PSY 322
Clinical Psychology I

Course Manual

Lawal, A.M

PSY 322

CLINICAL PSYCHOLOGY I

By

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Copyright

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Vice-Chancellor's Message

The Distance Learning Centre is building on a solid tradition of over two decades of service in the provision of External Studies Programme and now Distance Learning Education in Nigeria and beyond. The Distance Learning mode to which we are committed is providing access to many deserving Nigerians in having access to higher education especially those who by the nature of their engagement do not have the luxury of full time education. Recently, it is contributing in no small measure to providing places for teeming Nigerian youths who for one reason or the other could not get admission into the conventional universities.

These course materials have been written by writers specially trained in ODL course delivery. The writers have made great efforts to provide up to date information, knowledge and skills in the different disciplines and ensure that the materials are user-friendly.

In addition to provision of course materials in print and e-format, a lot of Information Technology input has also gone into the deployment of course materials. Most of them can be downloaded from the DLC website and are available in audio format which you can also download into your mobile phones, IPod, MP3 among other devices to allow you listen to the audio study sessions. Some of the study session materials have been scripted and are being broadcast on the university's Diamond Radio FM 101.1, while others have been delivered and captured in audio-visual format in a classroom environment for use by our students. Detailed information on availability and access is available on the website. We will continue in our efforts to provide and review course materials for our courses.

However, for you to take advantage of these formats, you will need to improve on your I.T. skills and develop requisite distance learning Culture. It is well known that, for efficient and effective provision of Distance learning education, availability of appropriate and relevant course materials is a *sine qua non*. So also, is the availability of multiple plat form for the convenience of our students. It is in fulfillment of this, that series of course materials are being written to enable our students study at their own pace and convenience.

It is our hope that you will put these course materials to the best use.

Prof. Isaac Adewole
Vice-Chancellor

Foreword

As part of its vision of providing education for "Liberty and Development" for Nigerians and the International Community, the University of Ibadan, Distance Learning Centre has recently embarked on a vigorous repositioning agenda which aimed at embracing a holistic and all encompassing approach to the delivery of its Open Distance Learning (ODL) programmes. Thus we are committed to global best practices in distance learning provision. Apart from providing an efficient administrative and academic support for our students, we are committed to providing educational resource materials for the use of our students. We are convinced that, without an up-to-date, learner-friendly and distance learning compliant course materials, there cannot be any basis to lay claim to being a provider of distance learning education. Indeed, availability of appropriate course materials in multiple formats is the hub of any distance learning provision worldwide.

In view of the above, we are vigorously pursuing as a matter of priority, the provision of credible, learner-friendly and interactive course materials for all our courses. We commissioned the authoring of, and review of course materials to teams of experts and their outputs were subjected to rigorous peer review to ensure standard. The approach not only emphasizes cognitive knowledge, but also skills and humane values which are at the core of education, even in an ICT age.

The development of the materials which is on-going also had input from experienced editors and illustrators who have ensured that they are accurate, current and learner-friendly. They are specially written with distance learners in mind. This is very important because, distance learning involves non-residential students who can often feel isolated from the community of learners.

It is important to note that, for a distance learner to excel there is the need to source and read relevant materials apart from this course material. Therefore, adequate supplementary reading materials as well as other information sources are suggested in the course materials.

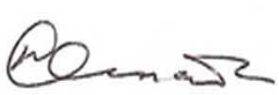
Apart from the responsibility for you to read this course material with others, you are also advised to seek assistance from your course facilitators especially academic advisors during your study even before the interactive session which is by design for revision. Your academic advisors will assist you using convenient technology including Google Hang Out, You Tube, Talk Fusion, etc. but you have to take advantage of these. It is also going to be of immense advantage if you complete assignments as at when due so as to have necessary feedbacks as a guide.

The implication of the above is that, a distance learner has a responsibility to develop requisite distance learning culture which includes diligent and disciplined self-study, seeking available administrative and academic support and acquisition of basic information technology skills. This is why you are encouraged to develop your computer skills by availing yourself the opportunity of training that the Centre's provide and put these into use.

In conclusion, it is envisaged that the course materials would also be useful for the regular students of tertiary institutions in Nigeria who are faced with a dearth of high quality textbooks. We are therefore, delighted to present these titles to both our distance learning students and the university's regular students. We are confident that the materials will be an invaluable resource to all.

We would like to thank all our authors, reviewers and production staff for the high quality of work.

Best wishes.



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INTRODUCTION TO CLINICAL PSYCHOLOGY

GENERAL INTRODUCTION AND COURSE OBJECTIVES

This course is designed to orient students to the field and profession of clinical psychology. The course covers the history of the discipline, history of clinical psychology as a profession in Europe, America and Nigeria, assessments procedures as various psychotherapies and biological treatment of mental disorders with current standards and evidenced-based practices. Students will learn about theoretical approaches and common assessment and treatment activities of clinical psychologist and gain an appreciation for the current issues in the area of clinical psychology.

Objectives of the Course

The objectives for this course include:

1. to introduce the students to definition and history of clinical psychology
2. to understand and be able to explain the principles guiding in the field of clinical psychology
3. to be able to list the roles of clinical psychologists and settings where their roles are applicable
4. to discuss various theoretical perspectives in clinical psychology and List the classification systems of psychological disorders
5. to introduce students to the major psychotherapies available in clinical psychology, and
6. to identify certain drugs used for the treatment of some specific mental disorders.

At the end of the course, students are expected to have the knowledge of what the area of clinical psychology entails.

LECTURE ONE

Expected duration: *1 week or 2 contact hours*

1. 0. A DEFINITION OF CLINICAL PSYCHOLOGY

Introduction

In this lecture, following questions should be clear to the student. How clinical psychology is defined as an area of specialization in the field of psychology. Who a clinical psychologist is and the differences between clinical psychologists and other psychologists. How clinical psychologists function in their various departments.

1.1.Objectives

At the end of this lecture, students would have able

1. To summarily discuss the clinical psychology field as an area of specialization in psychology.
2. To differentiate a clinical psychologist from other psychologists
3. To itemize functions of a clinical psychologist.

1.2.Pre-Test

1. In your own words what is clinical psychology?
2. List to ways to suppose clinical psychologists are relevant to a medical unit?

1.3. CONTENT

1.3.1. Definitions of Clinical Psychology

Clinical Psychology is a branch of psychology devoted to the study, diagnosis, and treatment of people with mental illnesses and other psychological disorders. In other words, clinical psychology is an area of specialization in the field of psychology that utilizes the theories and principles of psychology to help individuals live a stable and normal life. Clinical

psychology is viewed as the application of knowledge and method from all substantive fields of psychology to the promotion and maintenance of mental and physical health of the individual. Clinical psychologists also explain the cause and course of illness, help in developing prevention, assessment and treatment of all forms of mental and physical disorders in which psychological influences have direct, indirect or main effect in contributing to or can be used to relieve an individual's distress or dysfunctions. From all these perspectives, you can reliably infer that clinical psychology is relevant to the psychiatry and other medical specializations. In summary clinical psychology is a branch of psychology responsible for the understanding and treating psychopathology.

ITQ: which of the three statements best defines clinical psychology?

ITA: A) Clinical psychology is a field of psychology and mental illness

B) Clinical psychology is a field that understands mental illnesses and other psychological disorders

C) Clinical psychology is a field of psychology primarily concerned with understanding and treating mental and psychological illnesses.

