotcoms selling web treatments, and more added each day. The preponderance of e-psychotherapies are offered by nonmedical clinicians, and it is often difficult to evaluate the credentials of the practitioners. A minority of these web clinics include telephone conversations alongside e-mail chat. E-mail treatment is inexpensive but many clinicians believe it is of dubious value, hence you get what you pay for. How can words alone be beneficial to patients? If e-mail help is limited to informational help, rather than counseling or treatment, and goals are limited, and conceptually understood, it seems feasible that some useful parameters for e-service could be defined. If a life is saved by a well-timed persuasive e-comment, how would we discover this unknown benefit? The rapid condemnation of all e-services without exploring individually what each is doing seems hasty and gratuitously cautious.

Many psychotherapists exchange e-mail with patients. When this mail is sent within an active clinical exchange, the interaction is similar to a voice mail message, and is simply a new component of treatment. E-dialogue is another way for our patients to reach us, to confess secrets hard to admit face to face, to let us know more of aspects of a distraught inner self, and

therefore provide more grist for the mill of an ongoing therapy.

V. IMPEDIMENTS, CONTROVERSIES, AND CAVEATS

Why hasn't tele-psychotherapy been embraced far and wide by practitioners with technical savvy when it seems such a logical extension of office treatment? The primary obstacle is probably money. As yet, there are no reimbursement codes for billing tele-psychotherapeutic videoconferencing visits unless your clinical work in done in rural areas. The managed care companies that underwrite much psychotherapy in the United States have not yet discerned that tele-psychotherapeutic visits are likely to save considerable funds when conducted in rural and urban settings. The studies demonstrating this have simply not been done yet.

There is also no reimbursement for e-mail correspondence, rural or otherwise. When clinicians permit e-mail correspondence, they either have to do this as a gift of time, or a billing arrangement must be agreed on with the individuals involved. When the patient's psychotherapy coverage is within a managed care program, the clinician is breaching the managed care contract by charging for e-mail treatment time. The concerned clinician is faced with an unpleasant dilemma when supplementing office visits for a fragile patient with an e-mail correspondence. If this exchange is done without fee, does this generosity have a tinge of self-sacrifice by the clinician? How would this effect the treatment over time? Alternatively, if a billing arrangement is set behind the back of managed care rules, what message does this give the patient about the therapist's ethics? There is no good solution given today's managed care contractual agreements for clinicians.

The solution might be to limit e-mail correspondence to self-pay patients. A policy of this sort would enhance the development of tiered mental health services with the best care given to the wealthiest patients who can afford to self-pay out of discretionary funds. This seems an unfortunate division of services for discerning who gets the most flexible treatment. Another solution might be to create public sector services for everyone offered by one government agency instead of our current complex system. We are a long way in the United States from a unitary mode.

In countries with government health care coverage for all citizens, it will probably prove easier to establish tele-psychotherapeutic practice. The complex challenges of finding liability coverage for clinicians for novel tele-treatments would be dealt with by a central authority, and reimbursement for telecare for all citizens could be efficiently planned. In the United States with its complex health care apparatus, each independent clinician will have to struggle to find tele-treatment liability coverage usually through a professional society. At the time of this writing there is scant malpractice liability coverage sold for tele-psychiatry by psychiatric insurers. The American Psychiatric Association is unfortunately not likely to make this available anytime soon even as an add-on to the usual malpractice package. Teletreatment programs operating out of medical schools and graduate psychology and social work departments that self-insure the malpractice of staff clinicians will have more flexibility.

The logical way to bill for e-mail time is by bytes of time or minutes. Just as lawyers charge for varying lengths of time, psychotherapists might do the same. But the reimbursement system in American medicine (and psychotherapy falls into this category) is by service code, roughly but not precisely based on time. How long will it take to convert the standard procedure code system to a more flexible scheme for tele-psychotherapeutic care that above all else should have flexibility for session lengths whatever the method of delivery? Since this constitutes a radical change in reimbursement structures, it is likely to be slow in coming. Another more novel appraoch for payment of e-mail correspondence might be a monthly set fee for e-mail privileges.

The regulatory barriers to tele-psychotherapy are enormous, and are likely to be more complicated in the future, not less. In the United States, licensures for psychotherapeutic practice is issued by state. Clinicians are credentialed to practice locally. Tele-psychotherapy would be confined to a geographic area when large clinics establish satellites, but how are clinicians to be licensed when the primary clinic is in one state and the satellite(s) in another? The medical-legal issues are compounded even more when the treatment is between two nations or several. The European Union is establishing guidelines for telemedical care that will enhance the flow of treatment within these countries. The World Health Organization has a larger global focus as it seeks to establish telemedical rules for all nations. It too is working on guidelines for telemedical practice. Ultimately, the nations of the world will have global pacts for telemedical and tele-psychotherapy treatments, protection of patient privacy regulations, conventions for flow of medical data, and even, one hopes, global pharmaceutical rules so patients who travel may

easily get telemedical treatment and medications wherever they happen to be.

Today, whenever a therapist conducts tele-treatment with a patient in another country, or another state or province, the clinician is already operating in a legal gray area. Videoconferencing and telephone sessions held interstate or between national jurisdictions are not always clearly legally permissible, although they are also not quite against the law. For instance, does the clinician require a license to practice where the patient is located, however distant? Some would argue that an affirmative reply is correct, others not.

The G8 telemedical study group has members roughly comparable to the top eight global industrial powers. One of their strong recommendations is that when telemedical treatment is done, the license and governance in the location of the medical clinician should govern the transaction. Thus, clinicians will only require licenses, malpractice liability, and liability releases in one jurisdiction, not every location they are treating patients. It is not known, as sensible as this notion is, whether local governments will go along with such rules. How will chauvinism restrain itself from rearing its ugly head and launching protective turf battles? How will psychotherapy regional societies sit back and allow distant clinical intruders to compete for their available patient pool? Neither seems likely, although the alternative possibilities are dismal.

