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SCHOOL OF SCIENCE AND HUMANITIES

DEPARTMENT OF PSYCHOLOGY

UNIT – I – Counselling and Psychotherapy – SPSY1601

Introduction

Psychotherapy: Meaning and Objectives of Psychotherapy

Psychotherapy is the treatment given to mentally ill and emotionally disturbed people through psychological techniques. It is also called clinical intervention because in this method clinical psychologist use their professional capacity and try to influence and bring given changes in the behaviours of mentally ill and emotionally disturbed people.

Definition of psychotherapy

Wolberg (1967): "Psychotherapy is a form of treatment for problems of an emotional nature in which a trained person deliberately establishes a professional relationship with a patient with the object

- of removing, modifying or retarding existing symptoms,
- of mediating disturbed patterns of behaviour, and
- of promoting positive personality growth and development.

(Rotter): "Psychotherapy … is planned activity of the psychologist, the purpose of which is to accomplish changes in the individual that make his life adjustment potentially happier, more constructive, or both."

J. D. Frank (1982) elaborates this general theme as follows:

"Psychotherapy is a planned, emotionally charged, confiding interaction between a trained, socially sanctioned healer and a sufferer. Psychotherapy also often includes helping the patient to accept and endure suffering as an inevitable aspect of life that can be used as an opportunity for personal growth."

The psychodynamic approach to therapy focuses on unconscious motives and conflicts in the search for the roots of behaviour (Shedler, 2010). It likewise depends heavily on the analysis of past experience. The roots of this perspective reside in the original psychoanalytic theory and therapy of Sigmund Freud.

Fisher "Psychotherapy is a planned and systematic application of psychological facts and theories to the alleviation of large variety of human ailments and disturbances, particularly those of psychogenic origin".

J. D Page "Psychotherapy means treatment of mental disorders especially psychoneurosis by psychological techniques".

Thus psychotherapy is the systematic application of techniques derived from psychological principle, by trained and experienced professional therapists, for the purpose of helping psychologically troubled people.

Objectives of Psychotherapy

1. Psychotherapy aims towards, changing mal adaptive behaviour pattern.

2. Minimising or eliminating environmental condition that may be causing or maintaining such behaviour.

3. Improving interpersonal and other competences.

4. Resolving handicapping and disabling inner conflicts and alleviating personal distress.

5. Modifying inaccurate assumption about oneself and one's world and fostering a clear cut sense of oneself identity and opening of pathways to a more meaningful and fulfilling existence.

The chief objective of psychotherapy is to rid the patients of symptoms which make his life a burden to him, and it is the duty of the psychiatrists to help the patients regain his self- confidence and to strengthen his personality so that he can solve his own problems and adjust with the environment.

The Ultimate goal and some mediate goals of psychotherapy

Ultimate goals- The ultimate goal is what the psychologist wants to achieve at last.

Some of the ultimate goals are

1.Removing the symptoms.

2.Freeing the person to be self-actualizing.

3.Restoring earlier level of functioning.

4.Helping the patient find personal meaning and values.

Mediate goals- They are not less important than ultimate goal. The mediate goals define the needs which are necessary to move the patient towards ultimate goal.

1.Releasing pend-up feelings.

2.Conditioning or reconditioning of particular responses.

3.Examining ones values and concepts.

4.Muscular relaxation.

5.Becoming aware of unconscious impulses.

According to Sundburg and Taylor- The purpose/objective or goal of psychotherapy:

1.Strengthen the patient's motivation to do the right thing.

2.Reducing emotional pressure by facilitating the expression of feeling.

3.Releasing the potential for growth.

4.Changing habits.

5.Modifying the cognitive structure of the person.

6.Gaining self-knowledge.

7.Facilitating interpersonal relations and communication.

8.Gaining knowledge and facilitating decision making.

9.Altering or changing the bodily states.

10.Altering states of consciousness.

11.Changing the social environment.

It is helpful to view therapeutic approaches in these terms before considering psychoanalysis, client-centered therapy and other systems. These purposes do not correspond in any one-to- one fashion with the approaches of different schools. Rather, they are themes which run through different therapeutic systems, though one or another may be emphasized in each case. They also describe different patients or with the same patients at different points in the therapeutic process. Thus, a therapist attempting to alter the cognitive structures of a person in order for him to rectify distorted perceptions and beliefs may still find it necessary to encourage emotional release and/or enter directly into attempts to change the patient's social environment

Counseling and Psychotherapy

- **Counselling:**
- Helps people identify problems and crises and encourages them to take positive steps to resolve the issues.
- It is the best course of therapeutic treatment for anyone who already has an understanding of wellbeing, and who is also able to resolve problems.
- Counselling is a short-term process that encourages the change of behaviour.
- **Psychotherapy:**
- Helps people with psychological problems that have built up over the course of a long period of time.
- It will help you understand your feelings, thoughts and actions more clearly.
- Psychotherapy is a longer-term process of treatment that identifies emotional issues and the background to problems and difficulties.

Counselling is generally prescribed for a fixed number of sessions while psychotherapy is an ongoing process, often carrying on for years. This means that counselling is typically much more structured, with less room to explore thoughts and avenues compared to psychotherapy. This structure lends itself well to teaching the techniques that help to directly alleviate issues.

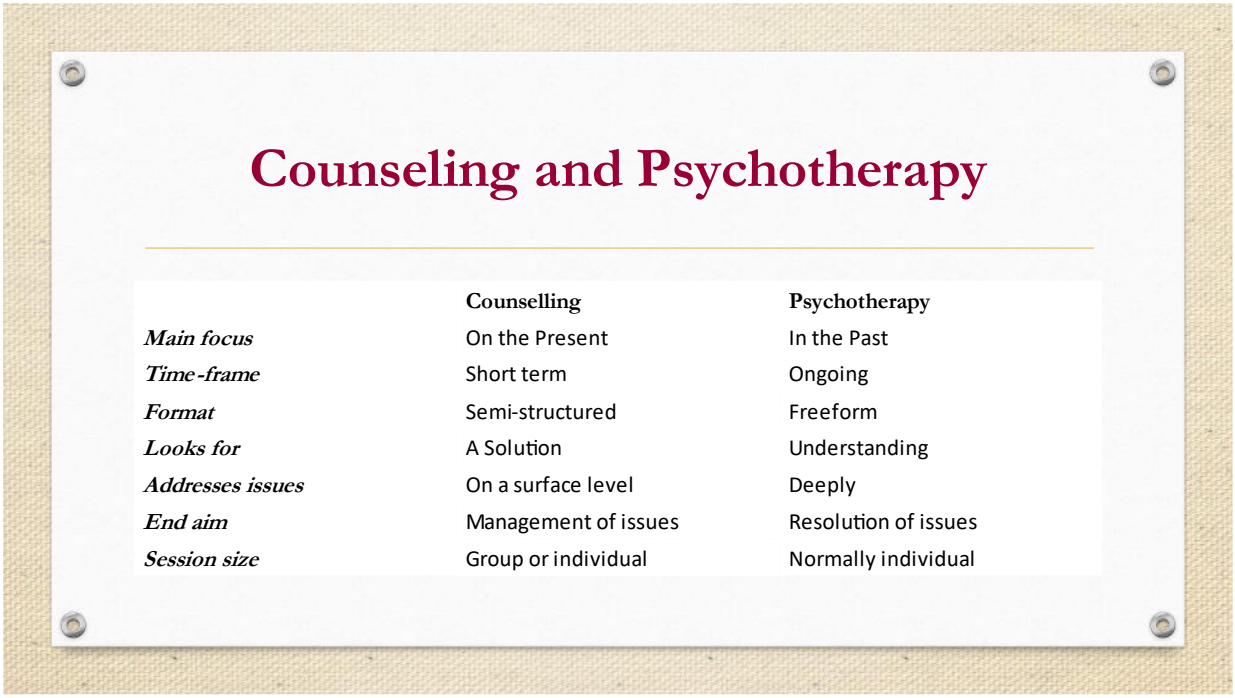

Fig 1 shows the differences between Counseling and Psychotherapy

Therapeutic process

- Many researchers view therapeutic process as evidently consisting of the interactions and communications that take place between patient and therapist during the regular meetings in therapy sessions. On this view, therapeutic process includes all of the events that can be observed and recorded during therapy sessions.
- Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific concerns, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.
- The psychotherapeutic process is usually divided into three phases:
- *The first phase* begins with the first meeting and ends by signing a therapy contract. The main task of the first phase is ***to assess the necessity of psychotherapy***, and to find the appropriate type of therapy.

- *The second phase* starts after signing the therapy contract and lasts until starting the conclusion of the therapy. This second phase takes up the lion's share of ***the therapeutic work***.
- *The third phase* is the ***conclusion of psychotherapy***. We start it after reaching the desired result, or when the therapy proves to be unsuccessful. The conclusion of the therapy is preparation for the prevention of relapse, as well.

Phase :1

- Getting in contact
- The first impression is found to be a determining factor in many aspects of life. After the first psychotherapeutic interview, 15-17% of the patients do not go to the first session, and further 26-30% drop out after the first or second session. The discussion of the patient's ambivalent feelings about therapy can help them a lot in making a decision.
- Setting up a diagnosis (DSM, ICD)

First psychotherapeutic interview

- The first therapeutic interview leads to the first case conceptualization which is shared with the patient.

Case conceptualization

- It is a starting point from which the therapist creates hypotheses about the risk, the causal and the sustaining factors of the psychic, social and behavioural problems of the patient.

Therapy contract

- As a result of the first case conceptualization, the therapist must be able to make a decision on the necessity of the therapy, its location, method, duration, frequency and its realistic goals.

Phase :2

- The first few sessions (3-7 sessions) are momentous. Changes coming about during the first sessions are decisive in regard to the outcome of the therapy.
    - 65% of the patients show a measurable improvement by the 7th session.

- When no improvement is reached in the beginning or the condition deteriorates by the third session, half of the patients quit therapy before time, or report the treatment to be ineffective at the end of the course.
- Consequently, when no improvement is made at the early stages, then case conceptualization must be recommenced, and the treatment needs to be adjusted to the needs of the patient.

Phase:3

- **The following conditions must be met to start to end the therapy**:
- a considerable improvements has taken place in achieving the treatment goals
- the patient is able to practise the skills they acquired during the therapy in solving their problems
- Main steps of the conclusion the therapy
- Suggest the opportunity for concluding the therapy
- Discuss the date of the last session
- Strengthen the skills and lessons learned by the patient throughout the therapy

The last phase of therapy

The effectiveness of the psychotherapeutic process can be evaluated based on the following four aspects:

- Number of symptoms decreases and/or abilities to tolerate (tolerance) effects of symptoms increases
- Adaptive capacities increase
- Consideration Insight increases
- Basic conflicts, patterns are solved, or become treatable

Therapist qualities

- Active Listener
- Strong Communicator
- Trustworthy
- Open
- Flexibility
- Optimistic
- Empathy, etc.

Effectiveness of Psychotherapy

The evaluation of patient outcome

At first sight this is a compelling index as the goal of treatment is to benefit patients. In practice, however, it is problematic. Its main shortcoming is that it is an indirect measure as patient outcome is affected by variables other than the quality of the treatment provided, a key one being the characteristics of the patients in question. Patients vary in their responsiveness to treatment (e.g., as a result of differences in the severity or duration of their problems, the extent of any comorbidity, and the presence of complicating life circumstances) and unless this is taken into account when evaluating outcome data a false impression may be obtained.