The correct answer is C, if you pick A you are wrong because clinical is not the only field of psychology or mental illness, if you pick B you are wrong because though clinical psychology understands mental and psychological illnesses but it does move than that. While C is right because first it is a field of psychology then it's a field that understands and moves on to treat psychological and mental illness (Psychology, understanding of illness and treatment of illness)

1.3.2. Differences between Clinical Psychologists And Other Psychologists

Clinical psychologist are different from other psychologists, what best distinguishes the clinical psychologist from his fellow psychologist? It is more a way of thinking (the clinical attitude than emphasis on particular subject matter or techniques). Clinicians are concerned with

understanding and helping individuals in psychological distress. In this pursuit, they engage directly with particular person in their actual life functioning, in their natural life situations they intervene in individual human lives, respecting their complexity and uniqueness. Clinical psychologists create theoretical and methodological skills, which involve clinical assessment and measurement tools. They are scientists trained in the methods and procedures for conducting investigations. They are also professionals trained to provide direct services to client. Clinical psychologists are health care professionals who work predominantly, though not exclusively, in the field of mental health.

ITQ: You've in the board of an institution that requires employing a psychologist that will help in the helping of patients who are already at the end of life (palliative care). The HOD of the unit now affirms that the main criteria needed for the job is 'a professional who understands patients individually and their complexities and who would also be able to intervene in easing them to death…' who will be your ideal psychologist out of the following three

a) developmental psychologist

b) clinical psychologist

c) social psychologist

ITA: if you pick (a) you are wrong because though developmental psychologist are people who understand how development from childhood to oldage they arenot appropriate to intervene in easing psychopathology like illnesses causing death. If you pick (b) you are right because this is the difference between a clinical psychologist and other psychologists, if you pick (c) you are wrong because though social psychologists understand and explain our interactions with people in the society they do not manipulate and intervene in our actual life functioning to access and lessen distress.

1.3.3. Main Activities of Clinical Psychologists:

1. ***Psychological Assessment:*** It involves the assessment of people through the use of psychological tests and principles to obtain a better understanding of psychological attributes and pathologies. Examples of psychological tests used include California Personality Inventory (CPI), Minnesota Multiphasic Personality Inventory (MMPI-2), Eysenck Personality Questionnaire (EPQ), State-Trait Anxiety Inventory (STAI) among others.

2. ***Psychological Treatment:*** It is the use of psychological procedures to help others to lessen or remove distress and difficulties in functioning. There are many forms of psychological treatment, ranging from brief, practical procedures for overcoming specific fears to lengthy and complex treatments. Examples of psychological treatment procedures include Cognitive-Behavioural Therapy, Psychoanalysis, just to mention a few.

3. ***Psychological Evaluation*:** It is the use of psychological principles to evaluate the effectiveness of treatments or other forms of intervention. Clinical psychologists have been involved in developing methods of evaluating psychotherapies as well as physical forms of therapy.

The aforementioned are the main activities of clinical psychologist; however, there are also others, such as research, training of other professional staff, involvement in administration, health services, policies, and others. All these functions shall be explained extensively when discussion the roles of clinical psychologist in the subsequent lectures.

1.3.4. Clinical Approach in Psychology

A psychological approach is clinical to the extent that it attempts to understand people in their natural complexity and in their continuous adaptive transformations. In the history of language, the term *clinical* evolved from ancient roots and changes its meaning with time, deriving from the Greek word for ‘Bed’. Its medical connotation was only later attached. In

medical usage, clinical first described cases at the sick bed but latter generalized to include any setting. Indeed clinicians today treat ambulatory out-patient in contrast to hospitals where bed-ridden inpatients are to be found. But the constant core of meaning in medicine or psychology is on direct engagement with and concern for an individual.

However, there are some concepts used to explain that as adjective in expression, such as *clinical training, clinical intervention* and *clinical science,* the term is appropriately used to characterize the learning experiences, therapeutic activities and requisite knowledge of the clinicians. *Clinical judgment* and *clinical responsibility* describe the thinking and values of the clinicians who may be required to take actions on behalf of his patients even if based on incomplete knowledge. In medical diagnosis, *clinical test* are distinguished from *laboratory test* depending on whether diagnosis depends primarily on direct observation and evaluation by the clinicians or whether laboratory procedures and technicians are involved by contrast in psychology. The term *clinical assessment* is used inclusively regardless of the procedures involved provided that its aim is the understanding of the individual patient.

Box 1.3: The Main activities of Clinical Psychologist
Clinical psychologist does a variety of activities in the treatment, study and diagnosis of mental illness and other psychological disorders. It is however, important to note:

- Psychological assessment.
- Psychological treatment.
- Psychological evaluation.

1.4. Summary

In the lecture, we have understood that clinical psychology is a branch in the field of psychology that involves the use psychological principles, procedures and test to asses, diagnose

and treat mental disorders. Major activities of clinical psychologists include psychological assessment, evaluation and treatment. The clinical approach in psychology is the direct engagement with and concern for an individual patient.

1.5. Self – assessment questions SAQ

1. Clinical psychology is an area of specialization in psychology itemize 3 reasons why this is aptly so.
2. A Clinical psychologist is distinguished from other psychologist in the psychology field; give at least four reasons for this allusion.
3. List the main functions of the clinical psychologist and the 3 minor activities

Text for further reading

1.Defining psychopathology in the 21st century: DSM-V and beyond. Helzer, J.E. & Hudziak, J.J. (2002). Washington, DC: American Psychiatric Press.

2. Abnormal psychology, Nolen-Hoeksema

References

Uwaoma, N. (2002). *Clinical/Abnormal Psychology in Modern Africa.* Rescue Publishers, Abba Rorad, Owerri. Nigeria.

LECTURE TWO

2.0. BRIEF HISTORY OF CLINICAL PSYCHOLOGY

Expected duration: *1 week or 2 contact hours*

Introduction

The lecture is to introduce you to the history of clinical psychology in Europe, America and Nigeria. Clinical psychology has its root in the psychometric and dynamic tradition of psychology.

2.1. Objectives

At the end of the lecture, you should be able to:

1. Understand the historical background of clinical psychology in Europe, America and Nigeria.
2. Know some individuals that have contributed greatly to the development of clinical psychology in Nigeria.

2.2. Pre-Test

1. What do you understand as psychometric tradition of psychology?
2. What do you understand as the dynamic tradition of psychology?

2.3. CONTENT

2.3.1. History of Clinical Psychology in Europe and America

Clinical psychology is a recognized profession in many countries round the world as one of the main helping professions in changing maladaptive behaviors. However, the recognition of clinical psychology as a profession was at different times in different countries. Clinical

psychology has root in both the psychometric and dynamic tradition of psychology. The *psychometric tradition of psychology* emphasizes measurement and individual differences mainly in intellectual processes was of greater prominence in the earlier history of the field when emphasis was largely on mental testing. The *dynamic tradition of psychology* focuses on motivational adaptation and personality change, had its greatest impart at a later date and is represented in the concern of clinicians with personality dynamic development and psychotherapy.

However, the two trends co-existed over the short history of psychology and intertwine in the development of clinical psychology. Both traditions are rooted in the 19th century European psychology, but they moved readily and flourished in the intellectual climate of America of the 1890's. Indeed the functionalist orientation, which came soon to characterize American psychology, made particularly fertile soil for the clinical fields. Americans has little patience for psychology, a profession which dissects into minute details the structures of the minds, or for one, which speculates philosophically about its ultimate nature emphasizing what could be empirically studied and measured.

The field is often considered to have begun in 1896 with the opening of the first psychological clinic at the University of Pennsylvania by Lightner Witmer. In the first half of the 20th century, clinical psychology was focused on psychological assessment, with little attention given to treatment. This changed after the 1940s when World War II resulted in the need for a large increase in the number of trained clinicians. American psychology had an early and continuous concerned with altering and improving human functioning. Applied psychologist addresses problems of industry, education and social behavior. Also, psychological growth and personality dysfunction had an early and prominent place in American psychology. Witmer also in 1912 introduces the first issue of the journal called clinical clinics.