Who will be responsible for monitoring long distance treatments? Will this be done by the medical/psychotherapy societies in the clinician's jurisdiction or in the patient's? There is little agreement so far on what is considered adequate care utilizing videoconferencing, and even less of a consensus regarding e-word or text-based treatment. Standards of care must be determined, but given the paucity of scientific data on tele-psychotherapy, how will these be set? Interest in tele-treatment is not adequate yet for sufficient research to be funded to make these assessments. When agreement is finally reached, will it be possible to allow enough flexibility so creative clinicians can continue to generate new and exciting techniques and methods? Alas, in psychiatry, practice guidelines geared to protect patients and guarantee a high standard of care are being established that may eliminate deviation from a strict conservative norm. So in the short term patients are protected, at grave risk of an overall atrophy of creativity in the field.

The privacy issue has evoked much concern. When videoconferencing networks with a few private linkages are established, it is easy to create encryption of data and sufficient firewalls around the database server so the patients are as close to guaranteed privacy as is possible. But when the Internet is used for videoconferencing, or for e-mail, for modestly funded programs or treatments, how will privacy of data be promised if it flows between many servers that cannot be regulated by clinician or patients?

In the United States, extensive standards governing both privacy and security of health information are being developed and implemented under HIPAA (the Health Insurance Portability and Accountability Act of 1996). This law threatens high fines and even criminal penalties for unauthorized release of information. The security requirements will mandate some form of access control or encryption to protect electronic data traveling over a communications network. Other countries are enacting similar legislation. But how will every psychotherapist know these rules and follow them when the available unregulated Internet is so seductive?

The issue about which there is the most controversy is the entire matter of cyberspace psychotherapy or treatment by e-mail. Is it simply bad treatment and therefore negligent only designed to make a fast buck for its purveyors? Or are there circumstances when e-care might be appropriate or necessary? If so, what are these? Robert Hsiung, M.D., at the University of Chicago, is editing a book on e-therapy. He is well suited to do this as he runs a message board for patients with a million hits per month that he moniters himself, clearly not an easy task. Dr. Hsiung believes that e-care should not be carelessly relegated to tele-psychotherapeutic malpractice without a careful exploration of its salutary potential. But how will we decide what e-care is helpful and what is not in the face of the paucity of evidence-based clinical research to allow these determinations to be made based on scientific data?

Horror stories exist of Internet fraud: self-appointed therapists with no training setting up shop on the web. Who should regulate such practice? Should there be monitoring for consumer, or in this case, patient protection? Is this monitoring an invasion of privacy? Who will decide? No doubt, in time government commissions will develop to scrutinize web businesses, including all psychotherapeutic transactions, but if both parties have encryption and firewalls, this will not be an easy task.

One caveat: If you are going to utilize e-mail in your existing psychotherapeutic practice, make sure your patients know how often you read your letters. You do not want a new patient or anyone to send you an e-note full of suicidal ideation, homicidal yearnings, confessions of

horrific crimes, or any other shared desperate feelings that you should have acted on but instead missed with dire consequences, because you had not had sufficient time to review your mail.

We have so much to discover and learn about tele-psychotherapy. The best of us is only an e-treatment toddler awkwardly staying up and finding the correct path.

VI. CLINICAL TALES AND THE ISSUE OF TELE-TRANSFERENCE

Patient confidentiality has been protected by eliminating or altering identifying data.

A. Case History 1

Thomas is a tall, elegant, middle-aged man with a large brood of interesting tow-headed children. He has had two brief courses of psychotherapy with me several years apart each involving e-technology. He came to his first visit with great reluctance, and arrived incredibly late to underscore that sentiment. He had always taken great pride in his competence and independence, and like many people, stigmatized psychiatric illness, and felt any need for treatment was an embarrassing weakness. His father had service-connected bipolar disease related to battle experiences during World War II; he viewed this man with both sympathy and pity. He sought help from me when he realized he was losing control of his most valuable commodity, time, and had given up any hope of remedying the situation himself.

His first treatment occurred when Internet access was considered quite precious and was sold by the minute, and was usually a privilege for the wealthy or a perk of academia. Thomas was neither. He described how he sat in his office at the end of a grueling day of back-to-back meetings, and signed on to the web to relax. Soon he found himself in chat rooms where he easily found women offering delightful e-company. Conversations would go on for hours, and were quite expensive. He found himself lying to his wife about his unusual long evening hours at the office. He was horrified by his dissembling, and the huge expense for his e-habit. He felt addicted to the web and its chat rooms, and his self-reproach for this loss of control was enormous. He believed he loved his wife and did not understand his incessant web flirtations.

In the past he had had several serious episodes of depression that he waited out; all of these had a seasonal component. His usual state was mildly ebullient: He needed little sleep, and his productivity was impressive. His only impulsive behavior in the past was with food; to his chagrin his weight went up and down. He exercised long hours to control his girth given his tendency to eat too much.

During several months of treatment, which involved an extraordinary number of cancellations, which he easily rationalized away as due to urgent situations at work, we discussed his marriage, its strengths and weaknesses. While it was apparent to me that Thomas was lonely in what appeared to be a faltering marriage, he had not allowed himself to acknowledge this. He saw his addiction to the web as analogous to overeating; and just as his weight would go up and down, so would his Internet time.

Thomas is a highly intelligent fellow. He enjoyed the opportunity to explore his past, his marriage, his parents' commitment to each other, and the nature of their relationship to him, and even our cautious study of his relationship with me. In time, he acknowledged how disappointed, sad, and bored he felt with his wife. His web friendships, which developed into romances, were thrilling.

