Make Every Session Count: How Does Therapy Help?

Disorders Responsive to Specific Treatments

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Disorders Responsive to Specific Treatments

IN RECENT YEARS mental health professionals have made great strides in the development of specific therapies for the treatment of a number of psychological disorders. These approaches (outlined below) include both psychological therapies and medical treatments that have been shown to be effective in carefully conducted research. For many years, some therapists have, unfortunately, made unsubstantiated claims that their particular brand of therapy was effective and often times boasted that their approach was good for "everything that ails you." We feel strongly that potential psychotherapy clients are on much more solid ground when they seek out therapeutic approaches that have documented effectiveness.

It must be made clear that research studies are conducted with large groups of people, and even when a particular treatment is shown to be effective (or superior to other approaches) this certainly does not mean that all people treated by that approach experience substantial improvement. Even with the most tried and true treatments, some people may have a less than desirable outcome. Be that as it may, the potential therapy client who is well informed is clearly in a better position to know which approaches are most likely to successfully address their unique problems or concerns.[1]

In discussing specific treatments, we will first describe and define those disorders for which specific treatments have been developed. This will be followed in each case by a brief description of those therapies that have been shown to be effective.

Depression

Depression can present in a number of different ways, but most people suffering from depression experience some of the following symptoms:

- Mood changes: sadness, despair, or irritability
- Lack of vitality, enthusiasm, and motivation
- Difficulties with concentration and forgetfulness
- Physical complaints:

- Weight gain or weight loss
- Insomnia or excessive sleeping
- Loss of sexual desire
- Exhaustion and fatigue
- Occasionally, intense restlessness

• Suicidal ideas

• Feelings of powerlessness or hopelessness

• Feelings of worthlessness or low self-esteem

Psychotherapies

Cognitive Therapy (Beck 1976). In depression it is common for people to perceive the world in extremely negative and pessimistic ways. Your view of others, the future, and yourself tend to accentuate what is inadequate, bleak, or tragic. This leads to a pervasive, depressive, and hopeless view of the world. In cognitive therapy the therapist actively works with the client to help him or her to spot negative thinking and to challenge it (to engage in more accurate and realistic thinking and perceiving). This is done not only in therapy sessions, but also by way of between-session homework projects. Cognitive therapy is an active and directive form of psychotherapy that has been shown to be very effective in treating mild to moderately severe depression.

Behavior Therapy (Lewinshon 1984). Behavior therapy for depression focuses largely on encouraging clients to become more active in social and recreational events. Depression often results in marked social withdrawal, and as a consequence, depressed people become progressively cut off from meaningful and enjoyable life activities. The theory is that diminished positive experiences can significantly increase depressive symptoms. And research has demonstrated that when people are involved in a program that pushes them to get active, this alone can often reduce depressive symptoms. This approach is helpful for people suffering with mild-to-moderate depression.

Interpersonal Therapy (Klerman and Weissman 1984). Interpersonal therapy (IPT) is derived from the observation that a common source of distress and depression emanates from problematic or dysfunctional

relationships. In IPT clients are taught how to develop effective skills for communication and problem solving. Often this includes therapy sessions that involve the client and significant others (spouse or the entire family). IPT has also been shown to be quite effective in treating mild to moderately severe depression.

Biological Approaches

1. Antidepressant medication is quite effective for the treatment of moderate to severe depression (see chapter 18).

2. Excessive alcohol consumption is a common cause of depression (it can have a devastating effect on brain functioning), therefore **reducing or eliminating alcohol consumption** can be a very effective approach to treating depression. (Note: If alcohol use is excessive, discontinuation should always be medically supervised. Acute alcohol withdrawal can be dangerous.)

3. Regular exercise and moderate **exposure to bright light** (for example, daylight for about one hour a day) have been shown to be helpful in treating some forms of depression.

4. Severe depression can be successfully treated by **electro-convulsive therapy** (ECT).

Panic Disorder

Recurring episodes of intense anxiety that come on suddenly, rapidly escalate to a level of panic, and usually subside within five to twenty minutes. During such "attacks" people may experience many of the following symptoms:

- Trembling, nervousness, panic
- Shortness of breath and a smothering sensation
- Rapid heartbeat, lightheadedness, dizziness
- A sense of impending doom or the belief that one is either "going crazy" or about to die
- After a number of such attacks, people often develop phobias (for example, a fear of crowds, fear of driving, fear of being away from home)

Psychotherapies

Cognitive Therapy (Beck and Emery 1985): Often during the first moments of a panic attack, as the person begins to notice some physical symptoms, the mind becomes flooded with "catastrophic thoughts." These generally are highly emotionally charged conclusions such as "Oh, my God, I'm having a heart attack!" or "I feel like I am going crazy." These thoughts, in a powerful way, actually throw gas on the fire. Such conclusions (as natural as they may be when one is feeling panic) scare people and intensify the attack. In cognitive therapy for panic attacks, the therapist helps the client learn to use calming and realistic thinking (self-talk) in place of catastrophic thinking. One example would be to actively tell oneself, "This is a panic attack…It's very uncomfortable, but not dangerous…Also I know that these attacks usually last only a few minutes…Hang in there, and it will pass soon." Cognitive therapy (especially when combined with interoceptive therapy and breathing techniques—outlined below) has been shown to be very effective in the treatment of panic disorder.