In Britain, clinical psychology was not formally recognized until after the Second World War and it then took until 1966 before a division of clinical psychology was formed in the British Psychological Society (BPS). In the USA and the UK a significant impetus to the development of clinical psychology came from the two world wars. The need to recruit and select suitably qualified service personnel led to the development and use of psychological tests and other assessments. Psychologists were confronted with real-life problems and thereby required to apply their knowledge and skills. In the United States the psychological trauma caused by battle and injury resulted in psychologists becoming involved in treatment as well as assessment, and the wartime emergency hospital in Britain became interested in similar problems.

ITQ: A major factor that made clinical psychologist to come to the fore in the Europe and North America was what? (a) War (b) industrialization (c) research

If you picked (a) you're right, why, the WW2 brought a lot of war veterans which required psychological care of improving functioning. If you pick (b) industrialization you are wrong because the technological advancement in machinery is not the reason for the requirement of the psychological care. (c) research if you pick c you're wrong, because despite the first clinic in 1912 and its subsequent journal it was not acknowledged until 1940's in the US

2.3.2. History of Clinical Psychology in Nigeria.

The history of clinical psychology in Nigeria is a little not too clear. Psychology as a field of study in the Nations University in the mid 70s and clinical psychology was built into the general course leading to the award of Bachelor of Science (B.Sc) psychology. Presently, only some few schools offer postgraduate courses in clinical psychology. No professional body regulates the courses. The Nigerian Association of Clinical Psychologist has not been functioning very well not until recently when it was resuscitated in its national conference held

in Benin, 2008. The contribution of psychology and clinical psychology is not so much felt in Nigeria; little wonder when the field of psychology is mentioned as a field of study, many show ignorance. Though, federal government recently realizes the need of clinical psychologists in federal hospitals, it has not been fully implemented as directed.

However, the contributions of the following individuals and institutions have built the discipline of psychology and clinical psychology to its present state in Nigeria. Professor Awaretefe of the university of Benin, Professor Denis Ugwuegbu of the university of Ibadan, Professor P. F. Omoluabi of the university of Lagos, Professor P. Ebigbo of the department of medicine University Nigeria Teaching Hospital Enugu, Professor Helen O. Osinowo and Dr. B. O. Olley of the university of Ibadan, Dr. Utomi and Professor Oyefeso and others. These people have affected the development of clinical psychology in a great measure in Nigeria. It should be noted that the names so presented are not rank in any other of importance or seniority. The departments of psychology at the university of Ibadan, university of Lagos, university of Nigeria Nsukka, University of Jos and others recently created department of psychology across the nations have all contributed to the development and training of clinical psychologists in Nigeria. It is therefore time for the professional bodies to wake up, and now that there are a lot of students entering the field of psychology to start regulating and contributing their professional and expertise knowledge to the training and development of psychology and contributing to the development of Nigeria touching people's lives for better living.

ITQ: the body organizing and regulating the practice of clinical psychology in Nigeria is founded in 2008? (a) Yes (b) No

If you pick yes, you're wrong because 2008 was the first meeting after a long hiatus for the NACP and not the founding of organizing body. If you pick no, you're right because the conference was what was founded in 2008.

Box 2.3: The History of Clinical Psychology
Clinical psychology as a profession started with the Lightner Witmer clinic in University of Pennsylvania, in 1912. The by the end of the world war II there was increased need for clinicians. In Nigeria the following are important to note:

- It started as a field of study in the mid 1970s.
- The practice has no regulatory body in Nigeria.

2.4. Summary

Historical background to the clinical psychology as a profession occurred at different times in different countries. However, we noted that the area of specialization could be traced to the Europe where it was first originated before it further flourished in America in 1890's and other places, while the relevance was deeply felt in the late 1940's after the war both in Europe and America . Notable individuals were mentioned in the development of the field of psychology and the clinical psychology as a profession in Nigeria such as Awaretefe, Omoluabi, Ebigbo and Osinowo.

Self – assessment questions (SAQs)

1. Write a short story (no more than 60 words) describing how clinical psychologist evolve in Europe and America using all the details from the witmer clinic to date
2. The clinical profession had been through a lot in Nigeria can you mention at least 3 people who had impacted the profession in Nigeria?

Reference

Osinowo, H. O, Imhonde, H. O. and Olley, B. O. (2004). *A step into Clinical Psychology*, RYCE, Benin City.

LECTURE THREE

3.0. MAJOR THEORETICAL PERSPECTIVES IN CLINICAL PSYCHOLOGY

Expected duration: *1 week or 2 contact hours*

Introduction

This lecture introduces to you the major theoretical perspectives in explaining behavior in clinical psychology. These perspectives are sometimes referred to as models or theories of psychopathology. Each of these perspectives is discussed along with some essential tools used in assessing and giving therapy in clinical psychology.

3.1. Objectives

At the end of the lecture, you should be able to:

1. Discuss and differentiate among the various models/perspectives in clinical psychology
2. List and Identify the major tools used in clinical psychology

3.2. Pre-Test

1. What do you understand as the psychodynamic perspective in clinical psychology.
2. How can free association be applied as a technique in psychoanalysis?

3.3. CONTENT

Clinical psychology is dominated in terms of training and practice by essentially some major perspectives, theories or models. Some of the major perspectives/models are Psychodynamic, Humanistic, Cognitive, Behavioral, and Group Therapy, Family Therapy and Couple Therapy.

3.3.1. Psychodynamic Perspective

The term psychodynamic is related to the dynamic interplay of psychological processes. The Psychodynamic perspective was developed out of the psychoanalysis of Sigmund Freud. This perspective assumes that psychological disorder results from anxiety produced by unresolved conflicts and forces of which an individual is not aware of (i.e. in unconscious mind) and various mechanisms he uses to repress it. In other words, the core object of psychoanalysis is to make the unconscious conscious—to make the client aware of his or her own primal drives (namely those relating to sex and aggression) and the various defences used to suppress them.

The essential tools of the psychoanalytic process are the use of *free association*, *dream analysis* and *transference.* Free association is a tool where the client is encouraged to express to the therapist all thoughts, feelings, wishes, sensations, memories and images that come to mind, however embarrassing or trivial they might seem. Dream analysis is a tool in which interpretation aided by free association is applied to the *manifest content* of dreams in an effort to reveal their *latent content* which invariably consists of unconscious wish fulfilments that are potentially disturbing to the dreamer and would interrupt sleep if they were not disguised through symbolism. Transference is defined as the tendency to take unconscious thoughts or emotions about a significant person (e.g. a parent) and "transfer" them onto another person.

Major variations on Freudian psychoanalysis practiced today include Self Psychology, Ego Psychology, and Object Relations Theory. These general orientations now fall under the umbrella term *psychodynamic psychology*, with common themes including examination of transference and defenses, an appreciation of the power of the unconscious, and a focus on how early developments in childhood have shaped the client's current psychological state.

ITQ: A psychoanalyst is helping a client overcome obsessive gambling and he tells the client to talk about just anything that comes to his mind in therapy what type of technique is he using to help the client? (a) Dream analysis (b) transference (c) free association

If you picked (a) You are wrong! Dream analysis is applying interpretation to dream in an attempt to indentify unresolved conflicts and anxieties. If you picked (b) You are wrong again! Transference is transfer of emotional feelings to the therapist in lieu of the real individual who the client has conflict with. If you picked (c) You are right! Why? Free association is a technique where the clients freely talks about anything coming to mind that the therapist might understand the unresolved conflict in the client.