One day he announced he was done with therapy, although he had just made a plan to meet one of his web girlfriends across the country during a business trip. He had never before considered infidelity and given his lapsed Catholicism, he would not abandon the sacrament of marriage without much soul-searching. Apparently he was not to do that with me as an accomplice.

Years later, Thomas contacted me again. He was now involved in a real love affair and was considering leaving his wife, and no, he had never met his cross country date when last we met. He was becoming increasingly depressed, and anxious about his confusing situation. His lover was pressuring him to end his marriage so she could leave her annoying husband, but he found himself reluctant to tear apart his children's family while they were still quite young. He enjoyed their company enormously and did not want to give up daily contact with them. Leaving his wife would be easier, though even this would be daunting.

At first his anxiety was nearly incapacitating and required the aggressive use of a tranquilizing SSRI antidepressant. When both his wife and his lovers' husband learned of the affair, not surprising given the frequent mid-day and evening assignations, he became deeply suicidal. Despite this, he refused to come in for office visits with the frequency his serious illness required, claiming work obligations. This explanation had already

seemed a convenient cover for his avoidant behavior, which had not responded to interpretation.

I knew him well enough to understand his need to distance himself, even at a time when he felt extremely fragile, could not be altered. This very private man had to maintain his boundaries with me, no matter what the cost, including the risk of suicide. He was unwilling to plan telephone visits claiming an absence of privacy on all his phones; he was terribly worried that someone would listen in. (This treatment was before personal cell phones.)

So I turned to the web to supplement his visit schedule as the only alternative to having information from him about his level of potential lethality, and thus a site for titrating his medications frequently, and a place to nurture him with well-chosen words. I insisted he maintain an e-mail correspondence with me, daily when necessary at a frequency determined by me, so I could follow the depth of his suicidal ideation. His treatment consisted of a weekly visit and for a month near daily e-mail notes. During this time, he decided to end his affair and concentrate on improving his marriage. When his suicidal depression improved, we slowly weaned his e-mail nurturance.

He continued his treatment with decreasing frequency while he described the benefits of his newly discovered focus on his marriage. His wife was now experienced as his long lost best friend. The privacy each partner needed to sustain a long commitment did not allow for intimate lovemaking, and he adjusted to the lost thrill of his love affair versus the reliability of his marriage.

One day he cancelled a visit for what seemed like a spurious reason. A nonjudgmental inquiring e-mail went unanswered. Once again, his real and virtual treatments ended abruptly.

Thomas' second treatment could have been foreshortened when he became acutely suicidal but refused to allow me to determine the appropriate pace of our office meetings given his life-threatening illness. It was obvious that any attempt on my part to challenge or control him would have met with complete resistance, and the likely premature disruption of his treatment. My suggestion that we turn to a virtual conversation allowed for an ongoing discourse that could not be held elsewhere. Had we only had a weekly office visit with no supplementation, I would have never known if Thomas was safe. He could not be counted on to contact me if he became dangerously low. Plus I knew he could be overwhelmed by urges he could not control as he had been with spectacular binges of sweets. We both recognized that he might have become overwhelmed with suicidal impulses. The virtual conversations allowed for daily care, which he needed, without what for him would have been an overwhelming intensity of intimate real office dialogue. Thank goodness there was e-mail. It may have kept him alive.

B. Case History 2

Anna lives in Hong Kong with her husband and children. Her spouse has a lucrative and interesting job that pulled the family from a much appreciated community on the east coast. Anna's oldest daughter has just hit menarche, the youngest is still in diapers, and there are a few sons in between. Anna feels she should be content with the opportunity to live in a fabulous city especially with her recent affluence. Instead she is miserable. Her mother-in-law contacted me for help.

Anna, like many expatriates, is homesick and misses her family, her home, her language, and her culture. She speaks eloquently about her many travails, but she believes she should be happy. She is pensive about the origin of her gloom, offers biological and philosophical explanations, and also is deeply ashamed.

There are no English-speaking psychiatrists in her Asian city that she can find despite a circle of expatriate friends. She does not know the local language so cannot utilize local care. I agreed to have telephone consultations with her only if she had office visits with me regularly when she returns to the states on visits.

That was 6 months ago and since then she has sometimes been quite ill. One serious downswing reminded her of a postpartum illness when she stayed in bed for a month and had both infanticidal and suicidal thoughts. She often has high energy spells with racing thoughts and not infrequent fabulous shopping sprees at the many terrific stores.

I have arranged to have medication sent abroad to her but only products with a wide margin of safety. I have told her she needs more effective but riskier pharmaceuticals, but am waiting to prescribe mood stabilizers until we have videoconferencing visits. I hope this caution makes sense to her; I have explained that I need to see her if I am giving her a medicine that can be toxic. Voice alone will not give me adequate diagnostic cues.

We are planning a video link soon, so more aggressive care is imminent. In the meantime, she is feeling euthymic right now, though she doubts this will last long.

Anna's telephone psychiatric consultations will soon be enhanced with the addition of videoconferencing. She is likely to be my only transcontinental patient until telepsychiatric liability is available for long-distance care. Her telecare is untraditional but given her circumstances, it seemed the most reasonable alternative.

C. Case History 3

Maureen at 50 is finally happily married, though little else about her life is pleasurable. She sought my help about a year ago when her last psychiatrist moved away and she felt perilously close to a suicide. She did not want to do this to her beloved spouse, though she cared little for her own life.