The evaluation of treatment sessions

A more widely used method for assessing the skill of therapists is the evaluation of the quality of their treatment sessions (i.e., therapy quality is being used as an index of therapist competence). This therapy quality method requires that treatment sessions be evaluated using a standard procedure. In the field of cognitive behaviour therapy (CBT), for example, common practice is for treatment sessions to be rated using the Cognitive Therapy Scale (CTS; Young & Beck, 1980, 1988) or its revised version (CTS-R; Blackburn, James, Milne, & Reichelt, 2001). These measures require that treatment sessions (usually recordings of them) be evaluated by a rater with respect to the presence and quality of certain therapist-determined features (e.g., the eliciting of key cognitions, the use of

guided discovery, the setting of homework). On this basis a score is generated and if it is above a specified threshold the session is judged to have been delivered sufficiently well

Evaluation of standardised role plays

A third way of assessing therapists' ability to implement treatments is through their performance in standardised role plays. This method is well established in medical education (where it is referred to as an "objective structured clinical examination" or OSCE; e.g., Newble, 2004), but it has only been employed to a limited extent to evaluate psychotherapeutic skills. This approach, however, has certain advantages over the therapy quality method of assessment, particularly as a means of evaluating the outcome of training. It will be discussed later.

Recommendations regarding the assessment of therapy quality

There is only one way of directly assessing therapy quality which is to evaluate treatment sessions themselves. This requires rating sessions live or preferably assessing recordings of them.

As will be clear from the account above, substantial changes need to be made to the instruments currently available and their mode of use. The main changes are as follows:

- i. Content – The features assessed need to encompass what are presumed to be the active components of the psychological treatment concerned and, depending upon the context, more generic psychotherapeutic elements. Each needs to be carefully defined, operationalised and specified in a manual for raters.
- ii. Reliability – Rating schemes need to be devised that can be used reliably by raters representative of those who will utilise the instrument.
- iii. Validity – This needs to be established both with respect to a total score, representing the overall quality of the session concerned, and a threshold score for judging the session to have been delivered sufficiently well for the treatment to be likely to achieve its expected effects.
- iv. Protocol – This needs to specify the following:
    - - The number of full sessions (or part-sessions) to be rated, and how they should be selected. If the goal is to evaluate the quality of a course of treatment it is important that a representative, and sufficiently large, sample of the treatment be assessed. With

some treatments it might be important to specify that sessions be selected from specific sections of the treatment. Therapists should not be involved in selecting which sessions are rated (unless the assessment is for supervision purposes).

- - The choice of rater and the qualifications required to be one. The rater should be blind to the therapist's identity (again, unless the assessment is for supervision purposes).

Ethical and Legal issue in psychotherapy

Competence of therapist

Competence is defined as ''the possession of required skill, knowledge, qualification or capacity'' .It is very important that therapists are aware of their competence, with regard to the level of his/her knowledge, training and supervised experience in a particular kind of therapy. In addition to the 7 above, some of the authors also include 'emotional competence' to knowledge and technical skills . This actually means, whether the therapist is aware of his emotional state while dealing with their clients. It is important that the therapists refrain from initiating or continuing a therapy when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work in a competent manner. Further, when a therapist becomes aware of personal problems that may interfere with performing their duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they 8 should limit, suspend, or terminate the therapy .

Responsibilities of Therapist From an ethical point of view, it is important that the therapists are aware of their responsibility 9 towards their clients .These include: Responsibilities to the client 1. Therapy should be undertaken only with professional intent and not casually and/or in extra professional relationships. 2. Contracts involving the client should be realistic and clear. 3. Therapists take all reasonable steps to avoid harm to their clients as a result of the therapy. 4. Therapist should seek supervision or refer the client in situations which are beyond their competence.

Responsibilities to self as a therapist 1. It is the responsibility of the therapist to maintain their own effectiveness, resilience and ability to help clients.They monitor their own personal functioning, and seek help or refrain from therapy when their personal resources are sufficiently depleted to require

this. 2. Therapists should not undertake therapy when their functioning is significantly impaired by personal or emotional difficulties, illness, alcohol, drugs or any other cause.

Informed Consent

Informed consent to therapy is invaluable as it ensures that a patient's decision to take part in 10 psychotherapy is informed, voluntary, and rational .Although it is presumed that seeking help of the therapist for their problems by the patient means implied consent, but this does not amount to "informed consent".

Therapeutic contract

The therapeutic contract should be a written document, which includes the responsibilities of the therapist and the client in participating in a particular psychotherapy.It should cover the following: 1. Time: the time of the day when the therapy is to be conducted and provision of change in exigencies.

Duration: the contract must include the duration of each sessions (say 50 minutes)

3. Frequency of sessions: Frequency of the sessions will be_____ per week (usually agreed upon between the client and therapist depending on the variety of the problems and symptoms).

4. Late to the session: If the therapist will be ever late, he will try to let the client know in advance, even if the delay is just a few minutes. If the therapist is responsible for delay in start of the session and the client can stay longer, then the therapist will see the client you for the full time.If the client arrives late for an appointment, then the session may still end at the scheduled time, however if it is possible than the session may go to the full time. If either the therapist or the client is late by more than 15 minutes and don't inform the other party than the session will stand cancelled. However, in such a situation either of the party has to bear the financial liability.

5. Cancellation: In the event of either the client or therapist are unable to keep the appointment, they are required to provide twenty-four (24) hours notice of cancellation or they will be charged for the session.

6. Fees: the client is supposed to pay Rupees ____ for each 50 minutes session. Client should make the payment is to be made at the beginning of the session. If the duration of the session extends beyond one hour than the patient will be required to pay an additional fee.

7. Emergency contact: If the patient needs to contact the therapist between sessions, she/he should call at _____number and leave the message and also mention that it is an emergency.If the therapist doesn't call back the client in _____ time (say 30 min), patient should attend the emergency outpatient department of the hospital. 8. Issues of confidentiality: The therapeutic contract should mention that the therapist will maintain confidentiality of the information revealed during the psychotherapy

8. Termination: If the client decides to discontinue the therapy, he will make this known to the therapist within a session, so that an end date can be decided and the client and therapist can work towards an appropriate ending.Termination of therapy cannot be done on phone, nor be the decision solely of the client (This is to safeguard the client as frequently, during the therapy, client may have to discuss underlying difficult material which has been kept suppressed for the years

9. Gifts: No gifts will be accepted by the therapist from the client and neither the therapist will offer any gifts to the client.

11. Self disclosure: The therapy will focus on the issues of the client and the therapist will not respond to any questions regarding the personal details, and any such attempt by the client will be interpreted. 12. Home work assignments: As part of the therapy client will be given some home work assignments in between the sessions, and the client is expected to carry out the same. If the client comes to the session, without completion of the homework assignment, then the therapist has the right to cancel the session. However, in such situation, the client has to pay for the session.

13. Documentation: The therapist may take notes during the therapy session.

14. Recording: The therapist may tape record/video record the therapy session for documentation and supervision purposes.

15. Provision for revision: If required by either the therapist or the client the contract will be revised after mutual discussion. 16. No suicide contract: In case, patient is suicidal, the contract can include the clause that patient is not going to harm her/him, and in case she/he has the urge to indulge in the self harming behaviour, she/he will contact the therapist.

Confidentiality Maintaining confidentiality is the foundation of the psychotherapy. Without the assurance about the confidentiality, the clients cannot be expected to reveal embarrassing, sometimes personally 20 damaging, information in treatment setting . As part of the medical profession, the therapists are expected to maintain the confidentiality of their clients. However, it is important to remember that the ethical requirement of confidentiality overlaps with the law, hence, answers to some of the situations can only be predicted by an understanding of both ethics and law. Hence in situations where things are not clear the therapist should seek legal consultation

Boundary issues during Psychotherapy Boundary issues in psychiatry and psychotherapy per se, don't have black and white answers. Nonsexual boundary crossings can enrich therapy, serve the treatment plan, and strengthen the 22 therapist–client working relationship

Post termination ethical issues As with other issues related to boundaries, post-termination relationships between therapist and the client have always being an issue of debate. Although, there is no law to bar the physician to have sexual relationship with their ex-patients, but it is more or less accepted that it is unethical to terminate the psychotherapy for having a sexual relationship with the client. Regarding the post-termination sexual relationship, there are different views. Some of the authors take the stand that the client may agree for such a relationship because of unresolved transference and hence it is unethical

Questions:

1. Explain the objective of Psychotherapy

2. Explain the ethical issues in Counselling and Psychotherapy.

3. Describe Counselling and Psychotherapy.

4. Infer the Therapist qualities.

5. List out and explain the therapeutic processes

References:

1.Hersen, M. & Sledge, W. (2002). Encyclopedia of psychotherapy. Academic Press.
2.Yalom, I. (2009). The Gift of Therapy. Harper Perennial: New York.

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What is Psychodynamic Therapy? A Definition

Psychodynamic therapy is a "global therapy," or form of therapy with a holistic focus on the perspective of the client. The alternative, "problem-based" therapies, such as **cognitive behavioral therapy**, aim to reduce or eliminate symptoms instead of exploring the client's deep-seated needs, urges, and desires (McLeod, 2014).

This translates into significant differences between these therapies in terms of goals, techniques, and general approach.

"In contrast [to behavioral therapy], dynamic psychotherapy, which facilitates a patient's rewriting of his life narrative, his picture of himself, his past, present, and future, seems uniquely positioned to address the depth of a individual's experience."

Richard F. Summers

The global vs. problem-based therapy dichotomy is not the only factor that sets psychodynamic therapy apart from these other, more common forms of therapy. Psychodynamic therapy involves the interpretation of **mental** and emotional processes rather than focusing on behavior (Strupp, Butler, & Rosser, 1988).

Psychodynamic therapists attempt to help clients find patterns in their **emotions**, thoughts, and beliefs in order to gain insight into their current self. These patterns are often found to begin in the client's childhood since psychodynamic theory holds that early life experiences are extremely influential in the psychological development and functioning of an adult (Matthews & Chu, 1997).

Psychodynamic therapy aims to help the client identify important pieces of the puzzle that makes them who they are and rearrange them in ways that allow the client to form a more functional and positive sense of self:

"We see the central task of psychotherapy as the rewriting of a more complex and useful narrative of the patient's life and experience."

Richard F. Summers Psychodynamic therapy sessions are intense and open-ended, dictated by the client's free association rather than a set schedule or agenda. They are typically scheduled once a

week and last about an hour. While Freud's psychoanalytic therapy (described in more detail below) demanded a much greater investment of time, current psychodynamic therapy is generally practiced in a less intensive manner (WebMD, 2014).

Modern psychodynamic therapy also substitutes a pair of chairs for the stereotypical couch and usually places the therapist and client face-to-face rather than keeping the therapist hidden from the client's view.

In these sessions, the therapist will encourage the client to talk freely about whatever is on their (conscious) mind. The thoughts and feelings discussed will be probed for recurring patterns in the client's unconscious mind.

This form of therapy is commonly used with clients suffering from depression or anxiety diagnoses, and there is some evidence suggesting that psychodynamic therapy may be as effective in treating depression as other forms of therapy (WebMD, 2014).

Goals of Psychodynamic Therapy

The main goals of psychodynamic therapy are to (1) enhance the client's self-awareness and (2) foster understanding of the client's thoughts, feelings, and beliefs in relation to their past experiences, especially his or her experiences as a child (Haggerty, 2016). This is accomplished by the therapist guiding the client through the examination of unresolved conflicts and significant events in the client's past.

The assumption in psychodynamic therapy is that chronic problems are rooted in the unconscious mind and must be brought to light for **catharsis** to occur. Thus, the client must have the self-awareness to discover these unconscious patterns of thought and an understanding of how these patterns came to be in order to deal with them.