3.3.2. Humanistic Perspective

Humanistic psychology was developed in the 1950s in reaction to both behaviorism and psychoanalysis, largely influenced and popularised due to the person-centred therapy of Carl Rogers (often referred to as Rogerian Therapy) and existential psychology developed by Victor Frankl and Rollo May. Rogers believed that a client needed only three things from a clinician to experience therapeutic improvement—*congruence, unconditional positive regard* and *empathetic understanding* (MacMillian, 2004). By using phenomenology, inter-subjectivity and first-person categories, the humanistic approach seeks to get a glimpse of the whole person and not just the fragmented parts of the personality (Rowan, 2001). This aspect of holism links up with another common aim of humanistic practice in clinical psychology, which is to seek an integration of the whole person, also called *self-actualization*. According to humanistic thinking, each individual person already has inbuilt potentials and resources that might help them to build a stronger personality and self-concept. The mission of the humanistic psychologist is to help the individual

employ these resources via the therapeutic relationship. There are major expectations of a therapist with an orientation from the humanistic perspective. These include *emphatic, unconditional positive regard and congruence.*

Empathy is the capacity to understand and enter into another person's feeling and emotions or to experience something from the client's point of view. It is quite different from sympathy. Empathic therapists are ones who can transmit to the client sense of being understood. The expression of emphatic conveys a kind of sensitivity to the needs, feelings and circumstances of the client. Unconditional positive regard is nothing more and nothing less than a respect for the client as a human being. Your attention or response to a client should not be based on or attached to any condition. Congruence (or genuineness as sometimes called) occurs when therapists express the behaviour, feeling or attitudes that the client stimulates in them. In other word, they do not smile if they are angry. Rogers believe that in the long run, clients would respond favourably to this honesty and congruence, knowing that here was a real person dedicated to their welfare.

ITQ: A humanistic therapist will expect a client to respond to three of the following

I. Congruence II. Hope III. Unconditional positivity IV. Unconditional positive regard V. Sympathy VI. Empathy. (a)I, IV and VI (b) I, II and III (c) I, IV and V

If you picked (a) You're right because the therapy is built on congruence, unconditional positive regard and Empathy. If you picked (b) you're wrong, because Hope and unconditional positivity is not part of the foundations of humanistic therapy. If you picked (c) you're wrong because sympathy is actually part of the errors and don'ts of humanistic therapy.

3.3.3. Cognitive Perspective

Cognitive therapy sees individuals as active participants in their environments, judging and evaluating stimuli, interpreting events and sensations, and judging their own responses. As individuals develop, they think about their world and themselves in different ways. Their beliefs and assumptions about people, events, and themselves are cognitive schemas. Individuals have automatic thoughts that are derived from these beliefs that they are not aware of. How individuals shift from adaptive beliefs to distorted beliefs is referred to as cognitive shifts in Beck's system.

There are two major off shoot from the cognitive perspective, Cognitive Behavioural Therapy (CBT) by Beck and Rational Emotive Behaviour Therapy (REBT) by Ellis, both of which grew out of Cognitive psychology and Behaviourism. CBT is based on the theory that how we think (cognition), how we feel (emotion), and how we act (behaviour) are related and interact together in complex ways. In this perspective, certain dysfunctional ways of interpreting and appraising the world (often through *schemas* or *beliefs*) can contribute to emotional distress or result in behavioural problems. The object of many cognitive behavioural therapies is to discover and identify the biased, dysfunctional ways of relating or reacting and through different methodologies help clients transcend these in ways that will lead to increased well-being. There are many techniques used in cognitive behavioural therapy, such as systematic desensitization, socratic questioning, and keeping a cognition observation log in order to understand thinking patterns of an individual. An individual with faulty thinking pattern is expected to go through what is called cognitive restructuring using some of the aforementioned techniques to have a proper thinking pattern that will positively affect his feeling and behaviour. While REBT, though works on how we think but in a nutshell explains dysfunctional beliefs as " three main forms of

emotions": 1. I *must* do well, 2. You *must* treat me well , 3. The world *must* be easy. These beliefs require challenging.

ITQ: Wole a civil engineer has been having problems with his boss since his current promotion and he has actually received query from his boss over his assessment of a contract which had gone bad. Since then Wole believes his boss had preference for his native man who they vied for this post together despite that the other colleague had received queries too in the past .But he has not agreed that Bako is a very painstaking and critical man even pushing himself to the limit. Wole is presently depressed and in therapy.

What therapy might be the most appropriate to treat his depression with these little information?

(a) Psychoanalysis (b) exposure therapy(c) Rational Emotional Behavioral Therapy

If you picked (a) you're wrong because we don't have enough information to do psychoanalysis for the client and it's usually based on unresolved conflicts which we know nothing of. If you picked (b) you're wrong because exposure therapy is a graded exposure to feared stimulus and this is not appropriate response. If you pick (c) you're right because we have the information that he has dysfunctional emotion which if challenged will help the client to function normally.

3.3.4. Behavioural perspective

- This perspective focuses on the belief that all behaviours are as a result of learning. this form of therapy was highly influenced by the works of I.M.Sechenov's "Reflexes of the Brain" and C. Darwin's evolutionary arguments. This influenced Ivan Petrovich Pavlov 1849-1936, Russian physiologist to do research on the physiology of digestion, conditioned reflexes and the origins of neurosis and this developed ideas on conditioned reflexes working with dogs. Which fused into classical conditioning and responses such as Food **(unconditioned stimulus)** leads to salivation **(unconditioned response)**

,Food & bell **(conditioned stimulus)** are paired repeatedly, Bell alone leads to salivation **(conditioned response)**, If bell ceases to be followed by food, **extinction** occurs.

Also, Operant conditioning which explains that behaviour which is followed by satisfying consequences is more likely to reoccur and behaviour which is followed by unpleasant consequences will occur less frequently. Having concepts such as positive reinforcement, negative reinforcement, punishment and token economy.

ITQ:

3.3.5. Group Therapy, Family Therapy and Couple Perspectives

History has shown that group therapy was practised as a method of choice by only a handful of dedicated therapists. Others used it primarily because their caseload was so heavy that group therapy was the only means by which they could deal with a large numbers of patients. Sometimes group therapy was used as a supplementary technique in psychological intervention. All these have indicated that group therapy as a method has achieved considerably more visibility and respectability in psychological intervention. Different approaches to group therapy have emanated from different theoretical background. From psychoanalytic point of view, what group therapy does is that it becomes a vehicle through which an individual patient can express and eventually understand the operation of unconscious forces and defences and thereby reach a higher level of adjustment.

The origins of family therapy can be traced to the 19th century social work movement. However, it was until mid 20th century that family therapy became a popular form of treatment. Family therapy works with couples and families, and emphasizes family relationships as an important factor in psychological health. The central focus tends to be on interpersonal dynamics, especially in terms of how change in one person will affect the entire system. Therapy

is therefore conducted with as many significant members of the "system" as possible. Goals can include improving communication, establishing healthy roles, creating alternative narratives, and addressing problematic behaviours.

Couple therapy is not limited to “married” couples, but can be provided to unmarried couples, same-sex couples, and others. In one sense, couple therapy can be construed as a form of family therapy. For example, when a husband and wife are seen together and the focus of treatment is on marital relationship itself rather than on the problems of the individuals, a form of family therapy seems to be involved.

Box 3.3: The Major theoretical perspectives in Clinical Psychology

Clinical psychology works with a lot perspectives which underline the type of treatment modality to be used by the practitioner. Some of these major perspectives are:

- Psychodynamic theory
- Humanistic Perspective.
- Cognitive theory.
- Humanistic theory
- Behavioral theory
- Group, Family and couples perspective

3.4. Summary

In the lecture, major perspectives sometimes called theories or models in clinical psychology were discussed. Some of the major perspectives discussed were Psychodynamic, Humanistic, Cognitive Behavioral, and Group Therapy, Family Therapy and Couple Therapy.