She was often morbidly ill as a young woman and her arms are covered with innumerable scars from self-mutilation. She now will not wear clothing that shows her arms as she is so ashamed of these revealing white lines. So she hides beneath hand-woven fabrics in an interesting palette. Her overeating, always a problem, has recently gotten completely out of control. She has doubled her weight. An all too familiar feeling of deadness will not abate and she wonders, without any tears, if she will ever feel alive again, not that she cares much.

Recently a pain in her abdomen turned out to be the result of rare benign tumors in both kidneys. The largest was embolized, but her extreme discomfort continues and it seems likely that surgery will be necessary. During her weekly psychotherapy visits, she cracks black comedic jokes, and converses with my two French mastiffs, but says little to me.

Early on in her care, she accepted my invitation to send e-mails with reports of her food intake. We were not able to successfully curb her binge eating, though she described her struggles with control, and other critical emotional events. Recent notes are of visits with this specialist and that. She also in e-writing reveals her fears, her despair, and her anguish, all of which cannot be spoken. As her mood disorder does not respond to pharmaceuticals, we rely on therapy, real and virtual, to control her demons and one hopes, slowly heal her many wounds. She is witty and talented, and I am determined to enliven her—this will require ingenuity on both our parts, but luckily we have an abundance of patience. She has done so well in the past in overcoming her slicing impulses, there is room for optimism.

Maureen's e-mail correspondence is much like Thomas'. Her letters allow for self-revelation that is impossible to achieve face to face. She can accept warmth and kindness from me in writing that would seem disingenuous in my consulting room where she spends her time amusing me. Her e-treatments sometimes seems like the most useful treatment but I know she values our meetings as well. I like and respect her and recognize her talents that too often have been ignored. Our shared pleasant hours are salutary given the abuse in her childhood.

Many therapists will eventually use videoconferencing or e-mail in a similar fashion. Patients will insist on this flexibility, and therapists will comply. Teletreatments will be common, and will be understood to be nothing more or less than traditional care expanded by technology.

The relationship between patient and therapist will be equally available for scrutiny as an office treatment. Transference is a term that describes our predilection for misinterpreting relationships due to prior experiences usually in our childhoods. Thus an adult neglected in childhood will too easily find adult insult and injury. Tele-relationships will take longer to develop intensity but despite this attenuation, the full panoply of emotions will ensue. To be sure: tele-treatment will have transference aspects, despite the altered venue.

VII. TWO PRELIMINARY STUDIES

By early 1999, the web was suddenly abuzz with exciting activity. America Online was selling inexpensive global connectivity, and Amazon.com was selling books. How could this new technology be a potential source of benefit to my patients? The answer was not obvious.

After attending my first telemedicine conference in the fall of 1999, I decided to try out the technology in my practice to reduce the stress of separation at the time of my holidays, which seemed overwhelmingly distressing for some of my most fragile and dependent patients. These accounts are strictly anecdotal, there was never any plan to produce verifiable data. I was simply trying out what might be helpful in the most preliminary way. If my conclusions were positive, scientific studies might be warranted later.

A. Study 1: January 2000

The editor of a prominent telemedical journal suggested that low-cost videophones might suffice for long distance telepsychiatric treatment. Shortly before a trip to London for a conference sponsored by this colleague, I ordered six such videophones. Five were handed out to five fragile patients most likely to find the break in treatment troubling. The sixth phone went to England with me.

1. Results

2/5 Patients acted out by not appearing for their scheduled tele-visits.

3/5 had televisits with images appearing at a sluggish frame rate that had no semblance of reality. Voice and picture were poorly synchronized, not only did image lag way beyond sound, but the picture itself fragmented with movement creating a psychedylic effect.

1/5 A bipolar male used to long distance telephone treatment declared the video of no benefit.

1/5 A paranoid schizophrenic woman would not look at the camera, though her husband enjoyed the unique experience of a trans-Atlantic video-conversation

1/5 A bipolar woman was delighted with her video-talk with me and believed seeing me defused her anguish.

2. Conclusion

Low end videoconferencing is minimally better than telephone without video. Clinically useful videoconferencing should approximate real time with well synchronized movement and sound.

B. Study 2

I had announced a holiday to Nepal and invited patients to e-mail me if necessary during my lengthy absence. My practice would be covered by a local psychiatrist during this hiatus, but e-mail greetings were available during recuperative stays in Kathmandu between treks.

1. Results

Eighteen patients wrote, five more than once. No patient required a single visit with another psychiatrist during my holiday, or needed a day hospital or inpatient stay.

2. Conclusion

An e-mail during a long break in treatment may obviate the need for an office visit by another clinician. Such e-mails may alleviate suffering due to separation anxiety as well. Reimbursement for such e-mail correspondence might save on the overall cost of treatment.

VIII. TELE-PSYCHOTHERAPY TOMORROW

Today we are nearly at launch position for tele-psychotherapy (to use the space exploration metaphor again). Our current treatment model, except in rural areas, presumes patients will come to our offices for visits. In the not too distant future, the usual visit will be virtual. This will enable patients to access care from anyplace they happen to be that has appropriate telecommunication links.

In the case of a disaster, whether natural or manmade, health care relationships will be established almost immediately by bringing in videoconferencing and other telemedical equipment, if necessary, linked by remote satellite. When counseling is available immediately for victims, posttraumatic stress disorder will be prevented or diminished in at-risk populations.

Videoconferencing equipment will soon be on airplanes to calm nervous passengers, or support flight attendants handling challenging situations. Internet in real time will allow patients with phobias to find support as they fly. Such equipment will be on board ships, and even on space crafts!

Troops in combat will wear dog tags with lifetime medical histories; medics will carry small terminals to transmit this information to ships nearby, or to consultants across the ocean. Just as medically compromised patients will have access to improved immediate treatment, tele-psychotherapies will soon be supported for many emergencies.