Psychodynamic Theory, Perspective, and Key Concepts To truly understand psychodynamic therapy, you need to go back to its roots. While this type of therapy has changed over the last century, it is still built on the foundations of some of the earliest work in modern psychology. In the late 19th century, Sigmund Freud was working on his grand idea of the human mind and the theory of human development. His theories laid the foundation for decades of psychological research and practice.While many of these theories were eventually found to conflict with hard evidence gained

through scientific research, they formed the basis for psychodynamic theory and sparked a bold new school of thought that still exists today, in a modified and updated form.

He proposed that the human mind is composed of three parts:

1. The id, which consists of instinct and forms the basis of the unconscious mind;
2. The superego, or moral component that houses our beliefs of right and wrong;
3. The ego, the mediator between the animal instinct of the id and the enlightened moral thought of the superego (Haggerty, 2016).

Freud hypothesized that these components grew out of certain stages in **childhood development**. He believed humans are born with the id, develop the ego as a toddler, and add the superego around the age of five. Freud's hypothesis led him to the logical conclusion (based on his theory) that one's personality is firmly rooted in their childhood experiences.

While Freud believed that each component formed in each human, the development of each component could be significantly influenced by one's environment and family relationships. These factors could contribute to the development of a healthy sense of self and effective functioning, or they could trigger the development of neuroses and dysfunctional or distressing patterns of thought.

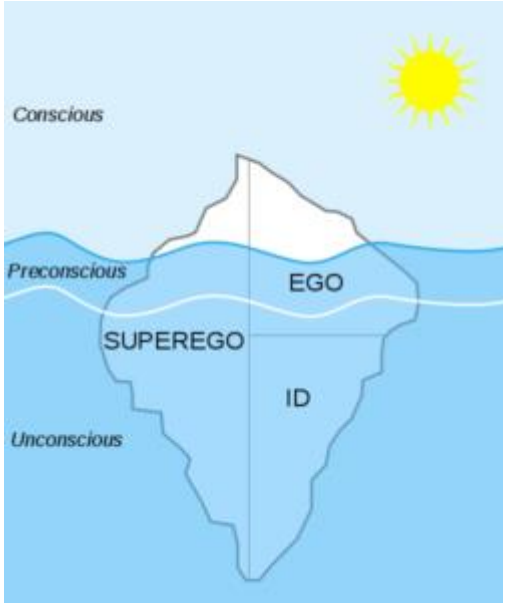
Whether the development led to positive or **negative patterns of thoughts** and belief, Freud held that that which truly drives human behavior is buried deep within the human mind, in what he termed the unconscious mind.

Freud theorized three levels of the mind:

1. The Unconscious: this level is where our instincts, deeply held beliefs, and many patterns of thought and behavior reside; we are not consciously aware of anything at this level, but Freud believed the contents of the unconscious mind make up the vast majority of who we are, what we want, and how we behave in order to get what we want.
2. The Subconscious or Preconscious: this level is between the conscious and unconscious, and can be called up to consciousness with a purposeful effort from the individual; the contents of this level are just below the surface of consciousness.

3. The Conscious: this is the level at which we are fully aware; Freud believed this was the level with the least defining content, the level that makes up only a tiny sliver of who we are.

Based on this theory, Freud insisted that to truly address our issues and solve our problems, we must dig deep into the unconscious level. This is where we store our unspoken values, the beliefs we do not even realize we have, and the patterns of thought and behavior developed in our childhood.



While psychodynamic theory has outgrown many of Freud's simplistic ideas about human nature, many of the assumptions that underlie the psychodynamic approach are reminiscent of Freud's work:

- The unconscious mind is one of the most powerful drivers of human behavior and emotion;
- No behavior is without cause—all behavior is determined;
- Childhood experiences exert a significant influence on thoughts, emotions, and behavior as an adult;
- Important conflicts during childhood development shape our overall personality as adults (Freud, 1899).

Freud's theories directly support the methods of psychoanalysis, but also help form the basis of psychodynamic theory and inform the methods and techniques used in today's psychodynamic therapy.

Psychoanalysis: The Freudian Approach

While psychoanalysis and modern psychodynamic therapy grew from the same source, there are several important differences between the two forms of therapy.

1. First, the timeline and duration of psychoanalysis are far more intensive than modern psychodynamic therapy. Psychoanalysis is generally conducted in two to five sessions per week, lasting several years (McLeod, 2014).

2. Second, the physical layout of the office or therapy room is significant—in psychoanalysis, the client (or patient, as they are usually called) lies on his or her back on a couch while the therapist sits behind them, out of their line of sight. In modern psychodynamic therapy, it is much more common for therapist and client to face one another, or at least remain in the other's field of vision.

3. Third, the relationship between therapist and client/patient is much more imbalanced than in modern psychodynamic therapies. The position of the therapist and client suggests a significant imbalance of power, with the therapist acting as a distant and detached expert with techniques and knowledge that will not be shared with the client. Meanwhile, the client acts as a troubled supplicant who relies on the therapist for their expertise in teasing out the dysfunctional thoughts and beliefs that plague them (McLeod, 2014).

Some of the psychoanalytical practices have survived or been adapted for modern use, but this uneven **relationship between therapist and client** generally does not carry over to current psychodynamic therapy. The therapist's role has been modified over the last century to alter the hierarchy and provide a more equal setting for treatment.

Role of the Psychodynamic Therapist

Today, the role of the therapist in psychodynamic therapy is to work with the client to discover the bases for their symptoms.

The therapist plays this role by encouraging the client to talk about the emotions they are feeling and helping the client to identify recurring patterns in their thoughts, emotions, and behaviors.

They can aid the client in finding the significance of these patterns and discovering the effects they exert upon the client.

One of the most important roles of the therapist is to probe the client's past. Discussion of the client's childhood and early life experiences will likely take up a large portion of psychodynamic sessions, as this form of therapy assumes these experiences have a significant impact on the client's current issues.

The therapist observes how the client interacts within the therapeutic relationship and add their own insight into the client's relationship habits to the discussion.

The psychodynamic theory holds that how the client acts in the relationship with the therapist usually mirrors how they act in other relationships, such as with a parent or other important adult from their childhood (WebMD, 2014).

In general, the therapist's role is to aid the client in connecting the dots between their past experiences and their current problems, and leverage their internal resources to address these problems.

Types of Psychodynamic Therapy

Throughout this piece, I have referred to psychodynamic therapy as a singular entity to make the discussion of psychodynamic therapies easier; but truthfully writing, psychodynamic therapy is more a category of therapies rather than a single type.

All of the therapies below are grounded in the same overarching model of psychodynamic theory, but they apply the tenets of this theory in different ways.

1. Brief Psychodynamic Therapy

The aspect of brief psychodynamic therapy that sets it apart from other types of psychodynamic therapies is right in the name: brief.

This type of therapy is generally conducted over the course of only a few sessions, or even just one session in some cases. Sometimes an individual struggling with a specific problem only needs to make a few important connections to overcome that problem.

For instance, if a client is suffering from acute anxiety with no known source, the identification of an event or circumstance that gave rise to this anxiety and a strategy for coping can be accomplished in one session.

While the resolution of problems should not be expected in one session for all those seeking treatment, there are several instances where identifying and dealing with a specific problem can be a relatively brief investment.

Brief psychodynamic therapy has been applied to situations like:

- Rape;
- Accident (traffic, physical injury, etc.);
- Act of terrorism;
- Acute psychological disturbances (like anxiety or depression);
- Traumatic family event (discovery of a secret, divorce, etc.).

For more information on brief psychodynamic therapy, visit this **link**.

2. Psychodynamic Family Therapy

This form of psychodynamic therapy is practiced in the **context of a family**, whether that family is comprised of two adults in a romantic relationship, a parent and child(ren), siblings, grandparents and grandchildren, a traditional nuclear family, or any combination of these family members.

This therapy is usually relatively long-term (versus the shorter term family therapy based on **CBT** or **IPT**) and often is instigated by chronic problems in the family (rather than a significant event or the emersion of a specific problem in the family).

Like other psychodynamic therapies, this form focuses on unconscious processes and unresolved conflicts but views them in the context of family relationships. The therapist will lead the family members through an exploration of family history, especially any **traumatic family events**.

Often, this form of therapy emphasizes the importance of the adult members of the family working out any conflicts with their own parents as a way to better understand the conflicts with their partner(s) and child(ren).

Psychodynamic family therapy can help families to discover and address the deep-seated issues that give rise to family problems, leading to a healthier and happier family dynamic.

3. Psychodynamic Art / Music Therapy

This non-traditional form of psychodynamic therapy involves the expression of feelings and emotions through art or music.

Like other types of psychodynamic therapy, this therapy is non-directive and non-structured, allowing the client to lead the session. It does not require any artistic or musical talent or ability, only that clients are able to use music or art to express themselves.

Clients may showcase specific pieces and talk about the emotions they evoke, connect them to events from childhood, or discuss the meaning they find in these pieces. Or, clients might bring in a specific song or album that they feel they can relate to on a deep level.

Alternatively, clients can actually create art or music in the session. It doesn't have to be "good" art or music, it only needs to convey the thoughts or feelings of the clients in a way that makes sense to them.

Through **art** and/or music, the therapist and client can build an understanding and form an important bond. They may find that art and music are better methods of deep communication than talking.

This type of therapy may be particularly well suited for those who are shy or otherwise find it difficult to talk, as well as clients who are experiencing crippling anxiety or fear which music or art can help to soothe.

You can learn more about psychodynamic music or art therapy through **this website** or this **Prezi slideshow**.

5 Psychodynamic Tools and Techniques Psychodynamic therapy relies less on **exercises and activities** than most other **types of therapy**, but there are some very important tools in the

psychodynamic toolbox that allow the therapist to delve deep into the unconscious mind with their clients.

The five tools and techniques below are common practice for many types of psychodynamic therapy.

1. Psychodynamic Diagnostic Manual (PDM)

The Diagnostic and Statistical Manual, or DSM, is often referred to as the clinical psychologist's Bible. The DSM serves as a framework for understanding and evaluating behavior within a therapeutic context.

Psychodynamic therapists and theorists sometimes critique the DSM's focus on observable symptoms and omission of more subjective experiences as criteria for diagnosis.

To solve this problem of disagreement over diagnostic criteria, a Psychodynamic Diagnostic Manual (or PDM) was released in 2006 as an alternative or complement to the DSM. Those practicing psychodynamic therapy may find this manual to be more useful in diagnosing and treating their clients than the standard DSM.

2. Rorschach Inkblots

While these ambiguous and untidy splotches of ink are closely connected to **Freudian psychoanalysis**, they are also used in some forms of psychodynamic therapy today.

The Rorschach Inkblot test seems to be a particularly misunderstood tool in the general population.

Pop culture has made the test out to be either an end-all, be-all test of an individual's personality, unique psychology, and predictor of all manner of mental health maladies, or a useless exercise in naming unnamable shapes.

In fact, the Rorschach test is neither of these things. It cannot illuminate your entire childhood experience, but it is also not a useless bit of trivia from a psychological era gone by.

The original Rorschach inkblots were developed in the early 1900s by psychologist Hermann Rorschach (Framingham, 2016). At the time, a popular game called Blotto involved a set of inkblots that could be organized into a poem or story or used in a round of charades.

Rorschach noticed that patients diagnosed with schizophrenia reacted differently to these inkblots, and began studying their use as a tool for diagnosis and discussion of symptoms.

His work resulted in a set of 10 inkblot images that can be presented to a client with the intention of observing and projecting based on their reactions to the images.

To conduct the Rorschach test, the therapist will present each inkblot to the client individually and ask the client to describe what they see. They are free to use the image as a whole, a piece of the image, or even the blank space surrounding the image to form an interpretation.

The therapist will take notes on the client's descriptions and how they interpret the image. They may also ask additional questions to get the client to elaborate on what they see.