3.5. Self – assessment questions (SAQs)

1. Explain any three models in clinical psychology.
2. Write short notes on the following tools in psychotherapy

(a) Unconditioned stimulus (b) Socratic questioning (c) unconditioned positive regard (d) free association.

References

McMillan, Michael. (2004). *The Person-Centred Approach to Therapeutic Change.* London, Thousand Oaks : SAGE Publications.

Rowan, John. (2001). *Ordinary Ecstasy : The Dialectics of Humanistic Psychology.* London, UK : Brunner-Routledge.

LECTURE FOUR

4.0. PRINCIPLES GUIDING CLINCAL PSYCHOLOGY AND FUNTIONS

Expected duration: *1 week or 2 contact hours*

Introduction

In this lecture, you will be exposed to the major principle guiding training of clinical psychologists. Specifically, you will be expected to be able to differentiate the clinical scientist model from the professional model in training clinical psychologists. Finally, you will be introduced to major functions of clinical psychologist and the settings where they are carrying out their professional roles.

4.1. Objectives

At the end of the lecture, you should be able to:

1. Know principles guiding training of clinical psychologists.
2. Differentiate the two major models in training clinical psychologists.
3. Understand major functions of clinical psychologists and settings where they work.

4.2. Pre-Test

1. Explain the experimental approach in clinical psychology.
2. How can you describe the training of clinical psychologist as a profession?

4.3. CONTENT

4.3.1. Principles Guiding in Clinical Psychology

There are certain principles guiding the training of clinical psychologists. Emphasis has been on the dynamic diagnostic and experimental approach in training clinical psychologists. In the dynamic approach, psychological test data could be used to shield light on clinical

adjustment with a view toward making recommendations and treatment plan that could be used by others. This suggests that the test data have some therapeutic implications. In the other hand, the experimental approach emphasizes verifying the scientific law where by one scientifically tests for psychological implication of some conditions. In the training of a clinical psychologist, one can identify two independent models, *the clinical scientist model* and *the professional model*. Clinical psychologists are trained in the two models.

4.3.1.1. The Clinical Scientist Model:

This model emphasizes experimental psychopathology where training is conducted to determine the effect of certain condition on developments of psychological dysfunctions in an individual. Using this model, clinical psychologists are also trained as researchers; where they are exposed to the different characteristics of individuals i.e. personality and how to measure them and understand how to discover new things in research. Clinical psychologists are often faced with assessment of individual traits; characteristics ways of handling issues, the Nature-Nurture controversy and the question is on how to measure this aspect of the individual. When a clinical psychologist identifies personality of the individual, he would be in a position to predict the behaviour of that person.

ITQ: A clinical scientist model of clinical psychologist is best described as someone who does (a) works exclusively in a university setting (b) works exclusively in a hospital (c) someone who teaches and works in a hospital

If you picked (a) you're wrong, why? Exclusive teaching is a scientist but not adding the clinical part. If you pick (b) you're wrong, why? Working only in the hospital is a clinical model while not adding the scientist component. If you pick (C) you're right! Why? The clinical scientist model does research to understand behavior while understanding the psychotherapeutic basics of treatment.

4.3.1.2. The Professional Model:

The training of a clinical psychologist involves exposure to how to conduct therapy, assessment, diagnoses and other professional practices. Basically, clinical psychology has the practical objectives of understanding, evaluating, controlling and treating of psychological problems such as insomnia, depression, anxiety etc. There is organized body of members with approved qualification. For example, The Nigerian Clinical Psychologists Association is only open to qualified clinical psychologist with at least Masters degree in clinical psychology. There are specific rules and regulations guiding members of this professional body. Clinical psychology as a profession, there are clearly stated codes of ethics. For instance, under no circumstances shall a clinical psychologist have carnal knowledge of his client who is currently under his treatment. It is appropriate to note here that the clinical psychologist remains one of the best-trained professionals in the mental health profession when it comes to evaluation, assessment of instrument, intervention methods and community or hospital programs.

ITQ: the emphasis on the assessment, diagnosis and practice will be more on the professional model than the clinical scientist model why?

(a) The training is focused more on basics of research writing

(b) The training is focused on a theoretical knowledge and the tenets of treatments and diagnosis.

If you picked a you are wrong because a clinical psychologist with only research writing will only be a scientist while if you picked (b) this is right because this is the core components of professional model.

4.4. Functions of Clinical Psychologists

Generally, the role of clinical psychologists is to assess and intervene in a wide range of problems where they have special expertise. The range of problem they deal with covers psychological conditions such as anxiety disorders, problems of disturbed and disruptive

behavior; everyday challenges and disorders of mental processes among others. In all these cases the psychologist is trying to understand or change an essentially psychological problem of an individual, family or group. Similarly, clinical psychologists are involved with an issue, which does not primarily relate to identify patients but affects the health care system as a whole. For example, a clinical psychologist may educate the community members on the ripple effects of vandalizing petroleum pipes; emphasizing its direct danger in individual and community members at large. How can community health centre designed education programme that will deter potential "vandalizers" from acting out their intention and become a peer educator to others. Other notable functions of clinical psychologist are discussed below:

4.4.1. Clinical Assessment and Intervention

Clinical psychologists assess clients' psychological and social problems, limitations and capabilities. There are perhaps, many ways of formally defining psychological assessment. Clinical assessment involves evaluation of an individual's strengths and weaknesses, a conceptualization of the problem at hand and some prescription for alleviating the problem. Assessment is not something that is done once and then forever finished. In many cases, it is an ongoing process in psychotherapy. It is the means to the end for the clinician. Before a clinical psychologist engages in therapy, he needs to understand the nature of the problem. In assessment, a common question that a clinical psychologist asks is "how is this patient or client functioning psychologically?" For example, in a case of drug addict who is presenting withdrawal problem, the psychologist observes the symptoms of withdrawal, secondly, the clinical psychologist identify the aspect of the environment such as stressful conditions at home, peer pressure and so on that predispose the individual to taking drugs. Furthermore, the psychologist identifies the cues within the environment that maintain the dysfunctional behavior i.e. drug taking behavior such as smoking of cannabis (Igbo) around the client residence and at

the end of the evaluation the clinical psychologist draws up a treatment program that will be best suited for that particular case of drug addiction.

Psychological intervention is a method of inducing changes in a person's behavior, thoughts or feelings. Therapeutic approaches of the clinical psychologist differ from that of the medical doctor. The medical doctor uses chemotherapy and surgery, while clinical psychologist uses psychotherapy (psychological therapy) in treating clients. During psychotherapy, the psychologist establishes a genuine relationship with the client. The therapist and the client work together as a team in order to resolves the client psychological problems. In some cases, therapy is undertaken to solve a specific problem or improve the individual's capacity to deal with existing behaviours, feelings or thoughts that are debilitating. In other cases, psychotherapy may be focused more on the prevention of problems than on remedying an existing condition. In still other instances, the focus of therapy is on increasing the person's ability to take pleasure in life or to achieve some latent potential.

ITQ: one of these is the appropriate sequence in any psychological intervention?

(a)Assessment – case formulation – treatment

(b) Case formulation - treatment – Assessment

(c) Treatment – Assessment – case formulation

If you have picked b or c you are wrong because Assessment is the first step in creating knowledge about clients' problem with case formulation (understand what keep problem) and before understanding the best form(s) of treatment of the illness.