Group therapies will be held with streaming video from disparate sites. Imagine the AA meeting with members from all seven continents.

If managed care has damaged the relationship between therapist and patient, tele-psychotherapy will promote healing of the wounds. Tele-treatment will restore the therapy relationship to the primacy it deserves, while the utmost of patient privacy will be guaranteed with encryption.

Someday we will have global conventions on licensing and global pacts on pharmaceutical distribution for people on the move.

Of utmost importance, should we develop and share our resources generously, is that rich and poor alike all over the globe could have access to the wisdom of our best clinicians. At last, worldwide excellent treatments are potentially an achievable goal, if only we make this our priority.

See Also the Following Articles

Cost Effectiveness ■ Economic and Policy Issues ■ Online or E-Therapy ■ Virtual Reality Therapy ■ Working Alliance

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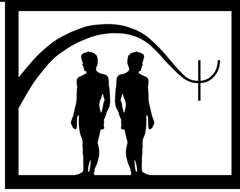

Termination

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I. Overview
II. Theoretical Bases
III. Empirical Research
IV. Summary
Further Reading

GLOSSARY

termination The end of psychotherapy.

All therapeutic relationships come to an end. This chapter discusses theoretical formulations and empirical findings concerning psychotherapy termination.

I. OVERVIEW

The ending of psychotherapy is commonly referred to as termination. The 1994 ethical standards of the American Psychological Association (APA) specify that therapists should terminate treatment with a client when the client does not require further therapy, or the client is not benefiting or is being harmed by continued service. Ideally, client and therapist make a mutual decision to discontinue therapy when the goals of treatment have been met.

In reality, however, the termination sometimes occurs because just one of the parties decides that it is time to end treatment. Client and therapist do not always agree on when termination should occur. Termination is sometimes forced on both client and therapist. Neither party may wish to terminate, but one of them may be moving to a new location or agency, insurance policies may limit therapy to fewer sessions than client and/or therapist view as sufficient, or agencies may have a rigid session limit.

The APA ethical standards require therapists to discuss termination with their clients and to provide "appropriate pretermination counseling." The nature of this pretermination counseling is not specified in the standards, but therapists are instructed to provide referrals for clients when appropriate. In 1994, Mathilda Canter and other colleagues who helped to construct the APA standards suggested that termination discussions should at least summarize the treatment and plan for the future. Oftentimes this future planning includes provision of referrals to other therapists and/or invitations to return to therapy in the future should the client encounter further difficulties.

II. THEORETICAL BASES

In 1993, Stephen Quintana summarized the major theoretical formulation of termination. He indicated that termination has been conceptualized from a psychoanalytic perspective as having two components—loss and development. The loss component was

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hypothesized to sometimes reach crisis proportions. It has received some attention with researchers such as Hans Strupp and Jeffrey Binder stating in 1984 that therapists must work to ensure that clients do not suffer a relapse of symptoms because of the loss of their relationships with their therapists. Therapists are also hypothesized to be affected by their loss of relationship with clients. In 1981, Rodney Goodyear argued that therapists who had not grieved past losses sufficiently were most likely to be disproportionately saddened by termination with clients. Quintana stated that some theorists even believed that anxiety surrounding termination has lead many researchers to avoid studying the process of termination altogether.

In 1933, Freud conceptualized that the loss triggered by psychotherapy termination facilitates the formation of an internal representation of the lost person (i.e., the therapist). The client compensates for the loss of the therapist by developing his or her own internal resources to replace what the therapist provided. Thus, termination is also viewed as a time of personal development. The client is viewed as maturing under the careful direction of the therapist much in the same manner that a child matures under parental guidance. When the client terminates therapy, he or she carries important internalized aspects of the relationship with the therapist that will facilitate the formation of new relationships with others.

Quintana updated this developmental conceptualization of termination to focus greater attention on the client's contribution to the therapeutic progress. He indicated that therapy is a process of continuing maturation of the client, and that termination is a time to call attention to the client's growth and the therapist's support of the client's progress. Quintana believed that termination is an opportunity to review the client's role in the therapeutic progress. In this way, the client clarifies what he or she did to facilitate change, and should problems arise after termination, the client may use these techniques to handle them. Finally, Quintana endorsed a conceptualization of termination as a sad time because of the loss of the relationship with the therapist that is tempered by the knowledge that the client has outgrown the relationship. Thus, termination represents a time to bid farewell to therapy and move on to new relationships. Quintana compared termination to graduation.

III. EMPIRICAL RESEARCH

Even though termination occurs in all therapy relationships very little research has been conducted on the termination process. Simon Budman and Alan Gurman suggested in 1988, that for many clients, therapy is an ongoing activity in their lives. They presented evidence that the majority of clients have had previous therapy, and 50 to 66% of clients who terminate will return to therapy within a year. This would tend to dampen the loss felt at termination, because therapy would not really be terminated in the sense that most clients return for further help in the future.

In 1985, Judith Marx and Charles Gelso asked 72 former clients at a university counseling center to indicate the most common behaviors and feelings surrounding their therapy terminations. Over 70% of the sample stated that they and their therapists summarized the therapy, assessed goal attainment, and planned for the future. Contrary to expectations, clients indicated significantly more positive than negative emotions surrounding termination. Clients also reported that more termination work was done when loss had been a theme of therapy, when the client had a closer relationship with the therapist, and when there had been more therapy sessions. The results supported a developmental view of termination rather than a conceptualization of termination as a crisis or loss.