While there is controversy over how valid and reliable the results of this test should be considered, many therapists find that they provide valuable qualitative information about how the client is feeling and how they think (Cherry, 2017). It has also been found to be somewhat effective in the diagnosis of thinking disorders (such as schizophrenia and bipolar disorder).

Those with these types of disorders tend to see and interpret the images differently than those without such diagnoses.

The important part of this test is the process of interpretation and description undertaken by the client, rather than any specific content seen in the inkblots. As such, the use of this test requires a highly trained professional to conduct, score, and interpret.

To see an online version of this test based on the work of researcher Harrower-Erickson, click **here**.

3. Freudian Slip

This may be the least formal (and perhaps least applied) technique in psychodynamic therapy, but it is certainly not a dead concept yet.

A "Freudian slip" is also known as a slip of the tongue or, more formally, parapraxes. These slips refer to instances when we mean to say one thing but accidentally let "slip" another, specifically when deeper meaning can be attributed to this slip.

For example, you might call it a Freudian slip when someone intends to say "That is your best idea yet!" but accidentally says "That is your breast idea yet!" You may assume that this individual has a certain anatomical feature in mind, or associates the person they are addressing with said feature.

Another example could be when you are feeling frazzled or overwhelmed at work and your boss pops by for a quick discussion. You aren't really paying attention, and you absentmindedly say "Thanks Mom" instead of using your boss' name. A psychoanalyst may consider this slip and decide that you have unresolved issues with your mother and that you are trying to fill the void of that parental relationship with your boss.

Freud (and some subsequent psychodynamic theorists) believed that these "accidental" slips of the tongue are not truly accidental, but actually reveal something meaningful about you. The Freudian theory holds that no behavior is accidental or random; rather, every move you make and every word you say are determined by your mind (conscious, subconscious, or unconscious) and your circumstances.

A psychodynamic therapist may pay special attention to any such slips, whether they occur in session or are simply related by the client during a session, and find meaning in the word substitution. They may conclude that a slip is actually a little piece of your unconscious finding its way to the surface, indicating an unmet desire or unknown association between two concepts.

While most modern psychologists agree that Freudian slips are generally just "slips," it's hard to argue that a slip of the tongue can't occasionally reveal an interesting connection in the speaker's mind.

4. Free Association

Free association may be the single most important and most used tool for psychodynamic therapists. This technique is simple and often effective.

In the context of psychodynamic therapy, there are two meanings attached to "free association:" the more official therapy technique of free association, and the general method of in-session discussion driven by the client's free association between topics.

The more formal technique involves the therapist reading a list of words and the client responding immediately with the first word that comes to mind. This exercise can shed light on some of the associations and connections the client has hidden deep below the surface.

This technique may not be as useful to a client who is resistant to the exercise or to sharing intimate details with the therapist. However, therapists should not assume that a client who pauses before responding is resistant—it may indicate that the client is getting closer to a repressed or highly significant connection.

Free association may provoke an especially intense or vivid memory of a traumatic event, called an abreaction. This can be extremely distressing for the client, but it can also lead to a healing experience of catharsis if the client feels like it helped them work through a significant problem (McLeod, 2014).

The less formal concept of free association is simply the tendency to allow the client to lead the discussion in psychodynamic therapy sessions. This kind of relaxed, non-structured approach to dialogue in therapy is a hallmark of psychodynamics.

Practicing this type of informal free association ensures that the therapist is not leading the client anywhere in particular and that the client is moving authentically from one subject to the next. This is critical in psychodynamic therapy, as it is unlikely to reach the unconscious sources of psychological distress without following the client's lead.

5. Dream Analysis

Another vestige of Freudian therapy, this highly subjective technique can prove useful for some, although its efficacy as a treatment technique is not proven via the scientific method.

However, the effectiveness of therapy cannot always be measured and codified by double-blind random control trials (RCTs), the gold standard of research.

Sometimes it is nearly impossible to determine which components or modes of treatment brought about success in therapy.

It is in this ambiguous environment that some of those not-quite-established techniques can contribute to real progress for the client. While dream analysis cannot be formally recommended as a reliable

and effective tool, it is unlikely to cause any harm and should, therefore, be left up to the client and therapist whether to include it in the treatment regimen.

Dream analysis is undertaken by discussing the client's dreams in detail. The therapist will guide the client through this discussion, asking questions and prodding the client to remember and describe the dream in as much detail as possible.

While the client talks about their dream, the therapist will attempt to aid the client in sorting the "manifest" content from "latent" content. The manifest content is what the client remembers about their dream—what happened, who was there, how it felt, the physical and temporal environment of the dream, etc. The latent content is what is beneath the surface of the dream, and this is where the meaning of the dream lies

(McLeod, 2014).

While Freud would nearly always find a repressed sexual urge or sex-related significance in the latent content, today's dream interpreters have broadened their scope of meaning.

There are nearly countless ways that therapists, coaches, counselors, and practitioners of the more mystical arts engage in dream analysis, none of which have been identified as more effective or useful than the others.

However, one popular method of analyzing dreams comes from psychologist and author Dr. Patrick McNamara. His theory of the dreaming process can be explored on an individual level, allowing the client to attempt to sort through their own dreams to find meaning.

McNamara's proposed process of dreaming is as follows:

1. Step One: The dreamer disentangles their consciousness from executive control/personal agency. In other words, the dreamer de-identifies with their usual self and sets up a "liminal state"—a state in which the dreamer is prepared to explore a new identity.

2. Step Two: The dreamer moves into this liminal space, opening him- or herself up to a world of possibilities in regards to their identity. This step is like taking off your usual "mask" and

set it aside in anticipation of finding a new mask.

3. Step Three: This step typically occupies the most time and material of the dream, in which the dreamer "tries on" a new identity. The dreamer may be experiencing fear or anxiety associated with shedding their identity, and he or she may seek to reestablish a sense of control by searching for another identity or alternate sense of self.

4. Step Four: The dreamer finds a new, altered identity or resumes their old identity. McNamara believes we are searching for a more unified sense of self, but that we often find an identity that includes aspects of our darker side (McNamara, 2017).

Questions:

1. Goals of Psychodynamic Therapy
2. Explain the Traditional psychoanalysis
3. Write a short note on free association
4. Explain in detail, psychodynamic therapy
5. Infer the Therapeutic factors
6. List out defense mechanisms.
7. Infer Adlerian therapy and Jungian therapy

References

1. Gobbard, G. Beck, J. Holmes, J. (2007). Oxford Textbook of Psychotherapy. OUP: London.
2. Gerring, R.J. & Zimbardo, P.G. (2006). Psychology and Life. Pearson

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SCHOOL OF SCIENCE AND HUMANITIES

DEPARTMENT OF PSYCHOLOGY

UNIT – III – Counselling and Psychotherapy – SPSY1601

What is CBT?

"This simple idea is that our unique patterns of thinking, feeling, and behaving are significant factors in our experiences, both good and bad. Since these patterns have such a significant impact on our experiences, it follows that altering these patterns can change our experiences" (Martin, 2016).

Cognitive-behavioral therapy aims to change our thought patterns, our conscious and unconscious beliefs, our attitudes, and, ultimately, our behavior, in order to help us face difficulties and achieve our goals.

Psychiatrist Aaron Beck was the first to practice cognitive behavioral therapy. Like most mental health professionals at the time, Beck was a **psychoanalysis** practitioner.

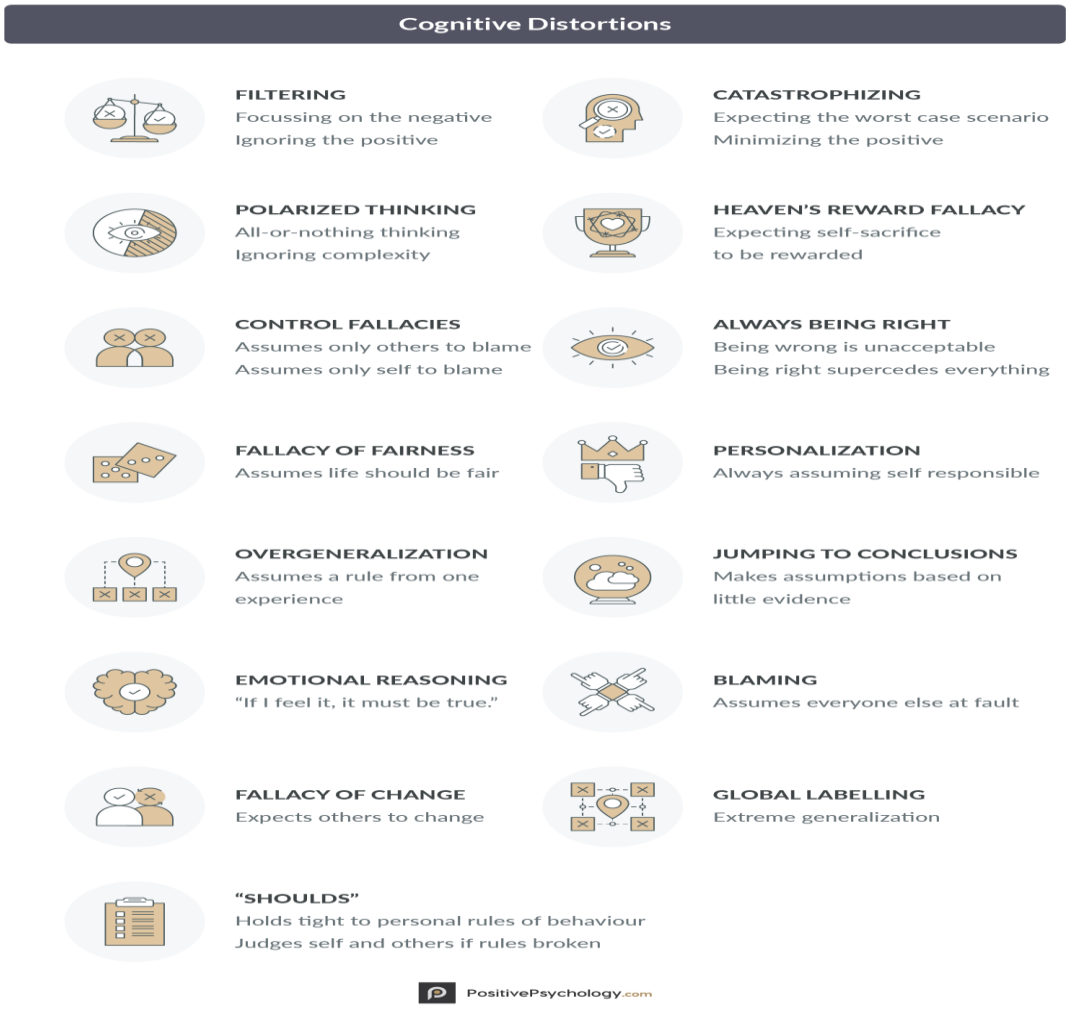
While practicing psychoanalysis, Beck noticed the prevalence of internal dialogue in his clients and realized how strong the link between thoughts and feelings can be. He altered the therapy he practiced in order to help his clients identify, understand, and deal with the automatic, **emotion-filled thoughts** that regularly arose in his clients.

Beck found that a combination of cognitive therapy and behavioral techniques produced the best results for his clients. In describing and honing this new therapy, Beck laid the foundations of the most popular and influential form of therapy of the last 50 years.

This form of therapy is not designed for lifelong participation and aims to help clients meet their goals in the near future. Most CBT treatment regimens last from five to ten months, with clients participating in one 50- to 60-minute session per week.

CBT is a hands-on approach that requires both the **therapist** and the client to be invested in the process and willing to actively participate. The therapist and client work together as a team to identify the problems the client is facing, come up with strategies for addressing them, and creating positive solutions (Martin, 2016).