Interoceptive Therapy is taught after the client has learned some basic cognitive approaches (as outlined above). In interoceptive therapy, the therapist works with the client during sessions to actually create some physical symptoms that the client typically experiences during panic attacks. For example, shortness of breath can be brought on by one minute of rapid breathing, or a racing heart can be provoked by running up and down a flight of stairs. Such physical symptoms typically cause a person with panic disorder to feel uneasy and frightened. But by inducing them intentionally, and then using calming and realistic "self-talk," clients can often quickly learn to gain mastery over the symptoms (rather than have the symptoms lead to fear and an escalation of panic). Interoceptive therapy paired with cognitive therapy is even more effective than cognitive therapy alone.

Graded Exposure: If phobias have developed then a technique called graded exposure (also referred to as systematic desensitization) is the treatment of choice (Wolpe and Wolpe 1988; Beck and Emery 1985). This approach however, is only effective once panic attacks have been nearly or completely alleviated (with psychotherapy and/or medication treatment, addressed below). Since graded exposure is a technique useful with other anxiety disorders, it is described in detail below.

Graded Exposure

When people have developed specific fears or anxieties (for example, fear of heights, fear of public speaking, social anxiety, or phobias developed in the midst of panic disorder), graded exposure is often the treatment of choice.

Here is how it works: Central to all fears and phobias are three features, (1) intense discomfort or anxiety, (2) feelings of being powerless or out of control, and (3) a strong urge to avoid the situation provoking the fear. To overcome such fears, it is important to first develop some anxiety management techniques. These may include reassuring "self-talk," relaxation, eye movement, and breathing techniques. Such techniques are taught during therapy sessions and practiced again and again until the client has mastered them.

Phase two of graded exposure involves establishing a *fear hierarchy*. The therapist and client will together develop a list of fearful situations that begin with low-level stressors and progress up to situations that are likely to be experienced as very frightening. Following is an example of a person who has developed a fear of driving her car.

Example Hierarchy

1. Getting in the car and sitting in the driveway with the engine off
2. Turning on the engine, leaving the car in park, then turning the engine off
3. Backing car onto street in front of home, then driving back into driveway
4. Driving down the street in front of home and then returning home
5. Driving around the block in the neighborhood
6. Driving two blocks away from home and back
7. Driving to a local store, but using back streets (not the freeway)
8. Driving on a major street to a local shopping mall
9. Driving on a freeway but not during rush hours
10. Driving on a busy freeway at rush hour and changing lanes

Such a hierarchy is made up of a progressive situation ranging on a scale from 1 to 10.

Phase three of graded exposure simply involves taking level one of the hierarchy and vividly imagining it during a therapy session. If any anxiety is experienced, the therapist, acting like a coach, helps the client use anxiety-management skills to reduce the feeling of anxiety. This is repeated, if necessary, until the client feels confident in his or her ability to reduce emotional distress. The next step may involve going into the real situation

described in hierarchy level one (a relatively low-stress situation) and again, if anxiety is experienced, using techniques to reduce distress. Movement to the next most stressful situation only occurs as the client has come to feel confident in his or her ability to manage anxiety.

At the heart of graded exposure is the acquisition of effective anxiety-management skills and the experience of an increased sense of mastery and self-confidence in approaching the feared situation. This behavioral approach is highly effective in the treatment of many different types of fears and phobias.

Biological Approaches

1. Breathing techniques: Often in the opening moments of a panic attack, breathing becomes abnormal (either rapid shallow breathing and/or sighing). Both of these patterns of breathing produce the following symptoms: light headedness, dizziness, and shortness of breath or a smothering sensation. These symptoms are understandably very distressing. However, some very simple breathing techniques have been shown to be highly effective in controlling these respiration-related anxiety symptoms and generally are approaches taught to people suffering from panic and other anxiety disorders. Breathing techniques fall into two categories. The first is recommended if symptoms of anxiety are just starting to occur and are mild. The technique involves taking a normal breath (*not* shallow, *not* deep) and then *slowly* exhaling through pursed lips, as if you were going to whistle. This type of breathing should continue until the anxiety completely subsides, which may take several minutes.