In 1992, Stephen Quintana and William Holahan extended Marx and Gelso's research to therapists by asking 85 therapists what termination activities they engaged in and having them rate their clients' reactions to termination. Each therapist was asked to choose two recent short-term therapy cases—a case in which the therapy outcome was successful and a case where the therapy outcome was unsuccessful. Like Marx and Gelso, Quintana and Holahan found that clients' reactions (as rated by their therapists) to therapy termination were significantly more positive than negative. Not surprisingly, in unsuccessful cases, clients were significantly more likely to devalue therapy. The ranking of termination activities by therapists corresponded closely to client rankings of activities in the Marx and Gelso study. In successful cases, however, therapists were more likely to discuss the course of counseling, client affective reactions to termination, and the end of counseling than in unsuccessful cases. This research suggested that therapists did a more complete job of discussing termination issues with clients from successful therapy cases than from unsuccessful cases.

In 1993, Susan Boyer and Mary Ann Hoffman tested the hypothesis that therapists' reactions to termination would be affected by the impact of previous losses in their lives and their perceptions of clients' sensitivity to loss. They asked 165 licensed psychologists each to

think of a client that they had seen for a minimum of 25 sessions. Therapists rated how sensitive they perceived these clients were to loss. Therapists also answered questions about their own grief reactions to past and present losses as well as questions about their perceptions and feelings surrounding termination with the client. They found that therapists' past grief reactions, present grief reactions, and perceived client loss predicted therapists' anxiety surrounding termination. Therapists' loss and perceived client loss, however, were unrelated to therapists' feelings of satisfaction with termination.

IV. SUMMARY

Termination is the capstone of psychotherapy. It should be a time when all that has gone before is discussed and solidified before the client leaves. Yet we know little about the process of termination. The results of the few studies of termination process suggest that for most clients and therapists psychotherapy termination is a relatively positive event rather than a traumatic loss. These findings support Qunitana's notion that termination serves a developmental function in which clients bid farewell to a relationship that they have outgrown. Loss appears to play a role in termination particularly when client and/or therapist have suffered past or present losses. In these cases, therapists are frequently more anxious about terminating, and loss is an important part of client–therapist termination discussions.

Study results show that most termination discussions cover what transpired during treatment, participants' feelings, and plans for the future. This seems to be particularly true when the outcome of therapy has been positive. When therapy has not been as successful, however, there is less discussion of the end of therapy, clients' reaction to termination, the course of therapy, and the client–therapist relationship. Thus, unsuccessful therapy is mirrored in a less thorough termination experience.

Much more research on the psychotherapy termination process is needed. Many variables need to be explored relative to termination. In particular, it is important to study client and counselor characteristics as they relate to the termination process.

See Also the Following Articles

Bioethics ■ Cost Effectiveness ■ Engagement ■ Informed Consent ■ Outcome Measures ■ Relapse Prevention ■ Resistance ■ Working Alliance

Further Reading

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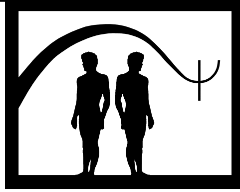

Therapeutic Factors

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GLOSSARY

analytic (or psychodynamic) therapy A primarily long-term, in-depth treatment concerned with conflictual intrapsychic forces, especially early libidinal urges and repressed childhood memories, which are uncovered and worked through via the interpretation by the analyst of the meaning of the patient's verbalizations.

behavior therapy (or behavior modification) Techniques of conditioning, shaping, and/or training—usually active, structured, time-limited, and directive—for the alteration of maladaptive symptoms and behaviors.

cognitive therapy A form of behavior therapy that addresses irrational beliefs and distortions of thinking, based on the fundamental idea that how a person perceives and structures the world determines personal feelings and behaviors.

existential approach (or analysis) A form of therapy that posits that a person's decisions, commitment, and responsibility for "choosing the future" give meaning to life, whereas choosing the past leads to boredom, meaninglessness, and despair.

interpersonal therapy A form of treatment that focuses on current life events—especially grief, developmental transitions, role disputes, and social deficits—based on the fundamental thesis that disorders are the result of unsatisfactory relationships and social maladaptation, the consequence of the individual's attempts to adapt to surroundings.

spiritual therapy A form of treatment based on six tenets of transcendence of soul and spirit—love of others, love of work, love of belonging, belief in the sacred, belief in unity, and belief in transformation.

I. INTRODUCTION

In an attempt to comprehend therapeutic factors in the total range of psychological treatments, one needs to differentiate the nonspecific elements that all psychotherapies are presumed to share, and the specific elements that may distinguish one school from the others. This article discusses the former under the headings of affective experiencing, cognitive mastery, and behavioral regulation, and the latter under the headings of analytical, behavioral, and experiential schools, each with its own variations. The therapeutic aspect of the therapist–patient relationship is discussed in its various forms: transferential and working alliances, and teacher–pupil and person-to-person relations. In clinical practice, these therapeutic factors are not categorical distinctions, but overlapping phenomena. An integration of past and present therapeutic factors is proposed.

II. NONSPECIFIC THERAPEUTIC FACTORS

The following features have been repeatedly cited as basic to all psychotherapies: an emotionally charged,

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confiding relationship; a therapeutic rationale (myth) that is accepted by patient and therapist; the provision of new information, which may be transmitted by precept, example, and/or self-discovery; the strengthening of the patient's expectation of help; the provision of success experiences; and the facilitation of the arousal of one's emotions. In their 1980 comprehensive analysis of the benefits of psychotherapy, Mary Lee Smith, Gene V. Glass, and Thomas I. Miller concluded that the weight of the evidence that now rests in the balance so greatly favors the general factors interpretation of therapeutic efficacy that it can no longer be ignored. Thus, above and beyond (or in addition to) the specific features of major modalities that technically differentiate them from one another, a number of universal conditions of therapeutic change have been hypothesized that unite all forms of treatment.

