The Psychotherapy Relationship

- What does therapy entail?
- The therapeutic relationship.
- Limitations on the relationship.
Who is likely to benefit from psychotherapy?

- YAVIS (Schofield)
  - Young
  - Attractive
  - Verbal
  - Intelligent
  - successful
Psychotherapy

• Psychoanalysis
• Brief psychotherapy
• Evidence-based psychotherapy
• Supportive psychotherapy
• Reeducative psychotherapy
• Reconstructive psychotherapy
Issues within the therapy session

- How the therapist acts.
- Expectations for the patient/client.
- The initial session.
- Session duration.
- Termination.
- Follow-up.
- Pro-bono.
- Therapist burnout.
Psychotherapy Patients’ Rights (Table 9.2 in your book)

- Confidentiality
- Respectful treatment
- Respect for boundaries
- Respect for individual differences
- Knowledge of the psychologist’s area of expertise
- Choice (patient has the right to choose a therapist v. having one assigned)
- Informed consent for therapy
Does Psychotherapy work?

- **Eysenck’s work**
  - Hans Eysenck (1952) meta-analysis of treatment outcomes.
  - 24 published studies of “neurotic” patients.
  - None of the studies included a control group.
  - 72% of neurotics recovered with non-specialized care.
  - Concluded that psychotherapy doesn’t work!
Smith & Glass (1977)

- Meta-analysis
- Rigorous design
- Looked at outcome literature
- Found a positive result
- The average effect size for all psychotherapies was .85.
<table>
<thead>
<tr>
<th>Researchers</th>
<th>Patient diag/tx</th>
<th># of studies</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christensen et al (1987)</td>
<td>OCD/exposure tx</td>
<td>5</td>
<td>1.37</td>
</tr>
<tr>
<td>Mattick et al (1990)</td>
<td>Agoraphobia</td>
<td>51</td>
<td>1.62</td>
</tr>
<tr>
<td>Dobson (1989)</td>
<td>Depression/Cog Tx</td>
<td>10</td>
<td>2.15</td>
</tr>
<tr>
<td>Robinson et al (1989)</td>
<td>Depression</td>
<td>29</td>
<td>.84</td>
</tr>
<tr>
<td>Giblin et al (1985)</td>
<td>Family Therapy</td>
<td>85</td>
<td>.44</td>
</tr>
<tr>
<td>Lyons &amp; Woods (1991)</td>
<td>RET</td>
<td>70</td>
<td>.98</td>
</tr>
<tr>
<td>Benton &amp; Schroeder (1990)</td>
<td>Schizophrenia</td>
<td>23</td>
<td>.76</td>
</tr>
</tbody>
</table>
Empirically Validated Treatments

- Anxiety and Stress:
  - CBT for panic disorder
  - CBT for GAD
  - Exposure treatment for Agoraphobia
  - Exposure/guided mastery for specific phobia
  - Exposure and response prevention for OCD
  - Stress Innoculation training for coping with stressors
Empirically Validated Treatments

- Depression
  - Behavior therapy for depression
  - Cognitive therapy for depression
  - Interpersonal therapy for depression
• Health Problems
  – Behavior therapy for headaches
  – CBT for bulimia
  – Multicomponent CBT for pain associated with rheumatic disease
  – Multicomponent CBT with relapse prevention for smoking cessation
Empirically Validated Treatments

• Problems of Childhood
  – Behavior modification for enuresis
  – Parent training programs for children with ODD

• Marital Discord
  – Behavioral marital therapy
Therapeutic Skills

- 30% of the variance in patient outcome = relationship factors.
- They need an encouraging, positive relationship.
Intervention techniques v. the relationship

• What is more important?
  – Intervention techniques
  – Relationship with the therapist
Therapist Skills

• What does a therapist need to do to effect change?
  – Show interest
  – Attempt to make patients feel comfortable
  – Offer encouragement and reassurance
  – Instill hope
  – Show sensitivity to patient feelings
  – Focus on practical assistance in problem solving and coping
  – Empathy, warmth, and genuineness (Rogers)
Therapist Skills

  - Behaviors that communicate genuineness include being consistent, non-defensive, respectful, relaxed, honest, and interested.
  - Warmth may be conveyed through respectful actions and statements, encouragement, and recognition of clients' effort and progress.
  - Can you teach these skills?
The Role of Caring

• What does the research say about caring on the part of the therapist?
• How do you show caring?
• How do you show respect?
Behaviors that make the patient wonder if the therapist cares.