Cognitive Distortions



Many of the most popular and effective cognitive-behavioral therapy techniques are applied to what psychologists call "**cognitive distortions**," inaccurate thoughts that reinforce negative thought patterns or emotions (Grohol, 2016).

There are 15 main cognitive distortions that can plague even the most balanced thinkers.

1. Filtering Filtering refers to the way a person can ignore all of the positive and good things in life to focus solely on the negative. It's the trap of dwelling on a single **negative** aspect of a situation, even when surrounded by an abundance of good things.

2. Polarized thinking / Black-and-white thinking

This cognitive distortion is all-or-nothing thinking, with no room for complexity or nuance—everything's either black or white, never shades of gray.

If you don't perform perfectly in some area, then you may see yourself as a total failure instead of simply recognizing that you may be unskilled in one area.

3. Overgeneralization

Overgeneralization is taking a single incident or point in time and using it as the sole piece of evidence for a broad conclusion.

For example, someone who overgeneralizes could bomb an important job interview and instead of brushing it off as one bad experience and trying again, they conclude that they are terrible at interviewing and will never get a job offer.

4. Jumping to conclusions

Similar to overgeneralization, this distortion involves faulty reasoning in how one makes conclusions. Unlike overgeneralizing one incident, jumping to conclusions refers to the tendency to be sure of something without any evidence at all.

For example, we might be convinced that someone dislikes us without having any real evidence, or we might believe that our fears will come true before we have a chance to really find out.

5. Catastrophizing / Magnifying or Minimizing

This distortion involves expecting that the worst will happen or has happened, based on an incident that is nowhere near as catastrophic as it is made out to be. For example, you may make a small

mistake at work and be convinced that it will ruin the project you are working on, that your boss will be furious, and that you'll lose your job.

Alternatively, one might minimize the importance of **positive things**, such as an accomplishment at work or a desirable personal characteristic.

6. Personalization

This is a distortion where an individual believes that everything they do has an impact on external events or other people, no matter how irrational that may be. A person with this distortion will feel that he or she has an exaggerated role in the bad things that happen around them.

For instance, a person may believe that arriving a few minutes late to a meeting led to it being derailed and that everything would have been fine if they were on time.

7. Control fallacies

This distortion involves feeling like everything that happens to you is either a result of purely external forces or entirely due to your own actions. Sometimes what happens to us is due to forces we can't control, and sometimes what it's due to our own actions, but the distortion is assuming that it is always one or the other.

We might assume that difficult coworkers are to blame for our own less-than-stellar work, or alternatively assume that every mistake another person makes is because of something we did.

8. Fallacy of fairness

We are often concerned about fairness, but this concern can be taken to extremes. As we all know, life is not always fair. The person who goes through life looking for fairness in all their experiences will end up resentful and unhappy.

Sometimes things will go our way, and sometimes they will not, regardless of how fair it may seem.

9. Blaming

When things don't go our way, there are many ways we can explain or assign responsibility for the outcome. One method of assigning responsibility is blaming others for what goes wrong.

Sometimes we may blame others for making us feel or act a certain way, but this is a cognitive distortion. Only you are responsible for the way you feel or act.

10. "Shoulds"

"Shoulds" refer to the implicit or explicit rules we have about how we and others should behave. When others break our rules, we are upset. When we break our own rules, we feel guilty. For example, we may have an unofficial rule that customer service representatives should always be accommodating to the customer.

When we interact with a customer service representative that is not immediately accommodating, we might get angry. If we have an implicit rule that we are irresponsible if we spend money on unnecessary things, we may feel exceedingly guilty when we spend even a small amount of money on something we don't need.

11. Emotional reasoning

This distortion involves thinking that if we feel a certain way, it must be true. For example, if we *feel* unattractive or uninteresting in the current moment, we think we *are* unattractive or uninteresting. This cognitive distortion boils down to:

"I feel it, therefore it must be true."

Clearly, our emotions are not always indicative of the objective truth, but it can be difficult to look past how we feel.

12. Fallacy of change

The fallacy of change lies in expecting other people to change as it suits us. This ties into the feeling that our **happiness** depends on other people, and their unwillingness or inability to change, even if we demand it, keeps us from being happy.

This is a damaging way to think because no one is responsible for our own happiness except ourselves.

13. Global labeling / mislabeling

This cognitive distortion is an extreme form of generalizing, in which we generalize one or two instances or qualities into a global judgment. For example, if we fail at a specific task, we may conclude that we are a total failure in not only that area but all areas.

Alternatively, when a stranger says something a bit rude, we may conclude that he or she is an unfriendly person in general. Mislabeling is specific to using exaggerated and emotionally loaded language, such as saying a woman has abandoned her children when she leaves her children with a babysitter to enjoy a night out.

14. Always being right

While we all enjoy being right, this distortion makes us think we must be right, that being wrong is unacceptable.

We may believe that being right is more important than the feelings of others, being able to admit when we've made a mistake or being fair and objective.

15. Heaven's Reward Fallacy

This distortion involves expecting that any sacrifice or self-denial will pay off. We may consider this karma, and expect that karma will always immediately reward us for our good deeds. This results in feelings of bitterness when we do not receive our reward (Grohol, 2016).

Many tools and techniques found in cognitive behavioral therapy are intended to address or reverse these cognitive distortions.

9 Essential CBT Techniques and Tools

There are many tools and techniques used in cognitive behavioral therapy, many of which can be used in both a therapy context and in everyday life. The nine techniques and tools listed below are some of the most common and effective CBT practices.

1. Journaling

This technique is a way to gather about one's moods and thoughts. A CBT **journal** can include the time of the mood or thought, the source of it, the extent or intensity, and how we reacted, among other factors.

This technique can help us to identify our thought patterns and emotional tendencies, describe them, and change, adapt, or cope with them (Utley & Garza, 2011).

2. Unraveling cognitive distortions

This is a primary goal of CBT and can be practiced with or without the help of a therapist. In order to unravel cognitive distortions, you must first become aware of the distortions from which you commonly suffer (Hamamci, 2002).

Part of this involves identifying and challenging harmful automatic thoughts, which frequently fall into one of the 15 categories listed earlier.

3. Cognitive restructuring

Once you identify the distortions you hold, you can begin to explore how those distortions took root and why you came to believe them. When you discover a belief that is destructive or harmful, you can begin to challenge it (Larsson, Hooper, Osborne, Bennett, & McHugh, 2015).

For example, if you believe that you must have a high-paying job to be a respectable person, but you're then laid off from your high-paying job, you will begin to feel bad about yourself.

Instead of accepting this faulty belief that leads you to think negative thoughts about yourself, you could take an opportunity to think about what really makes a person "respectable," a belief you may not have explicitly considered before.

4. Exposure and response prevention

This technique is specifically effective for those who suffer from **obsessive-compulsive disorder** (OCD; Abramowitz, 1996). You can practice this technique by exposing yourself to whatever it is that normally elicits a compulsive behavior, but doing your best to refrain from the behavior.

You can combine journaling with this technique, or use journaling to understand how this technique makes you feel.

5. Interoceptive exposure

This technique is intended to treat panic and **anxiety**. It involves exposure to feared bodily sensations in order to elicit the response (Arntz, 2002). Doing so activates any unhelpful beliefs associated with the sensations, maintains the sensations without distraction or avoidance, and allows new learning about the sensations to take place.

It is intended to help the sufferer see that symptoms of panic are not dangerous, although they may be uncomfortable.

6. Nightmare exposure and rescripting

Nightmare exposure and rescripting are intended specifically for those suffering from nightmares. This technique is similar to interoceptive exposure, in that the nightmare is elicited, which brings up the relevant emotion (Pruiksma, Cranston, Rhudy, Micol, & Davis, 2018).

Once the emotion has arisen, the client and therapist work together to identify the desired emotion and develop a new image to accompany the desired emotion.

7. Play the script until the end

This technique is especially useful for those suffering from fear and anxiety. In this technique, the individual who is vulnerable to crippling fear or anxiety conducts a sort of thought experiment in which they imagine the outcome of the worst-case scenario.

Letting this scenario play out can help the individual to recognize that even if everything he or she fears comes to pass, the outcome will still be manageable (Chankapa, 2018).

8. Progressive muscle relaxation

This is a familiar technique to those who practice mindfulness. Similar to the body scan, this technique instructs you to relax one muscle group at a time until your whole body is in a state of relaxation (McCallie, Blum, & Hood, 2006).

You can use audio guidance, a YouTube video, or simply your own mind to practice this technique, and it can be especially helpful for calming nerves and soothing a busy and unfocused mind.

9. Relaxed breathing

This is another technique that will be familiar to practitioners of **mindfulness**. There are many ways to relax and bring regularity to your breath, including guided and unguided imagery, audio recordings, YouTube videos, and scripts. Bringing regularity and calm to your breath will allow you to approach your problems from a place of balance, facilitating more effective and rational decisions (Megan, 2016).

These techniques can help those suffering from a range of mental illnesses and afflictions, including anxiety, depression, OCD, and panic disorder, and they can be practiced with or without the guidance

of a therapist. To try some of these techniques without the help of a therapist, see the next section for worksheets and handouts to assist with your practice.

Cognitive-Behavioral Therapy Worksheets (PDFs) To Print and Use

If you're a therapist looking for ways to guide your client through treatment or a hands-on person who loves to learn by doing, there are many cognitive behavioral therapy worksheets that can help.

1. Coping styles worksheet

This PDF **Coping Styles Formulation Worksheet** instructs you or your client to first list any current perceived problems or difficulties – "The Problem". You or your client will work backward to list risk factors above (i.e., why you are more likely to experience these problems than someone else) and triggers or events (i.e., the stimulus or source of these problems).

Once you have defined the problems and understand why you are struggling with them, you then list coping strategies. These are not solutions to your problems, but ways to deal with the effects of those problems that can have a temporary impact. Next, you list the effectiveness of the coping strategies, such as how they make you feel in the short- and long-term, and the advantages and disadvantages of each strategy.

Finally, you move on to listing alternative actions. If your coping strategies are not totally effective against the problems and difficulties that are happening, you are instructed to list other strategies that may work better.

This worksheet gets you (or your client) thinking about what you are doing now and whether it is the best way forward.

2. ABC functional analysis

One popular technique in CBT is *ABC functional analysis*. This technique helps you (or the client) learn about yourself, specifically, what leads to specific behaviors and what consequences result from those behaviors.

In the middle of the worksheet is a box labeled “Behaviors.” In this box, you write down any potentially problematic behaviors you want to analyze.

On the left side of the worksheet is a box labeled “Antecedents,” in which you or the client write down the factors that preceded a particular behavior. These are factors that led up to the behavior under consideration, either directly or indirectly.

On the right side is the final box, labeled “Consequences.” This is where you write down what happened as a result of the behavior under consideration. “Consequences” may sound inherently negative, but that’s not necessarily the case; some positive consequences can arise from many types of behaviors, even if the same behavior also leads to negative consequences.

This **ABC Functional Analysis Worksheet** can help you or your client to find out whether particular behaviors are adaptive and helpful in striving toward your goals, or destructive and self-defeating.

3. Case formulation worksheet

In CBT, there are 4 “P’s” in *Case Formulation:*

- Predisposing factors;
- Precipitating factors;
- Perpetuating factors; and
- Protective factors

They help us understand what might be leading a perceived problem to arise, and what might prevent them from being tackled effectively.

In this worksheet, a therapist will work with their client through 4 steps.

First, they identify predisposing factors, which are those external or internal and can add to the likelihood of someone developing a perceived problem (“The Problem”). Examples might include genetics, life events, or their temperament.