Aside from equivocal research findings from extensive comparison studies of outcome, other lines of support have been cited for a universality thesis. These include cross-cultural, historical, and religious examinations of the recurrent nature of healing agents, particularly the "placebogenic" roles of suggestibility, persuasion, trust, and hope, in changing or curing patients throughout the ages; the paucity of proof that special technical skill, type of training, theoretical orientation, or professional discipline is significantly related to therapeutic results; and, within the past decade, controlled studies of some commonly shared ingredients of successful outcome.

A. Affective Experiencing

Some form of strong emotional arousal was probably the primary tool in the psychotherapeutic cures of primitive man. Often seances were conducted in the presence of a select group of individuals (the psychotherapists of their day), and emotional excitement was induced through smoking, drinking, drugs, and rhythmic music. Such affectively charged situations facilitated patient regression and eased the confession of sins. This type of affective purging process was the prototype for the earliest known structured psychotherapeutic attempt to deal with man's problems.

The specific Freudian version of this was the now-classic "cathartic method," whereby abreaction occurred, with the emergence of repressed memories through the technique of free association. Behavior therapies have also had their affective counterparts in reproducing anxiety-evoking stimuli in imagination or *in vivo* (with or without the accompaniment of relaxation techniques for purposes of systematic desensitization). Flooding and implosion procedures, for example, re-create high-intensity exposure to feared objects or situations, with the expectation that patients will experience their anxiety as fully as possible and, exhausted with fear and relief, will no longer respond as they used to. Similarly, aversion therapy, by presenting an unpleasant and sometimes painful stimulus, at least temporarily disrupts emotional equilibrium as a precursor of change through reconditioning.

By far the most extensive resurgence of the therapeutic use of emotional arousal and release occurs in the "experiential" approaches. Reichian therapy, Lowenian bioenergetics, and Rolfian structural integration aim to express the affect trapped in the body posture not by analyzing defensive character armor as Wilhelm Reich originally did, but by physically manipulating the muscles that underlie it. Psychodrama enacts the expression of feelings through dramatic improvisations, while uninterrupted lengthy marathon sessions seek emotional access through the by-products of physical exhaustion. Comparably, primal scream and Morita use prolonged isolation and sensory deprivation to lower resistance and break down cognitive defenses—the former expressed in a sobbing, screaming, seizurelike episode to recapture the pain of the primal past, the latter by activating anxiety and distress as a preparatory step toward the creation of a state of spiritual readiness for rediscovering the beauty of life. A basic rationale for such diverse methods is that they aim to facilitate therapeutic change by producing excessive cortical excitation, emotional exhaustion, and states of reduced resistance or hypersuggestibility.

Emotional arousal is one of the major effective ingredients of successful psychotherapy. Following a strong abreaction, there occurs a period of exhaustion that produces heightened acceptance in which the patient appears bewildered, dependent, and eager to find a comforting solution from the therapist. Three experiments by Rudolf Hoehn-Saric in 1978 showed that heightened arousal made patients more receptive to suggestion and therefore more willing to change attitudes than they were under low-arousal conditions. Arousal combined with cognitive confusion yielded even better results than arousal in patients with undisturbed cognitive functions. Heightened arousal under conditions of cognitive disorganization helped to "unfreeze" attitudes necessary for change. Thus, affective experiencing—as a universal change agent in the psychotherapies—may be globally defined as arousing excitement and responsiveness to suggestion: unfreezing and expression of feelings.

The major roles and functions of affective experiencing thus are to set the emotional state for receptivity to

change, to ease the cathartic release of repressed material, and to facilitate patient accessibility by reducing resistance and breaking down defenses. In short, the patient, through the dislodging of persistent chronic attitudes, is made more available for a new cognitive paradigm. However, Hoehn-Saric's results also reflect the finding (often observed clinically) that intense emotional arousal, however profound and necessary to set the stage for therapeutic change to occur, is difficult to sustain. Attitude changes that occurred were short-lived, and repeated interventions were required for such change to be established into a more stable new position. This observation parallels Sigmund Freud's earlier acknowledgment of the limitations of the cathartic method and his significant theoretical transition from release of repressed affects and traumatic memories to their systematic exploration and understanding, that is, from catharsis to insight as the ultimate aim of therapy. It is also consistent with the research conclusion that although heightened arousal under conditions of cognitive organization helps to unfreeze an attitude, it does not necessarily lead to a new solution unless it is followed by cognitive learning.

That is, perhaps the major role of affective experiencing is to emotionally prepare the patient for new cognitive input. Indeed, pure catharsis is considered most effective only in certain limited psychiatric conditions. Moreover, "peak experiences," which may offer attractive opportunities for rapid change, often do not carry over beyond the immediate encounter. In fact, when three therapy groups of differing duration were compared, the curative value of catharsis appeared to diminish in the longest-term group. Thus, some form of affective experiencing appears to be universally applicable, but perhaps largely as a preliminary stage of treatment. Ideally, this means that it should be succeeded by, or combined with, other therapeutic agents that have complementary roles and functions, to maximize or prolong its effectiveness.

B. Cognitive Mastery

All therapies, in some measure, provide the patient with cognitive mastery, whether they offer the classical, well-timed interpretations of Freudian psychoanalysis or, as in Albert Ellis's rational-emotive therapy, have the therapist "sing along" with the patient a litany of the patient's irrational false beliefs. Cognitive mastery thus refers to those aspects of treatment that use reason and meaning (conscious or unconscious) over affect as their primary therapeutic tools, and that attempt to achieve their effects through the acquisition and integration of new perceptions, thinking patterns, and/or self-awareness. A prototype of a cognitive change agent is the therapeutic application of insight, defined as the process by which the meaning, significance, pattern, or use of an experience becomes clear—or the understanding that results from this process.