4.4.2. Consultation

Clinical psychologists can act as consultants by offering guidance to both laypersons and human service organization. The role of the consultant is to guild consultees toward creating their own improvement in the groups or organization they represent. For example, clinical

psychologist can act as a consultant to a teacher in a school setting. In this regard the clinical psychologist provides the teacher with the best assessment tool that fits a particular student. A typical clinical psychologist can function as a consultant to a community mental health center and at the same time is working on a part time basis for a psychological consulting firm, and also consult with local chapter of self-help group such as the Alcoholic Anonymous Group (AA), helping individuals with alcoholic problem.

4.4.3. Administration

Some clinical psychologists serve as executives, managers or lecturers in organizations such as the university or psychology department. An administrator guilds and control the effort of a group toward some common goal through the use of skills in planning, organizing, assembling resources, directing and controlling. Clinical psychologist is competent in assessment, therapy, teaching and consultation and for this reason is better equipped with the tools of administrative duties.

4.4.4. Research

This is a very dynamic and vital aspect of all forms of human endeavours. Clinical psychologists undertake research investigations that lead to new discoveries daily. Research can also be directed at examining causes and consequences of psychological dysfunctions, for example, the role of negative life event on psychological functioning of one of the clinical psychology students. The clinician may be interested in the cause of high admission rate at health center just before examinations. A clinical psychologist may also be interested in the study of relapse, identifying the psychosocial factors responsible for the relapse of a particular psychological disorder.

4.5. Settings where Clinical Psychologists Function

Clinical psychologists carry out their scientific and professional work in many settings. Clinical psychologists work in a wide variety of settings. These include hospitals, mental health clinics, schools, universities, governmental agencies, prisons, police department and military bases. Many clinical psychologists also work in private practice.

Box 4.5: Functions of Clinical Psychologist
Clinical psychologist does a variety of functions but primarily they are to assess and intervene appropriately in a wide range of psychopathological areas. To do this they often do the following:

- Clinical assessment and intervention.
- Psychological Consultation.
- Administration.
- Research.

4.6. Summary

This lecture explained the principles guiding clinical psychology as a profession. The general function of the clinical psychology is to assess and intervene in a wide range of problems where they have special expertise. However, other major classified functions of the clinical psychologists are clinical assessment and intervention, consultation, research, and administration. Finally, settings where clinical psychologist could be found include hospitals, mental health clinics, schools, universities, governmental agencies, prisons, police department among others.

Self – assessment questions (SAQs)

1. Mention at least two basic principles guiding clinical psychology
2. Explain the basic differences between the two major models of the clinical psychologist.
3. List the functions and settings of clinical psychologists pairing them in at least four different settings.

References

Osinowo, H. O, Imhonde, H. O. and Olley, B. O. (2004). *A step into Clinical Psychology,* RYCE, Benin City

Uwaoma, N. (2002). *Clinical/Abnormal Psychology in Modern Africa.* Rescue Publishers, Abba Road Owerri.

LECTURE FIVE

5.0. CLASSIFICATION SYSTEMS OF PSYCHOLOGICAL DISORDERS

Expected duration: *1 week or 2 contact hours*

Introduction

In this lecture you shall be exposed to the two classification systems of mental disorders commonly acceptable to the mental health practitioners. These are the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Disease (ICD). However, DSM-IV is a major focus in this lecture and this is described with examples.

5.1. Objectives:

At the end of this lecture, you should be able:

1. understand the two classification systems of mental disorders
2. identify the five axis in DSM-IV

5.2. Pre-Test

1. Briefly explain why you think the five axes are used in DSM-IV with an example of a disorder.
2. What is GAF scale?

5.3. CONTENT

5.3.1. Classifying Psychological Disorders

Categorization is essential to our survival because it allows critical distinctions to be made. Diagnosis is a type of expert-level categorization. It is used by mental health professional such as clinical psychologists to enable them to make important distinctions e.g. schizophrenia

versus bipolar disorder with psychotic features. A major purpose of diagnosis is to make predictions. Given a particular diagnosis, what is the likely course of the disorders? Will the disorder respond to treatment? Which treatment? Success in making such predictions depends on the availability of a diagnostic system that can be used to classify disorders in a reliable fashion. There are two classification systems of mental illness commonly acceptable to the mental health practitioners. These are the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Disease (ICD). Presently the DSM in use is the fourth edition-DSM-IV, while that of ICD is the tenth edition-ICD-10.

The most frequently used system for classifying psychological disorders is the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM). More than 200 psychological disorders are listed in the fourth edition of the DSM. One reason for revising the DSM is that diagnoses based on the categories listed in earlier editions were not sufficiently reliable. At times, different mental health professional that interviewed the same patient failed to agree on the diagnosis. To remedy this problem, the developers of the DSM, added rules for making diagnoses. The DSM spells out the number, severity and duration of symptoms that define a diagnostic category. The DSM concentrates on describing symptoms and providing rules for making diagnoses without offering specific models to explain the disorders.

The use of diagnostic labels can be a double-edged sword. Diagnostic can help advance our knowledge about the causes of disorders and aid in making treatment decisions, but diagnostic label may also create a stigma that can be difficult to overcome when looking for housing or a job or simply interacting with other people. Labels inevitably affect how we perceive and respond to others especially here in Africa; our responses to those labeled as having psychological disorders are often different from our responses to other people. In Nigeria, people

seem to have difficulties relating with someone who had been diagnosed to have a particular mental disorder. The major DSM-IV categories and examples of each are listed in below.

ITQ: A major advantage of mental health classification will be (a) to appropriately label people behaving abnormally by mental professionals (b) to agree to a consensus among mental health professionals what constitute each illness (c) to understand the differences between mental health issues in different cultures.

If you picked (a) you're wrong, why? The purpose of classification of mental illness is far from labeling and it's never intended for this which is why DSM is expected only to be used by qualified professionals (b) if you picked (b) you're right ! Yes, one of the major reasons for DSM was to have a common means of identifying issues in mental health. If you picked (c) you are also wrong! Why? Although DSM helps us to understand differences but it's not to understand these differences across cultures, these is a short coming of DSM.

5.3.2. A condensed version of the DSM-IV

Axis I: *Clinical Disorders or Other Conditions that may be a Focus of Clinical Attention*: For examples, disorders usually diagnosed in infancy, childhood, or adolescent (e.g. pervasive developmental disorders); cognitive disorders (e.g. delirium); mental disorder due to a general medical condition' substance-related disorders; psychotic disorders, adjustment disorder etc.

Axis II: *Personality Disorders and Mental Retardation:* For examples, personality disorders (e.g. borderline, antisocial, dependent); mental retardation (e.g. mild, moderate, severe mental retardation).

Axis III: *General Medical Conditions That are potentially Relevant to the Understanding or Management of the Individual's Mental Disorders:* For examples, HIV/AIDS, cancer.

Axis IV: *Psychosocial and Environmental Problems:* For examples, problems with primary support, educational problems, housing problems, economic problems, etc.

Axis V: *Global Assessment of Functioning (GAF) Scale:* The GAF scale considers psychological, socials and occupational functioning on a hypothetical continuum of mental health/illness. Do not include impairment in functioning due to physical/or environmental limitations. The codes in the GAF scale and their implications are described as follows:

Code	***Description***
91-100	(i.e. superior functioning in a wide range of activities, life's problems)
81-90	(i.e. absent or minimal symptoms such as mild anxiety before an exams)
71-80	(i.e. symptoms are present; they are transient and expectable reactions to psychosocial stressor such as temporarily falling behind in school work)
61-70	(i.e. some mild symptoms such as depressed mood and mild insomnia),
51-60	(i.e. moderate symptoms such as flat affect and circumstantial speech)
41-50	(i.e. serious symptoms such as suicidal ideation, severe obsesional rituals)
31-40	(i.e. some impairment in reality testing or communication such as speech is at times illogical, obscure, or irrelevant)
21-30	(i.e. behaviour is considerably influenced by delusions or hallucinations)
11-20	(i.e. some danger of hurting self or others such as suicide attempts)
1-10	(i.e. persistent danger of severely hurting self or others such as recurrent violence) or persistent inability to maintain minimal personal hygiene
0	(i.e. inadequate information).