- Overstructuring therapy
- Inappropriate self-disclosures
- Rigid use of transference interpretation
- Inappropriate use of silence
- Criticism
- Hostile tone or confrontational approaches, esp if they include aggressive criticism and sarcasm
Do therapists care about all patients?

• Is it necessary to develop feelings of caring for the patient?
Coherence

- With the treatment plan.
- Coherence with the techniques used.
- Confidence that this will make a difference.
- Handling doubts in therapy.
Complaints and goals

• How do you translate the patient’s complaints or symptoms into measurable goals?
  – During the course of therapy, the therapist may ask the question, *what do you want to get out of therapy?*
  – Some possible responses: *to stop procrastinating; get my old self back; get my head together; be a happier person.*
Complaints and goals

• Vague goals versus specific goals.
  – Operationalizing goals.
  – Example, patient with ADHD.
ADHD Goals

• **Psychoeducational Goals**
  – Assign books on ADHD: The patient was referred to specific reading material designed to increase his/her knowledge about ADHD.
  – Teach Problem-solving skills: The patient was taught problem-solving skills that involve identifying the problem, brainstorming solutions, evaluating options, implementing action, and evaluating results.
  – Teach self-control strategies: The patient was taught the self-control strategy of “stop, listen, think, and act” to assist him/her in curbing impulsive behavior.

• **Conduct Psychological Testing**
  – The patient was administered psychological testing in order to establish the presence of ADHD, a learning disability, and to assist with a description of strengths and weaknesses.

• **Refer for Psychiatric Evaluation**
  – Refer to a psychiatric for possible psychotropic medications.
Agreements and Contracts

- Preliminary formulation offered in the first meeting
- Provision that this plan will be updated
- Establish a written summary of the initial treatment plan
- Keep a record of the intended aims of the work
- Sign a written treatment plan or verbally collaborate and keep a written record (depends on the therapist)
Comprehensive Treatment Plan

Name:  
Date of first visit: 
Assets facilitating treatment: 
Barriers or challenges potentially interfering with treatment: 
Problem List: 
Goals, methods, Initial time frame: 
Patient informed Consent and participation: 
I have discussed this plan with Dr. Fallahi, understand it, and with my full and informed consent agree to the course of action outlined above.  

________________________  __________________
Patient Signature             Date
Building and maintaining the therapeutic relationship

• The first contact.
• With each interaction.
• Collaborative relationship.
• The therapist is not passive.
• Keep your focus on the patient.
• Resist distractions.
• Recall information about your patient.
• Disclosing information about yourself.
• Recognize your own biases and control yourself.
The therapeutic relationship

• What if the patient pushes your buttons?
• How do you know if you have a good relationship with a patient?
  – Desire to have contact.
  – Information is shared.
  – Positive affect is expressed.
  – There is a sense of teamwork.
  – Negative feelings are productive.
Cultural Competence

- Are we meeting the cultural needs of our patients?
- 15.7% of the US population = racial/ethnic background is something other than white.
- Underrepresentation in psychology at all levels.
- What is the effects of having so many White, middle-class male therapists?
Minority Clients are underserved

- Substandard treatment commonplace.
- Negative psychological diagnoses.
- Inferior & differential counseling services.
- Underutilization of counseling services.
- Lack of minority therapists play a role?
The call to cultural competence.

Underrepresentation of minority groups in professional counseling training programs = reinforces the perception that counseling is generally irrelevant to their needs.

Discomfort of white therapists working with persons from different cultural and/or racial populations.

Why? Negative stereotyping, lack of knowledge about the group, generalized anxiety.