   Technique number two is to be used if anxiety symptoms have become intense and one is experiencing noticeable lightheadedness/shortness of breath. The client is taught how to breathe in and out, repeatedly, into a paper bag or other small, enclosed space (paper lunch bag, empty Kleenex box, or head under the covers). This approach, when used until all anxiety symptoms disappear, helps to restore normal levels of blood gases in circulation, and is remarkably effective in quickly reducing anxiety symptoms.

2. Elimination or reduction of substances: Caffeine, decongestants, and alcohol are known to increase panic symptoms.

3. Antianxiety and antidepressant medication: can be highly effective in treating panic disorder (see chapter 18).

Generalized Anxiety Disorder (GAD)

GAD is a form of chronic anxiety; the person feels anxious or tense almost every day. This is not in response to specific stressful events. Rather the GAD sufferer finds that every day events trigger continuous anxiety. Unlike panic disorder, people with GAD rarely or never experience full-blown panic attacks; however, they may suffer from the following symptoms:

- Tension or nervousness
- Exaggerated sensitivity to low-level stresses
- Physical complaints: tension headaches, insomnia, gastrointestinal distress, muscle tension
- Fatigue
- Feeling on guard or apprehensive

The hallmark of GAD is **worry** (fretting, anticipating bad or troublesome events, self-doubting). GAD often begins in adolescence or early adulthood and may last a lifetime if untreated.

There is some evidence to suggest that one aspect of GAD is hypersensitivity or chronic over-arousal of the stress- response system in the body (brain and sympathetic nervous system).

Psychotherapies

Anxiety-management techniques have been developed that are often very helpful in reducing chronic anxiety. These include the following approaches:

a. **Cognitive therapy**: The focus of cognitive therapy for GAD includes: (1) *Risk assessment*: systematic assessment of likely risks involved in everyday situations (this can help to counter the tendency to anticipate disaster or catastrophes). It encourages willful, conscious, and rational assessment of potential risks as well as an evaluation of the likelihood that negative outcomes will occur (a person may worry, "If I contradict my boss, I'll get fired"), and the anticipation of this

outcome generates anxiety. On closer examination, the person may develop clarity about the objective realities, (other employees have contradicted the boss and no one has been fired). (2) Worry often occurs in an automatic and unexamined way. Cognitive approaches also involve techniques designed to help people more consciously evaluate stressful situations. For example, keeping a "worry record," scheduling "worry time" to devote to careful assessment and reflection about stresses. (Instead of ongoing or continuous worry that occurs in an automatic and habitual way, setting aside twenty to thirty minutes a day to intentionally worry often, paradoxically, reduces generalized anxiety. (3) *Problem solving*: specific approaches to problem solving have been developed that often result in people feeling less anxious and in more control. Such techniques are often taught and practiced as a part of cognitive therapy.

b. **Decreasing physiological arousal**: Three techniques have been found to be effective in reducing physical symptoms of anxiety. These include relaxation training (see page 110), meditation, and eye-movement techniques (see page 121).

c. **Exposure therapy**: Once anxiety management techniques have been mastered, clients are encouraged to approach certain situations in their daily lives that have, in the past, been sources of significant anxiety. They then use learned techniques to reduce anxiety. Repeated success with *exposure* eventually leads to increased feelings of self-confidence and a reduction in anxiety.

Biological Approaches

1. A program of regular exercise (moderate exertion is okay, aerobic-level is better) has been shown to consistently reduce generalized anxiety

2. Eliminating substances that increase anxiety such as caffeine and decongestants can often make for a remarkable decrease in generalized anxiety

3. Medical treatment for GAD may include the use of certain antidepressants (Paxil, Prozac, Zoloft, Celexa, or Serzone) and/or the nonaddictive tranquilizer Buspar.

Social Phobia/Social Anxiety

Intense uneasiness in social situations or while interacting with others is one of the most common anxiety disorders. This typically leads one to avoid social gatherings and may result in leading an isolated or lonely lifestyle.

Psychotherapies

Anxiety management and graded exposure: The client and therapist discuss in some detail those situations that provoke anxiety. Then the client is taught anxiety-reduction techniques followed by graded exposure. Such approaches are most successful if accompanied by the acquisition of assertive skills (see below) and rehearsal in a supportive group setting.