Together, they collaborate to identify precipitating factors, which provide insight into precise events or triggers that lead to "The Problem" presenting itself. Then they consider perpetuating factors, to discover what reinforcers may be maintaining the current problem.

Last, they identify protective factors, to understand the client's strengths, social supports, and adaptive behavioral patterns.

4. Extended case formulation worksheet

This worksheet builds on the last. It helps you or your client address the "Four P Factors" described just above—predisposing, precipitating, perpetuating, and protective factors. This formulation process can help you or your client connect the dots between core beliefs, thought patterns, and present behavior.

This worksheet presents six boxes on the left of the page (Part A), which should be completed before moving on to the right-hand side of the worksheet (Part B).

1. The first box is labeled "The Problem," and corresponds with the perceived difficulty that your client is experiencing. In this box, you are instructed to write down the events or stimuli that are linked to a certain behavior.

2. The next box is labeled "Early Experiences" and corresponds to the *predisposing* factor. This is where you list the experiences that you had early in life that may have contributed to the behavior.

3. The third box is "Core Beliefs," which is also related to the *predisposing* factor. This is where you write down some relevant core beliefs you have regarding this behavior. These are beliefs that may not be explicit, but that you believe deep down, such as "I'm bad" or "I'm not good enough."

4. The fourth box is “Conditional assumptions/rules/attitudes,” which is where you list the rules that you adhere to, whether consciously or subconsciously. These implicit or explicit rules can *perpetuate* the behavior, even if it is not helpful or adaptive. Rules are if-then statements that provide a judgment based on a set of circumstances. For instance, you may have the rule “If I do not do something perfectly, I’m a complete failure.”

5. The fifth box is labeled “Maladaptive Coping Strategies” This is where you write down how well these rules are working for you (or not). Are they helping you to be the best you can be? Are they helping you to effectively strive towards your goals?

6. Finally, the last box us titled “Positives.” This is where you list the factors that can help you deal with the problematic behavior or thought, and perhaps help you break the perpetuating cycle. These can be things that help you cope once the thought or behavior arises or things that can disrupt the pattern once it is in motion.

On the right, there is a flow chart that you can fill out based on how these behaviors and feelings are perpetuated. You are instructed to think of a situation that produces a negative automatic thought and record the emotion and behavior that this thought provokes, as well as the bodily sensations that can result. Filling out this flow chart can help you see what drives your behavior or thought and what results from it.

5. Dysfunctional thought record

This worksheet is especially helpful for people who struggle with **negative thoughts** and need to figure out when and why those thoughts are most likely to pop up. Learning more about what provokes certain automatic thoughts makes them easier to address and reverse.

The worksheet is divided into seven columns:

1. On the far left, there is space to write down the date and time a dysfunctional thought arose.

2. The second column is where the situation is listed. The user is instructed to describe the event that led up to the dysfunctional thought in detail.

3. The third column is for the automatic thought. This is where the dysfunctional automatic thought is recorded, along with a rating of belief in the thought on a scale from 0% to 100%.

4. The next column is where the emotion or emotions elicited by this thought are listed, also with a rating of intensity on a scale from 0% to 100%.

5. Use this fifth column to note the dysfunctional thought that will be addressed. Example maladaptive thoughts include distortions such as over-inflating the negative while dismissing the positive of a situation, or overgeneralizing.

6. The second-to-last column is for the user to write down alternative thoughts that are more positive and functional to replace the negative one.

7. Finally, the last column is for the user to write down the outcome of this exercise. Were you able to confront the dysfunctional thought? Did you write down a convincing alternative thought? Did your belief in the thought and/or the intensity of your emotion(s) decrease?

6. Fact-checking

One of my favorite CBT tools is this **Fact Checking Thoughts Worksheet** because it can be extremely helpful in recognizing that your thoughts are not necessarily true.

At the top of this worksheet is an important lesson:

Thoughts are not facts.

Of course, it can be hard to accept this, especially when we are in the throes of a dysfunctional thought or intense emotion. Filling out this worksheet can help you come to this realization.

The worksheet includes 16 statements that the user must decide are either fact or opinion. These statements include:

- I'm a bad person.
- I failed the test.
- I'm selfish.
- I didn't lend my friend money when they asked.

This is not a trick—there is a right answer for each of these statements. (In case you're wondering, the correct answers for the statements above are as follows: opinion, fact, opinion, fact.)

This simple exercise can help the user to see that while we have lots of emotionally charged thoughts, they are not all objective truths. Recognizing the difference between fact and opinion can assist us in challenging the dysfunctional or harmful opinions we have about ourselves and others.

7. Cognitive restructuring

This worksheet employs the use of Socratic questioning, a technique that can help the user to challenge irrational or illogical thoughts.

The first page of the worksheet has a thought bubble for "What I'm Thinking". You or your client can use this space to write down a specific thought, usually, one you suspect is destructive or irrational.

Next, you write down the facts supporting and contradicting this thought as a reality. What facts about this thought being accurate? What facts call it into question? Once you have identified the evidence, you can use the last box to make a judgment on this thought, specifically whether it is based on evidence or simply your opinion.

The next page is a mind map of Socratic Questions which can be used to further challenge the thought. You may wish to re-write "What I'm Thinking" in the center so it is easier to challenge the thought against these questions.

- One question asks whether this thought is truly a black-and-white situation, or whether reality leaves room for shades of gray. This is where you think about (and write down) whether you are using all-or-nothing thinking, for example, or making things unreasonably simple when they are complex.

- Another asks whether you could be misinterpreting the evidence or making any unverified assumptions. As with all the other bubbles, writing it down will make this exercise more effective.

- A third bubble instructs you to think about whether other people might have different interpretations of the same situation, and what those interpretations might be.

- Next, ask yourself whether you are looking at all the relevant evidence or just the evidence that backs up the belief you already hold. Try to be as objective as possible.

- It also helps to ask yourself whether your thought may an over-inflation of a truth. Some negative thoughts are based in truth but extend past their logical boundaries.

- You're also instructed to consider whether you are entertaining this negative thought out of habit or because the facts truly support it.

- Then, think about how this thought came to you. Was it passed on from someone else? If so, is that person a reliable source of truth?

- Finally, you complete the worksheet by identifying how likely the scenario your thought brings up actually is, and whether it is the worst-case scenario.

These Socratic questions encourage a deep dive into the thoughts that plague you and offer opportunities to analyze and evaluate those thoughts. If you are having thoughts that do not come

from a place of truth, this **Cognitive Restructuring Worksheet** can be an excellent tool for identifying and defusing them.

Some More CBT Interventions and Exercises

Haven't had enough **CBT tools** and techniques yet? Read on for additional useful and effective exercises.

1. Behavioral experiments

These are related to thought experiments, in that you engage in a "what if" consideration. Behavioral experiments differ from thought experiments in that you actually test out these "what ifs" outside of your thoughts (Boyes, 2012).

In order to test a thought, you can experiment with the outcomes that different thoughts produce. For example, you can test the thoughts:

"If I criticize myself, I will be motivated to work harder" versus "If I am kind to myself, I will be motivated to work harder."

First, you would try criticizing yourself when **you need the motivation** to work harder and record the results. Then you would try being kind to yourself and recording the results. Next, you would compare the results to see which thought was closer to the truth.

These **Behavioral Experiments to Test Beliefs** can help you learn how to achieve your therapeutic goals and how to be your best self.

2. Thought records

Thought records are useful in testing the validity of your thoughts (Boyes, 2012). They involve gathering and evaluating evidence for and against a particular thought, allowing for an evidence-based conclusion on whether the thought is valid or not.

For example, you may have the belief "My friend thinks I'm a bad friend." You would think of all the evidence for this belief, such as "She didn't answer the phone the last time I called," or "She canceled our plans at the last minute," and evidence against this belief, like "She called me back after not answering the phone," and "She invited me to her barbecue next week. If she thought I was a bad friend, she probably wouldn't have invited me."

Once you have evidence for and against, the goal is to come up with more balanced thoughts, such as, “My friend is busy and has other friends, so she can’t always answer the phone when I call. If I am understanding of this, I will truly be a good friend.”

Thought records apply the use of logic to ward off unreasonable negative thoughts and replace them with more balanced, rational thoughts (Boyes, 2012).

3. Pleasant activity scheduling

This technique can be especially helpful for dealing with **depression** (Boyes, 2012). It involves scheduling activities in the near future that you can look forward to.

For example, you may write down one activity per day that you will engage in over the next week. This can be as simple as watching a movie you are excited to see or calling a friend to chat. It can be anything that is pleasant for you, as long as it is not unhealthy (i.e., eating a whole cake in one sitting or smoking).

You can also try scheduling an activity for each day that provides you with a sense of mastery or accomplishment (Boyes, 2012). It’s great to do something pleasant, but doing something small that can make you feel accomplished may have more long-lasting and far-reaching effects.

This simple technique can introduce more positivity into your life, and our **Pleasant Activity Scheduling Worksheet** is designed to help.

4. Imagery-based exposure

This exercise involves thinking about a recent memory that produced strong negative emotions and analyzing the situation.

For example, if you recently had a fight with your significant other and they said something hurtful, you can bring that situation to mind and try to remember it in detail. Next, you would try to label the emotions and thoughts you experienced during the situation and identify the urges you felt (e.g., to run away, to yell at your significant other, or to cry).

Visualizing this negative situation, especially for a prolonged period of time, can help you to take away its ability to trigger you and reduce avoidance coping (Boyes, 2012). When you expose yourself

to all of the feelings and urges you felt in the situation and survive experiencing the memory, it takes some of its power away.

This **Imagery Based Exposure Worksheet** is a useful resource for this exercise.

5. Graded exposure worksheet

This technique may sound complicated, but it's relatively simple.

Making a situation exposure hierarchy involves means listing situations that you would normally avoid (Boyes, 2012). For example, someone with severe **social anxiety** may typically avoid making a phone call or asking someone on a date.

Next, you rate each item on how distressed you think you would be, on a scale from 0 to 10, if you engaged in it. For the person suffering from severe social anxiety, asking someone on a date may be rated a 10 on the scale, while making a phone call might be rated closer to a 3 or 4.

Once you have rated the situations, you rank them according to their distress rating. This will help you recognize the biggest difficulties you face, which can help you decide which items to address and in what order. It's often advised to start with the least distressing items and work your way up to the most distressing items.

5 Final Cognitive Behavioral Activities

Before we go, there are a few more CBT activities and exercises that may be helpful for you or your clients that we'd like to cover.

1. Mindfulness meditation

Mindfulness can have a wide range of positive impacts, including helping with depression, anxiety, addiction, and many other mental illnesses or difficulties.

The practice can help those suffering from harmful automatic thoughts to disengage from rumination and obsession by helping them stay firmly grounded in the present (Jain et al., 2007).

Mindfulness meditations, in particular, can function as helpful tools for your clients in between therapy sessions, such as to help ground them in the present moment during times of stress. If you

are a therapist who uses mindfulness-based approaches, consider finding or pre-recording some short mindfulness meditation exercises for your clients.

You might then share these with your clients as part of a toolkit they can draw on at their convenience, such as using the blended care platform **Quenza** (pictured here), which allows clients to access meditations or other psychoeducational activities on-the-go via their portable devices.

2. Successive approximation

This is a fancy name for a simple idea that you have likely already heard of: breaking up large tasks into small steps.

It can be overwhelming to be faced with a huge goal, like opening a business or remodeling a house. This is true in mental health treatment as well, since the goal to overcome depression or anxiety and achieve mental wellness can seem like a monumental task.

By breaking the large goal into small, easy-to-accomplish steps, we can map out the path to success and make the journey seem a little less overwhelming (e.g., Emmelkamp & Ultee, 1974).