Source: From American Psychiatric Association (1994). Diagnostic and Statistical Manual of mental Disorders, (4th ed.), 32.

ITQ: if a man has a chronic medical illness which precipitated the clinical depression of a man, you are a clinical psychologist writing his report, on what axis will you note his medical condition?

(a) Axis IV (b) Axis II (c) Axis III. If you pick (a) you're wrong, because Axis IV identifies psychosocial and environment problems which may affect the clinical diagnosis. If you pick (b) then you're wrong, because Axis II identifies conditions which are relatively stable over life time such as personality and mental retardation and if you pick (c) you're right, Axis III identifies general medical conditions which may affect clinical conditions.

Box 5.3: Classification of Psychological Disorders

There are majorly two systems of classification of mental disorders DSM (Diagnostic and Statistical Manual of Mental Disorders) and ICD (International Classification of Disease). The main functions of these classification tools are to have consensus on what typifies a particular psychopathology and aid treatment decisions

5.4. Summary

The lecture has been able explained the two classification systems of mental disorders commonly acceptable to the mental health practitioners. These are the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Disease (ICD). The DSM-IV has five axes and this was described with examples of disorders categorized in each of the five axes. General Assessment Functioning (GAF) in Axis V was further described with codes available in it with examples of the likely disorders.

Post test

1. Briefly explain why the five axes are used in DSM-IV with an example of a disorder.
2. What do you understand as GAF scale?

Self – assessment questions (SAQs)

1. An individual suffering from occasional panic attack can be categorized under what code in the GAF scale?
2. Cite at least 5 examples of medical conditions that can predispose an individual to having mental illness.

Reference

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of mental Disorders*, (4th ed.), 32.

LECTURE SIX

6.0. ASSESSMENTS IN CLINICAL PSYCHOLOGY

Expected duration: *1 week or 2 contact hours*

Introduction

This lecture explains various assessments in clinical psychology. The lecture covers the interview, clinical assessment such as history taking/clacking a patient and mental state examination.

6.1. Objectives

At the end of the lecture, students should be able

1. To understand various assessment methods in clinical psychology
2. To know peculiar assessment tools available in clinical psychology.

6.2. Pre-Test

1. What are differences between the diagnostic interview and the intake interview?
2. Why are there needs for behavioural assessment in clinical psychology?

6.3. CONTENT

There are various methods of assessment in clinical psychology; and these methods are purely handled by trained expert and carried out in a peculiar environment. Generally, assessments in clinical psychology involve unique relationships built upon rapport, respect,

confidentiality, mutual trust and professional ethics. Assessments basically involve the therapist and client(s). Various assessments in clinical psychology cover the interview, personality, intelligence and behavioural assessments etc.

6.3.1. Interview in Clinical Practice

Interview is the clinician's basic technique for both assessment and psychotherapy. Interviews do typically occur early in the patient contact with the clinic and are by no means exclusive purpose to clarify the clinicians' understanding of the patient's problem in order to plan for therapeutic intervention. Assessment interview is at once the most basic and the most serviceable technique employed by the clinician. In the hand of a skilled mental health professional, its wide range of application and adaptability make it a major instrument for clinical decision making, understanding and prediction. Hearing about the patients' problem and efforts to solve them are two interlocking phases of continuous process. Both require sincere collaboration of the patient and the clinicians. In the traditional clinics, the patient gains entry into psychological treatment through a series of assessment procedure, which may include an intake interview, diagnostic interview, social history interview and psychological interview. The findings are then combined in decisions about further therapeutic programs. The purposes of the initial interview include:

a) To establish the interpersonal relationship (i.e. rapport).

b) To gain information about the patient and his problems (assessment)

c) To give information about the workings of the clinic, possible future programs, conditions of therapy and fees.

d) Bolstering the patient to resolve to improve if necessary through further therapy.

ITQ: Assessment will most aptly fit into which stage of the therapeutic relationship (a) Beginning (b) Middle (c) End. If you pick beginning,(a) you're right assessment is most often

excepted but not limited to the beginning of every therapeutic relationship. If you pick (b) and (c) you are wrong because although assessment is sometimes done at middle and end of sessions to determine improvement but it must have been carried out at the beginning or else no baseline to measure it against.

6.3.2. Kinds of Interview

1) *The Diagnostic Interview:* This is developed mainly in hospital practice in the Kraeplenian traditions. Such interviews are still more commonly used with psychiatric patients. The interview focuses mainly on the patient symptoms in order to describe as precisely as possible the type, extent, duration, past history and future course of the patients psychiatric illness. The complete psychiatric examination often includes a mental status examination, such as intellect and thought process, recent and long term memory, disorders of perception (e.g. hallucinations, illusions), belief (i.e. delusion), attention and orientation, emotional expression insight, behaviour and appearance.

2) *The Intake Interview:* This is design to introduce the patient to the clinic or hospital while judging whether its facilities are appropriate to his needs. The interview focuses on the patient desire, motivation for treatment, expectation from the clinics and alternative course of action. The patient is given information about the hospital procedures, fees, schedules and other matters, which might clarify his thinking about further contact.

3) *Social History or Case History:* This is expected to be taken by a social worker but where there are no social workers the clinician takes it. Age, family, number of children, jobs and so on are all taken here as the social and case histories.

Steps in Interview

i. The beginning and opening of an interview

ii. Setting interview goals

iii. Information gathering and problem definition

iv. Determination of the outcome of the interview

v. Closing the interview.

ITQ: if a clinician is seeing a patient with panic attack with agoraphobia which of the types of interview will be the most appropriate to understand duration, precipitation causes etc of illness.

(a) Intake interview (b) diagnostic interview(c) social case history

If you pick (a) intake interview, you're wrong because intake is needed when you are taking a patient into a facility for treatment which will not address the need of the client and therapist. If you pick (b) diagnostic interview, you're right because this is the best form of interview to understand client's concept of illness, beliefs, duration, precipitating factors etc and if you picked (c) you're wrong because social case history addresses the social history of the patient which most times is a fraction of the clients' life and not most times enough to understand the concept of the disorder.

6.3.3. Clinical Assessment

The major aim of clinical assessment is to be able to take a decision on how to go about the care of the client. If there is any psychological dysfunction, the clinician can identify the causes of the problem. When a clinician carries out the first clinical interview, he is able to gather base line data (the initial data that you gather on a client). This data are useful to make comparison between the initial level of functioning and the scores obtained once the client starts treatment. During clinical assessment the clinician identify the best assessment method; carries out the assessment after the examination of the patient, the clinician interpret the result on the basis of the client score on the assessment tools use. If the clinician has his own personal clinic and a client just works in, the clinician is under obligation to discuss his findings with the client.

If it is a referral case from a psychiatrist or other health professionals, the clinician may send the report to the referring health professional with or without discussing with the client.

6.3.4. Clacking a Patient

Four areas are involved in the assessment procedures:

1) *Preparation:* You obtain information from the patient, referral source, official records or from previous psychological records in order to have base line information for the purpose of comparison with present assessment.

2) *Input:* Here, the clinical psychologist talk of the kind of test, how many of them and what other things to do to the patient.