Assertiveness training: This is a specific type of therapy geared to teach clients a set of interpersonal interactions and communication skills. This can be accomplished in individual therapy, but is probably best when done in the context of a group. In **group therapy** assertive skills are discussed, modeled, and rehearsed within a supportive and encouraging setting. At some point clients begin practicing assertive behavior outside of therapy, in real life situations, in a graded exposure fashion (first tackling rather low risk/low stress situations, and with increasing success and mastery, approaching more problematic interactions). With repeated experiences and mastery, anxiety often subsides significantly.

Biological Approaches

Psychiatric medications that have been shown to be effective in treating some forms of social phobia include

- Antidepressants: especially those that affect the neurochemical serotonin—Prozac, Paxil, Celexa, Serzone, Zoloft
- MAO-inhibitors: Nardil or Parnate
- Beta blockers: Inderal
- Minor tranquilizers: Ativan or Xanax

Post-Traumatic Stress Disorder (PTSD)

This disorder is often seen in the aftermath of exposure to a very frightening event (being raped, almost being killed, witnessing the death of another person, being in a natural disaster or a combat situation). Common symptoms may include:

- Vivid re-experiencing of the traumatic event in thoughts, memories, or nightmares
- Avoiding situations which remind one of the traumatic event
- Memory impairment (amnesia for the event)
- Odd feelings of detachment, numbness, or unreality
- Intense feelings of anxiety, irritability, depression, and/or exquisite emotional sensitivity

A central problem in PTSD is that people become afraid of their memories and the feelings that such memories evoke. They may also develop phobias and avoidance of situations that tend to trigger distressing memories.

(Please note: PTSD emerging in the aftermath of fairly recently occurring traumatic events may be treatable in brief therapy. A more severe form of PTSD attributable to severe early childhood trauma, abuse, or neglect generally requires long-term psychotherapy).

Psychotherapies

Ultimately, clients who suffer from PTSD must be able to face and talk about the tragic events and painful memories. However, it is essential that this be done in a way where the person re-experiences memories and emotions, but is not overwhelmed by them. One of the most important aspects of therapy for PTSD is to develop a sense of safety in the therapeutic relationship. An effective therapist can be with the client, can hear about horrible experiences, and maintain his or her own emotional sturdiness. The client can come to see and know that these things can be talked about, without "blowing away" the therapist. Well-trained therapists are able to listen and understand intense emotions while providing support.

Anxiety-management technique: An important aspect of treatment of PTSD is the restoration of a personal sense of control over intense emotions. Techniques such as cognitive therapy and eye-movement approaches are often quite helpful. One particular, specialized version of this is referred to as EMDR (eye movement desensitization and

reprocessing [Shapiro 1995]).

Biological Approaches

Serotonin antidepressants (Prozac, Paxil, Celexa, Serzone, and Zoloft), generally prescribed in moderate-to-high doses, are quite helpful in providing clients with an enhanced capacity to maintain control over intense emotions.

Obsessive-Compulsive Disorder (OCD)

- Recurring, persistent, unpleasant or senseless thoughts or impulses which are difficult to prevent or ignore (constant worry about dirt and germs)
- Repetitive actions or rituals carried out in an attempt to reduce obsessive ideas (repeated hand washing, repeatedly checking and rechecking to make sure doors and windows are locked, constant attempts to keep one's home extremely neat and orderly)

Psychotherapies

Phase One: Exposure: The client is exposed to a feared situation. For example, if there is a fear of germs or contamination examples of exposure may be to remove garbage from a trashcan or to touch a toilet seat.

Phase Two: Response Prevention: Exposure typically results in significant distress, and is usually responded to by engaging in ritual behavior, such as repeated hand washing (which eventually helps to reduce anxiety). In this phase of treatment, the therapist helps to prevent the client from engaging in the anxiety-reducing ritual. Obviously, the initial result is considerable anxiety, although the therapist will make strong attempts to support and encourage the client to "hang in there." This part of the treatment continues for about forty- five minutes and then the session ends. The initial anxiety usually increases, but near the end of the session, many clients begin to notice anxiety subsiding. Typically this procedure is repeated a number of times (most often, requiring 18-20 sessions of exposure and response prevention).

Although this approach is initially difficult for clients to experience, after a number of sessions, they begin to

feel an increasing sense of mastery, as they come to know that, almost invariably, with time intense anxiety subsides. Exposure and response prevention have been shown to yield very good results for most clients with OCD.

Biological Approaches

1. Serotonin antidepressants are effective in about 60 percent of people suffering from OCD (see chapter 18).

2. Severe OCD that does not respond to psychotherapy or medications may be treated by a specific neurosurgical procedure (cingulate bundle cut).

Notes

1 For a comprehensive discussion of psychological treatments and research on effectiveness, please see *What You Can Change ... and What You Can't*, by Martin E. P. Seligman, Ph.D.. New York, Fawcett Columbine Publishers, 1993.