3. Writing self-statements to counteract negative thoughts

This technique can be difficult for someone who's new to CBT treatment or suffering from severe symptoms, but it can also be extremely effective (Anderson, 2014).

When you (or your client) are being plagued by negative thoughts, it can be hard to confront them, especially if your belief in these thoughts is strong. To counteract these negative thoughts, it can be helpful to write down a positive, opposite thought.

For example, if the thought "I am worthless" keeps popping into your head, try writing down a statement like "I am a person with worth," or "I am a person with potential." In the beginning, it can be difficult to accept these replacement thoughts, but the more you bring out these positive thoughts to counteract the negative ones, the stronger the association will be.

4. Visualize the best parts of your day

When you are feeling depressed or negative, it is difficult to recognize that there are positive aspects of life. This simple technique of bringing to mind the good parts of your day can be a small step in the direction of recognizing the positive (Anderson, 2014).

All you need to do is write down the things in your life that you are **thankful** for or the most positive events that happen in a given day. The simple act of writing down these good things can forge new associations in your brain that make it easier to see the positive, even when you are experiencing negative emotions.

5. Reframe your negative thoughts

It can be easy to succumb to negative thoughts as a default setting. If you find yourself immediately thinking a negative thought when you see something new, such as entering an unfamiliar room and thinking "I hate the color of that wall," give reframing a try (Anderson, 2014).

Reframing involves countering the negative thought(s) by noticing things you feel positive about as quickly as possible. For instance, in the example where you immediately think of how much you hate the color of that wall, you would push yourself to notice five things in the room that you feel positively about (e.g., the carpet looks comfortable, the lampshade is pretty, the windows let in a lot of sunshine).

You can set your phone to remind you throughout the day to stop what you are doing and think of the positive things around you. This can help you to push your thoughts back into the realm of the positive instead of the negative.

Questions:

1. Define Cognitive therapy
2. Explain its Basic principles
3. Explain in detail the theoretical background, history and development.
4. What you mean by Cognitive conceptualization.
5. Infer Behavior therapy and its Basic principles, theoretical background, history and development.
6. Explain the Techniques of classical conditioning and operant conditioning.

References

3. Gobbard, G. Beck, J. Holmes, J. (2007). Oxford Textbook of Psychotherapy. OUP: London.
4. Gerring, R.J. & Zimbardo, P.G. (2006). Psychology and Life. Pearson

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SCHOOL OF SCIENCE AND HUMANITIES

DEPARTMENT OF PSYCHOLOGY

UNIT – IV– Counselling and Psychotherapy – SPSY1601

What is Existential Therapy / Psychotherapy? A Definition

Existential therapy (or existential **psychotherapy**) is based on some of the main ideas behind existentialism as a philosophy, including:

- We are responsible for our own choices.
- We are all unique individuals due to the choices we make, and we are constantly remaking ourselves through these choices.
- We make our own **meaning in life**.
- **Anxiety** is a natural feature of human life.
- We must come to terms with this anxiety to live authentically (Burnham & Papandreopoulos, n.d.).

Built on these foundations, existential therapy aims to aid clients in accepting and overcoming the existential fears inherent in being human. These fears include:

- Freedom and responsibility
- Death
- Isolation
- Meaninglessness (Vallejos, 2016)

Coming face to face with any of the above, or realizing that you will confront one or all of these eventually, can provoke an overwhelming sense of dread or anxiety, potentially leading to a multitude of psychological and emotional dysfunctions.

While it may be comforting to simply not think about the inevitability of death or the loneliness we all experience from time to time, or to deny this inevitability, avoiding reality will not help us to live to address the real issues. Without accepting and finding a way to live with these realities of being human, it is impossible to live authentically.

Existential therapy will guide clients in learning to take responsibility for their own choices and making choices that align with their **values** and help them to live more authentically. This form of

therapy will not focus on fancy techniques or assigning homework to reach the desired results. The point is not necessarily to learn certain skills or pick up a particular habit but to form a realistic and authentic relationship with life.

Similarly, existential therapists are not the cold and aloof professionals or the white tower intellectuals of psychoanalysis, nor are they experts who assign the magical combination of exercises and assignments that allow a client to heal. Rather, existential therapists are fellow humans undergoing the same journeys and dealing with the same inevitable truths of the human condition (Diamond, 2011).

Founders of Existential Therapy

While the original philosophers credited with their contributions to existentialist thought may be considered the founders of existential therapy, there were a few practicing therapists who did the legwork of incorporating existentialism into a cohesive therapy.

Rank could be considered the "founding father" of existential therapy, given his initial foray into combining existentialism with psychoanalysis (Good Therapy, 2013). While he began his career mostly in sync with Freud and the theories behind psychoanalysis, Rank became more focused on the present than the past and more accepting of the emotions that are inherent in being human.

Paul Tillich and Rollo May carried on the existential therapy torch and helped bring it into the mainstream in the mid-20th century (Vallejos, 2016).

Irvin Yalom, another important personality in existential therapy, added his eleven therapeutic factors to **group therapy** in general, which included the importance of accepting and learning to exist with existential fears. This contribution helped popularize existential therapy as a type of therapy, while also adding a touch of existential therapy concepts to all group therapies that embraced Yalom's eleven factors (Good Therapy, 2015).

The Right Circumstances for Existential Therapy

Existential therapy is not appropriate for every individual or for every situation. Like all other forms of treatment, there are circumstances in which this therapy is most effective and circumstances in which another type of therapy would be advised.

Existential therapy is an excellent method for treating the psychological and emotional instabilities or dysfunctions that stem from the basic anxieties of human life (as noted above, freedom and responsibility, death, isolation, and meaninglessness). This can include depression and anxiety, substance abuse and addiction, and posttraumatic stress.

It will be especially effective for people who are open-minded and willing to explore the heavier themes in life, as well as those searching for and struggling to find meaning (Vallejos, 2016).

Due to the nature of existentialism, existential therapy is likely to help clients bring about a lasting change in their perspective, rather than encouraging short-term effort that the client may lose motivation to continue as soon as the sessions end.

However, existential therapy's focus on the main anxieties of human life may result in blindness to more immediate concerns or ignorance of the underlying issues a client is facing. It's all well and good to help a client overcome their fear of death, but if they are also facing paranoid delusions, overcoming the existential dread of death may not be the top priority at the moment.

This type of therapy may also be harmful to those who do not wish to dive into the existential depths, especially those who are purposefully avoiding confrontation with these ideas. While it is to every individual's benefit to come to terms with these inevitabilities, not every individual is ready to embrace existentialist ideas at any moment.

For some individuals, pushing them into consideration of death, isolation, and meaninglessness may result in unintended consequences, including deep depression, suicidal thoughts, or even suicide attempts.

Similarly, an individual who is only looking for a quick fix to his or her current challenges may not be ready or willing to dive into such an intense form of therapy (Vallejos, 2016).

The Existential Therapy Relationship

While the therapeutic relationship is vital in any form of therapy, it is especially important in existential therapy. As mentioned earlier, **the therapist** is not a distant expert who is magnanimously guiding a client through self-discovery; rather, he or she is a fellow human who has also experienced

existential anxiety and fear and aims to guide others through the difficult process of accepting and living with the inevitabilities of human life.

The therapist is not a passive or neutral presence in the therapy room. He or she is an active participant in the therapy sessions and must engage authentically with the client in order to facilitate healing. In existential therapy, putting up a composed and professional front can harm more than it helps – clients need to be able to connect with the therapist on a personal level.

Existential therapy may incorporate techniques or ideas from other forms of therapy, including **cognitive**, behavioral, **narrative**, and others, but all existential therapy sessions depend on the productive and close relationship between therapist and client to succeed (Diamond, 2011).

Questions:

1. What is Humanistic therapy?
2. Describe client- centered therapy
3. Explain the meaning of existence and purpose in life
4. What you mean by self-actualization?
5. Describe Gestalt therapy
6. Infer Existential therapy and logo therapy

References

5. Gobbard, G. Beck, J. Holmes, J. (2007). Oxford Textbook of Psychotherapy. OUP: London.
6. Gerring, R.J. & Zimbardo, P.G. (2006). Psychology and Life. Pearson

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SCHOOL OF SCIENCE AND HUMANITIES

DEPARTMENT OF PSYCHOLOGY

UNIT – V– Counselling and Psychotherapy – SPSY1601

What is Rational Emotive Behavior Therapy? A Definition

As suggested by the scenario above, rational emotive behavior therapy (REBT) differed from the other mainstream therapies of its day, mainly in the importance it placed on discussing and adapting how clients think (Ellis & Dryden, 1987).

It may sound obvious today, but Ellis' idea that the way we think has a significant impact on the way we feel was not a popularly held belief before he introduced his form of therapy.

Not only does REBT rest on the belief that the way we think influences our emotions and behavior, it attempts to help clients change the way they think to reduce negative symptoms and improve their **quality of life** (Albert Ellis Institute, 2014).

"People are not disturbed by things but rather by their view of things."-Albert Ellis

As this quote from Ellis shows, Rational Emotive Behavior Therapy assumes that many people with emotional or behavioral problems struggle due to the way they perceive their experiences rather than simply the experiences themselves. REBT aims to facilitate change in core beliefs and thought patterns that will clients more effectively deal with their problems and improve their ability to function and feel in a **healthy way** (Dryden, David, & Ellis, 2010).

REBT also differs from other early forms of therapy in its focus on the present; in fact, according to Ellis, a common irrational belief is that our past has a significant influence on our present life (McLeod, 2015)! While our past does, of course, shape who we are today, it is an irrational belief if you feel you cannot escape your past.

The goal of Rational Emotive Behavior Therapy is best summarized as "disputing" – challenging and questioning our irrational and dysfunctional beliefs and replacing them with more sensible and functional beliefs. The result is not just changes in a few thought patterns or reducing some problematic symptoms, but a **new perspective on life** (Albert Ellis Institute, 2014).

Theories Behind REBT

The theory underpinning this type of therapy is that humans are not entirely rational creatures (Taylor, 2016). This should go without saying, but sometimes we can use a reminder that humans are not simple computers that take an input, read it logically, and produce an appropriate output; rather, we

are complex “computers” with an unfathomably large number of inputs, complicated and mysterious internal processes, and an unfathomably large number of potential outputs.

While it is (as far as we know) impossible to be entirely rational, Ellis believed that approaching our problems in a more rational way could have a significant impact on our negative emotions and dysfunctional behaviors (Albert Ellis Institute, 2014). The most important challenge to tackle on the road to rationality is our dysfunctional or illogical thinking.

Ellis theorized that many of our emotional and behavioral problems spring from basic irrational assumptions or assumptions that are not totally grounded in reality and influence people to act in ways that are inappropriate, unhelpful, or even destructive (McLeod, 2015).

Based on this idea, Ellis developed a model to help explain, describe, and treat emotional and behavioral disturbances.

The ABCDE Model of Emotional Disturbance

Ellis hypothesized that irrational beliefs are the result of a person’s goals or desires being inhibited or blocked. When we don’t get or accomplish what we wanted to, we may develop irrational beliefs about ourselves or the world that help explain what happened (Ross, n.d.).

For example, imagine you are dead set on getting a job you applied for. You study up on the company, practice your interview answers, and make sure you’re looking extra sharp the day of the interview. Although you prepared extensively, the hiring manager decided to go with another candidate.

You may accept that this just wasn’t meant to be, or that you just weren’t the right fit for the job. However, you may also be heavily impacted by the decision and develop an irrational belief about why you didn’t get the job.

You might think, “I didn’t get this job because they can see that I’m a loser. I’m not good at anything and I never will be.”