Historically, primitive faith healing and the early stages of psychotherapy were very much alike in that neither initially attempted to provide insight. However, while faith healing continued only to maximize suggestion (essentially through affective experiences), Western psychotherapy became distinctive in departing from the primitive mode by moving into a second state—to correct problems by explaining them rationally. Going somewhat farther along this line, although the foundation of all therapies is the phenomenon of therapeutic suggestibility, primitive therapies are based almost entirely on irrational belief and dependency, whereas Western scientific therapies are more often founded on rational insight and independence.

Insight (through free association and interpretation) has been considered a *sine qua non* of the psychoanalytic process, yet all psychotherapies provide opportunities for change through cognitive channels—by means of explanation, clarification, new information, or even confrontation of irrational and self-defeating beliefs. Behavior therapies, once considered the antithesis of an insight-oriented approach, have increasingly incorporated cognitive learning techniques into their repertoire. Over time the behavioral model of treatment has radically changed from that of conditioning to social learning and information processing. The behavioral technique of thought stopping developed by David Wolpe, a cognitive variation of classical conditioning methods to extinguish anxiety, can be considered an early example of this change in approach. Albert Ellis's rational-emotive therapy, William Glasser's reality therapy, and Aaron Beck's cognitive therapy all share in direct attempts to correct stereotyped, biased, or self-defeating thinking patterns and dysfunctional attitudes and values, whereas others, like Victor Frankl's logotherapy and William Sahakian's philosophical therapy, are directed to the most profound cognitive reappraisals of life and its meaning. Even the most actively experiential therapies use cognitive techniques; for example, Gestalt "experiments" can be considered cognitively as a structured interpretation.

Thus, cognitive mastery as a universal therapeutic agent may be defined as acquiring and integrating new perceptions, thinking patterns, and/or self-awareness,

whether this is effected through interpretations, explanations, practical information, or direct confrontation of faulty thoughts and images. In contrast to affective experiencing, it serves as a rational component of treatment—to inform, assess, and organize change and to establish or restore ego control. Despite their therapeutic utility in providing a new perspective, meaning, or way of thinking, cognitive approaches are not always sufficient as change agents. Put succinctly, not all change is attributable to insight and not all insight leads to change.

In the final analysis, the criteria for attaining lasting insight must be judged by its personal and social consequences. In short, new thinking (or insight) that has been achieved in therapy must be worked through and incorporated into one's actions and behavior in everyday life; it must be transferred from the structured and safe confines of the therapist's office and put into active practice in the real world outside treatment. Thus, cognitive mastery, like affective experiencing, needs to be complemented by other therapeutic change agents. More specifically, although an affective experience may prepare the patient for cognitive learning, the latter requires gradual assimilation and behavioral application of new input, if therapeutic effects are to endure.

C. Behavioral Regulation

Behavior modification approaches have directly sought behavioral change as an active goal, and learning to self-regulate or control one's habitual responses has become the thrust of their therapeutic efforts. Methodologically, this has meant the use of an extensive repertoire of reinforcement and training techniques based on research in experimental animal and human social learning laboratories—from classical conditioning to explicit rewards and punishments, to shaping and modeling methods in imagination and *in vivo*.

Nonetheless, as already implied, behavioral regulation as a major change agent is no longer limited to the classical confines of a conditioning model; nor is it restricted to the immediate territory of the behavior therapies. Even psychoanalysis, which has been considered relatively weak as a model for behavioral change, and whose therapists must ideologically refrain from direct suggestion or deliberate manipulation, is by no means exempt from the use of behavioral regulation, at least implicitly. All therapies, albeit in less systematic and sometimes unintentional ways, use methods of behavioral reinforcement, feedback, and modeling. Analytic interpretation influences behavior by labeling, defining a problem, providing permission, implying a course of action, facilitating foresight, and the like. Indeed, research has experimentally demonstrated that subtle cues can shape the responses of patients. Examination of actual excerpts of Carl Rogers's so-called nondirective therapy confirmed that even incidental nods or "hmms" by the therapist positively reinforced client responses. On a more inaccessible level, unconscious identification with the therapist is considered an essential aspect of shaping and modeling the patient's behavior. In the final analysis, all therapy may be a matter of emotional, cognitive, and behavioral learning.

III. SPECIFIC THERAPEUTIC FACTORS

Although universal features undoubtedly exist, this does not mean that we must *ipso facto* minimize differences in psychotherapy. There are comparative conceptual studies of various forms of psychotherapy that typically cite striking contrasts among them. More recently, experimental studies of different schools have lent some scientific support to the separatist stance. Exemplary of such findings are the systematic studies of analytically oriented psychotherapy versus behavior therapy, supporting the view that these are highly contrasting styles of treatment. Moreover, the treatment procedures created, developed, and chosen in one society or within the context of a particular belief system, may not be transposable to another. This is especially evident in attempts at cross-cultural psychotherapy.

The current state of the art attests to the lack of clarity and lack of resolution of the specificity versus nonspecificity controversy in explaining what is the quintessence of the therapeutic cure. This conflicting state of affairs is further compounded by comparative studies of various psychotherapies, which suggest that one's espoused theoretical orientation regarding the nature of the healing process may not always be synchronous with one's actual practices. In a comparison research study of Freudian, Kleinian, Jungian, and Gestaltist therapists, descriptive ratings of the different approaches in action did not differentiate the respective schools of thought, the investigators (and, no doubt, the proponents themselves) naturally expected.

A. Analytical Schools

For the analytic therapist the ultimate task, in its most parsimonious and famous form, is to make conscious the unconscious. The ongoing therapeutic charge is to facilitate the emergence and comprehension of unconscious content. That is, such a therapist seeks to