Result: ineffective treatment for clients.
Need major reform

- Problems with theoretical counseling models – imply psychosocial development is uniform for all members of society.
- Ignore sociopolitical factors, e.g. class & power.
- Individualism emphasized.
- Cultural biases related to racism, prejudice, & discrimination built into the models used.
- Research also incorporates these biases.
To be oppressed = there must exist a dominant force.

If you buy into this, you are forced to look at our own participation in the dominant-subordinate process.

Theories of oppression are less familiar to therapists.

Oppression is a common experience. Groups that are oppressed? There are many, but these include Asians, Latinos, Blacks, etc.
The therapist needs to be culturally aware.
Command of knowledge, that the culturally skilled therapist should have. This includes the understanding of the effects of the sociopolitical system within the U.S.
Competencies

• Culture specific knowledge about the particular group.
• An understanding of the generic characteristics of counseling and psychotherapy.
• Gain knowledge of specific minority groups.
• Focus on concerns, e.g. value changes, acculturation, generational differences, parental pressures, dating, and religious issues.
• Seek supervision on these issues.
Competencies

• Have a wide repertoire of verbal & nonverbal responses, the ability to send messages accurately and appropriately, and the ability to use appropriate institutional intervention.

• Question: do we assume a universalist approach or a culture-specific approach?

• Fukuyama (1990).
• Cross-cultural counseling.
• Learn to work with different cultures versus learning about cultures.
• Problem>>> where do you get this training? These programs are rare.
• Americans value self-disclosure. So what type of patient do we want?
• It is not uncommon of patients of any ethnicity to withhold their most private thoughts/feelings/behaviors until he/she feels safe to share. Shouldn’t this be respected?
• Instead=== we pathologize this and assume that the patient is nonproductive & resistant.
Standard mental health services

- What we offer to people of color is often substandard.
- We don’t have good role models.
- We service the traditional white majority.
- We don’t deal with the politics of the white male dominant society.
- In the past, patients were expected to acculturate.
• We buy into the melting pot philosophy.
• Historically, we intellectualize racism, power, & discrimination.
• Little emphasis in training programs on understanding ourselves as cultural beings.
• Little focus on the culturally latent values, beliefs, & stereotypes of the therapist.
Barriers to multicultural therapy

- Melting pot myth
- Overemphasis on verbal self-disclosure
- Overemphasis on abstract & non-problem-solving strategies
- Monolingual orientation
- Overemphasis on long-term goals and future
- Lack of understanding on the whole person
- Lack of understanding of social focus
- Lack of appreciation for nonverbal communication
Barriers to multicultural therapy

- Ethnocentric worldview
- Ignorance of self-racism & cultural identity of others
- Lack of understanding of the dominant culture
- Lack of understanding of politically correct behaviors
- Marginality
- Oppression
- Issues relating to power
Barriers to becoming culturally competent

- Ethnocentricity: We are inundated with only “Western ideals. Relatively few US scholars ever cite international journals. Only 60% of scientists from the US felt that being connected to international scholars was very important.

- Xenophobia: unreasonable fear, distrust, or hatred of strangers, foreigners, or anything perceived as being different.

- Difficulty in accepting others’ worldviews.
Barriers to becoming culturally competent

- Accepting differences.
- Universality assumptions: theories, research, practice originated in the US … are they universally applicable?
Barriers to becoming culturally competent

• Personality styles & dispositions in protecting our ego.
• Problems can occur when we encounter difficult new situations.
Enhancing cross-cultural awareness & knowledge

- Increase our awareness & knowledge of cross-cultural issues. Encourage study-abroad programs.
- Graduate trainees … more difficult.
- Require coursework.
- Require competency in a second language.
Promote learning opportunities with international students within our training programs.

Integrate cross-cultural issues and knowledge in our therapy curriculum.

Develop regular communication opportunities with international students & colleagues.

Promote cross-cultural research & supervision & consultation.
• Overt racism versus unintentional racism
• Are stereotypes harmful?