Or, you might think, “The only reason I didn’t get this job is because the hiring manager had it out for me. It’s like the universe has it out for me!”

Both of these are thoughts that can help you explain why you didn’t get the job, but they are irrational and can lead to negative emotions and behavior down the road.

Using this scenario as an example, this is how the **ABCDE model** can explain the development (and the solution) of such problems (Ellis & Dryden, 1987):

A – Activating Event / Adversity

An activating event or adversity is something that triggers you to form an irrational belief, such as being turned down for the position. It is the first step in developing an irrational thought because the irrational thought is formed to **help you deal** with the event.

B – Irrational Belief

The "B" stands for the irrational belief that is formed in response to the activating event. This is a belief that you use to cope with the event, such as "I'm a loser, I'm useless, and I wouldn't be able to do the job anyway." While this is, of course, an incredibly hurtful thought, it can still be more comforting than having no idea why you didn't get the job. Irrational beliefs are surprisingly easy to develop.

C – Emotional and Behavioral Consequences

The third component is the consequences of this irrational belief. Irrational beliefs always have consequences, sometimes emotional, sometimes behavior, and sometimes both. In this case, the consequences may be that you lose your **self-confidence** or frequently feel sad (emotional) and stop applying to any jobs (behavioral).

D – Disputes or Arguments

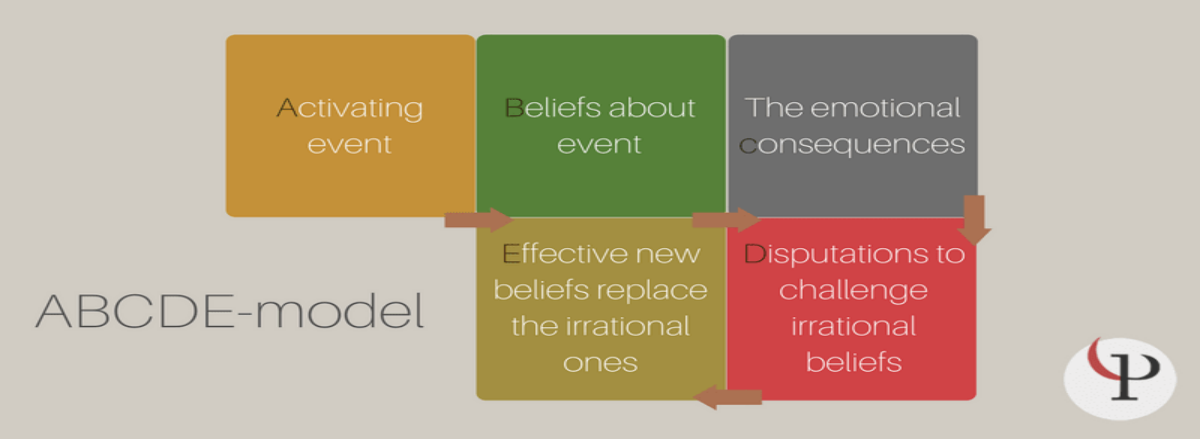
At some point, you may realize that you have an irrational belief that is causing you problems. You notice your loss of self-confidence and negative thoughts about yourself and begin to argue against your irrational belief. If you're working with a therapist, the therapist may help guide you in developing arguments against the belief and help you come up with evidence to the contrary, such as "I have an amazing spouse. My spouse wouldn't be with a 'loser' so I must not be a loser."

E – New Effect

When you have successfully countered the irrational belief, you will notice new (hopefully more positive!) consequences or effects. In our scenario, these effects might be increased confidence, applying to more jobs, and feeling good about your abilities. These effects are the positive outcomes

of holding more rational thoughts, like “I just wasn’t a good fit for that job, but I’ll find another” or “Maybe the hiring manager really didn’t like me, but that’s her loss” (McLeod, 2015).

The ABCDE model can be extremely helpful in tracing the development of irrational thought and providing a high-level outline of how to challenge and replace it.



REBT Exercises & Worksheets

There are many exercises, techniques, and **interventions grounded in Rational Emotive Behavior Therapy** and **CBT theory** that therapists use in treatment. There are also many exercises that can be completed individually if you are not currently working with a therapist.

This is a very small selection of the many great exercises available, but they provide a good representation of the kinds of activities that can help identify, challenge, and adapt harmful or destructive ways of thinking.

Identifying and Challenging Irrational Beliefs

This is a commonly used exercise in Rational Emotive Behavior Therapy and **CBT** in general, as it gets to the root of the problem according to REBT theory: the irrational belief.

This “Dysfunctional Thought Record” worksheet will walk you through the exercise. It includes a structured **journal** format in which the client can record their irrational thoughts and look for patterns or commonalities to get to the source of their problems.

The worksheet is divided into seven columns and includes enough space to note multiple irrational or dysfunctional thoughts.

1. In the first column, the client is to write down the date and time.
2. In the second column, the client should describe the situation they were in.
3. The third column is for writing down the automatic thought that arose.
4. In column four, clients should note the associated emotions they felt.
5. Column five is where the client should list any cognitive distortions that came up during this situation and automatic thoughts.
6. In the next column, the client should brainstorm effective alternative thoughts that can fight the dysfunctional automatic thoughts.
7. Finally, the seventh column is for writing down the outcome of the situation.

This exercise will facilitate the identification of negative, irrational beliefs and the development of effective arguments against these beliefs. Keeping a record of these thoughts can help anyone to organize their thoughts, connect their beliefs to their reactions, and discover potential patterns of irrational beliefs.

Consequences Analysis

This exercise can help clients recognize the consequences of their irrational beliefs about the things that are important to them. It can also assist the client in developing a solution that goes straight to the source instead of applying an emotional "Band-Aid" to their symptoms.

This "REBT Consequences Analysis" form can guide you or your clients through the exercise.

The first section of the worksheet is labeled "Target." It directs the client to identify a salient issue or problem they are struggling with. In addition, it directs the client to think about what their most important goals or values are, and to write these down as well.

The second section is labeled "Short-term consequences." This section gives the client space to write down the benefits (gains, pleasures, comforts) as well as the costs (damages, harms, losses) of continuing with their usual behavior. Once they have identified the benefits and costs, they can rate each area in terms of personal importance on a scale from 0 (lowest importance) to 100 (highest importance).

The third section is in the same format as the second section but focuses the client on long-term consequences instead of short-term consequences. Once again, clients are instructed to identify the benefits and costs of continuing with business as usual and rating the importance in these areas on a scale from 0 (lowest importance) to 100 (highest importance).

Finally, the worksheet asks the client, "What is the best outcome for you in the long-term?" Here, the client should consider the short- and long-term benefits and costs, and compare the expected consequences of continuing with their current thinking or behavior versus making some changes now.

Replacing Negative Beliefs with Positive Beliefs

This fundamental exercise helps clients confront negative and irrational automatic thoughts or beliefs. It encourages the use of reason and rationality to replace old, **self-critical beliefs** with new, more positive and more functional beliefs.

The Positive Belief Record worksheet can help clients complete this exercise.

It's an extremely simple and straightforward method of challenging one's beliefs with a scientific approach.

At the top of the worksheet, the client will find two boxes where he or she can write down the old belief and come up with a new belief to replace it.

Underneath the two beliefs is the heading "Evidence that supports the new belief (or isn't entirely consistent with the old belief." As you probably guessed, this is where the client can list the evidence that challenges their negative, irrational beliefs.

Enough space is provided to write down 10 pieces of evidence that support the new belief, or call the old belief into question. This evidence can include experiences you have had, something someone else has said to you, or anything else you can think of that supports the new belief or sheds doubt on the old belief.

Problem Formulation

This is another exercise that uses a rational approach to connect a situation to the usual response that follows and compares the usual outcome to the outcome if a more positive response occurred.

This worksheet outlines two types of emotional responses: unhealthy or problematic responses, and healthy (or target) responses.

In the first section, the client is instructed to identify and describe an activating event. This is an event that provokes an emotional response (the "A" in the ABCDE model). There are four subsections for the client to complete:

1. Describe the situation.
2. Isolate the critical factor (what it was about the event that affected you).
3. Notice and accept bodily sensations.
4. Invent a symbol/metaphor for the experience (one that explains how it felt).

Next, the client will describe the problematic response that follows this activating event ("B" and "C" in the ABCDE model).

The client is instructed to name the emotion, then list the thoughts and images associated with it (i.e., what was happening in your mind during the event?) and the actions and intentions that followed (i.e., how you reacted or wanted to react).

Finally, the client should describe what the healthy response would look like for him or her (the "E" in the ABCDE model).

The first component of the healthy response is the target emotion. Once the client has identified the target emotion, he or she should list the cognitive objectives (i.e., how the client would need to think in order to feel this emotion) and the behavioral objectives (i.e., what the client would need to do in order to feel this emotion).

This worksheet can help guide clients through a comparison of these two types of responses and help them recognize what a healthy response is. It can also help clients develop a plan to make the healthy response their default.

How REBT Relates to Positive Psychology

While Rational Emotive Behavior Therapy was developed long before **positive psychology** arrived on the psychology scene (around 1998-99), they share many of the same goals and areas of focus. Of

course, there are some areas of disagreement between the two, such as the strict focus on rationality in REBT versus the importance many positive psychologists place on feelings or even intuition, but in general, they fit together quite well.

Upon review of Rational Emotive Behavior Therapy and positive psychology, it turns out they have a lot in common:

- They both focus on removing or challenging the negative.
- They both place great importance on not only removing the negative but also on replacing the negative with positive.
- They both assume that people are competent and capable, and rely on guiding people through the process of finding better options for themselves and choosing the positive.
- They both recognize the vital importance of how people think, rather than focusing only on what they think.
- The ultimate goal for both REBT and positive psychology is to help people live better, more fulfilling, and happier lives.

Most importantly, even though there are theoretical differences and disagreements, they are not mutually exclusive. A client or practitioner in Rational Emotive Behavior Therapy will likely find much support and encouragement in positive psychology, and many positive psychologists recognize the importance of therapies like REBT and CBT.

It would not be incongruent to find a form of therapy that draws from both Rational Emotive Behavior Therapy and positive psychology.

Ultimately, any theoretical or philosophical differences between Rational Emotive Behavior Therapy and positive psychology are not really relevant, since they share the goal of improving lives by enhancing **positive emotions**, positive thoughts, and positive behaviors.

A Take Home Message

Hopefully, this piece has given you a useful introduction to the world of Rational Emotive Behavior Therapy. Although Rational Emotive Behavior Therapy was developed several decades ago, it is still

in use by psychologists and therapists around the world, and it helped lay the foundations for subsequent therapies that target the client's cognition.

Rational Emotive Behavior Therapy remains an effective method for helping people challenge their dysfunctional thoughts, encouraging them to use reason to approach their problem-solving, and replacing their negative beliefs with new, positive, and life-enhancing beliefs.

Questions:

1. What is Rational Emotive Behavior Therapy?
2. How REBT Relates to Positive Psychology
3. How one can Identifying and Challenging Irrational Beliefs
4. Infer the ABCDE Model of Emotional Disturbance
5. Explain the Theories Behind REBT

References:

- Albert Ellis Institute. (2014). Rational Emotive & Cognitive-Behavior Therapy. *The Albert Ellis Institute.* Retrieved from http://albertellis.org/rebt-cbt-therapy/
- Dryden, W., David, D., & Ellis, A. (2010). Rational emotive behavior therapy. In K. S. Dobson (Ed.), *Handbook of cognitive-behavioral therapies* (3rd ed., pp. 226-276). New York, NY: Guilford Press.
- Ellis, A. & Dryden, W. (1987). *The practice of rational emotive therapy.* New York, NY: Springer Publishing Company.