3) *Process:* This is the stage whereby information gotten from the patient is processed. Test administered are scored, interpreted; a diagnosis is made and suggestions are drawn. Also, suitable treatment for the patient recommended.

4) *Output:* Finally, a psychological report on the patient is written.

6.4. Some Assessment tools Available to the Clinical Psychologist

Assessment tools available to the clinical psychologist, ranges from the *personality inventory* to the *projective techniques*. Personality inventories and projective techniques can also be used in the assessment of normal personality; not only for psychopathology. The personality inventories concentrated more on the psychometric qualities of their measures, whereas projective techniques have tended to be less concerned with reliability, validity, and norms; rather are more interested in the richness of impressionistic interpretation and the clinical analysis of responses. Nevertheless, personality inventories and projective techniques serve similar purposes-sometimes for screening applicants in the industrial or educational contexts but more often for diagnosing patients in psychological clinics or counseling centers.

6.4.1. Personality Inventories

Personality inventories consist of items concerning personal characteristics, thoughts, feelings, and behaviour. Respondents mark those items on a personality inventory that they judge to be most descriptive of them. A typical personality inventory measures a broader range of variables and is usually more carefully constructed and standardized than a rating scale or checklist. Because of incorrect responses or untruthfulness of respondents, some inventories have special validation scoring keys to detect dissimulation or faking. These validation keys are not always successful in spotting faking, but they have been shown to be quite effective in certain situations (Norman 1963). Apart from faking (i.e. faking good or bad), acquiescence (i.e. the tendency to agree rather than disagree when in doubt), social desirability (the tendency to respond in a more socially acceptable manner), over cautiousness, extremeness, and other response sets may also cause problems in personality inventories. However, norms accompany most personality inventories.

Examples of highly acceptable personality inventories include: 90-item Eysenck Personality Questionnaire (EPQ) developed by Eysenck which consists of four subscales: *Neuroticism, Extraversion, Psychoticism* and the *lie* subscale. It is scored on the Yes and No basis. It has some reversed score also. Also, there is California Psychological Inventory (CPI) developed by H.G Gough. It is a 480 true-false item scale. Another personality inventory is the Minnesota Multiphasic Personality Inventory (MMPI) was first developed by S.R. Hathaway & J.C. McKinley. It is designed to assess personality characteristics indicative of psychological abnormality. The 550 statement items on the MMPI are to be answered ‘Yes”, “No”, or “cannot say”, currently MMPI-2 is in use with 567 items.

6.4.2. Projective Techniques

Projective technique is a term introduced by Lawrence Frank (1939) for ambiguous stimuli on which respondents can project their inner needs and states. Projective techniques are composed of relatively unstructured stimuli that the examinee is asked to describe, tell story about, complete, or respond to in some other manner. In contrast to the more direct personality inventories and rating scales, projective techniques are usually less obvious in their purposes and therefore presumably less subject to faking and response sets. Because projectives are relatively unstructured in content and open-ended in terms of the responses required, it is assumed that whatever structure is imposed on the stimulus material represents a projection of the examinee's own individual perception of the world. Their lack of structure is a double-edged sword in that it makes for difficulties in scoring. As a consequence of scoring problems most projective techniques do not meet conventional standards of reliability and validity. Since projective tests attempt to get an unconscious process, interpretations of responses to projective test materials have been greatly influenced by psychoanalytic theory and interpretation is further based on examinee's patterns of responses. Because of this, administration and scoring of projective tests require more training and sensitivity than a self-report inventory.

Examples of projective tests include the Rotter Incomplete sentences Blank where individuals are asked to complete specially written incomplete sentences. The Rorschach Inkblot Test consists of ten 51/2 by 91/2 cards. Each card contains one bilaterally symmetrical, black-and-white (five cards), red-and-gray (two cards), or multicoloured (three cards). The cards are presented individually and viewed at no greater than arms length. The examinee is told to report what is seen in the card or what might be represented by the inkblot. Every response to a Rorschach card may be scored on several categories: locations; determinant; content; popularity and accuracy. Also, the Thematic Apperception Test (TAT) developed by H.A. Murray. The TAT materials are 20 black-and-white picture cards depicting people in various ambiguous

situations, plus one black card. The examinee is asked to take approximately 5 minutes per story, telling what's going on now, what thoughts and feelings the people in the story have, what events led up to the situation, and how it will turn out. However, among the shortcomings of projective techniques are inadequacies of administration, scoring, and standardization. The lack of objectivity in scoring and the paucity and unrepresentative of normative data are particularly bothersome to psychometric specialists.

6.4.3. Behavioural Assessment

The goal of interest in the behavioural assessment is to ascertain the current factors in the treatment that can be used to alter behaviour. Behavioural assessment has a direct relationship with treatment. If the assessment has been correctly executed, it should identify correctly factors that will lead to a particular behaviour or elicit behaviour in a particular direction. For example if you notice that a child cries when the mother enters the room and moves closer to the child, that may be a behaviour that elicit the temper tantrum in the child. In behavioural assessment you define exactly what is to be measure and try to observe and record events or situations that precede or follow the behaviour. The instruments that can be used in behavioural assessment include wristwatch, checklist, chart, a pen, audiovisual tape, tape recorder, one-way mirror computers etc.

6.4.4. Mental State Examination (MSE)

In the mental state examination, the patient is described and tested with the followings:

i. General Appearance: that is, dress, cleanliness, grooming, facial expression, eye contact, gestures and posture).

ii. *Motor behaviour:* that is, increased motor activity: restlessness, agitation, and excitement. Diminished motor activity: retardation (slow), akinesia (stupor).

iii. Affect and Mood: that is, elevated mood (elation-euphoria), inappropriate affect (incongruity), loss of affect (shallow, flat, bluntness, apathy), love, hate, jealousy, surprise, perplexity, shyness, irritability.

iv. Thought and Speech: that is, *disorders of content of thinking* such as: paranoid, depressive, sexual, religion, control of influence, primary and secondary delusions, systematized or non-systematized bizarre delusion. There are *disorders of form of thinking* such as distortion of language formation (e.g. loose association of ideas, derailment of ideas etc). There are *disorders of possession of thinking* such: thought insertion, thought withdrawal, thought broadcasting. There are *disorders of stream of thinking* such as rapid thinking, slow thinking, thought blocking. Finally, there are *disorders of speech production* such as stammering, repetitive speech, word salad etc.

v. Perception: that is, illusions, hallucinations, body image disturbances, depersonalization, derealization, change in intensity of sensations, change in size of sensations.

vi. Disorders of cognitive functions: such as consciousness, attention and concentration.

vii. Disorders of Memory: such as loss of memory (amnesia), immediate, recent and remote memory.

viii. Disorders orientation: that is time, places, and person.

ix. Intelligence: such above average, average and below average or deficiency in intelligence.

x. Insight and Judgment: such as awareness of the presence of symptoms of mental disease and awareness of the need for treatment. This could be loss of insight, partial insight, or insightful, Sense of judgment (e.g. common sense).

ITQ: A clinician interested in the cognitive status of a 75 years old man suspected of dementia and brought to the clinical psychologist for evaluation will most probably use which of these

assessment tools (a) Thematic Apperception Test (TAT) (b) Minnesota Multiphasic Personality Inventory -2 (MMPI-2)(c) Mental State Examination(MSE)

ITA: If you pick (a) Thematic Apperception Test (TAT), you're wrong because (TAT) is a test of subconscious processes. If you pick (b) MMPI-2, you're also wrong because this a test of personality which is not purpose of evaluation. If you pick (c) MSE, you're right because this is the most appropriate way to assess mental process which is the effective deficit in dementia.

Box 6.4: Assessment tools in clinical psychology

Assessments are used are trained experts to understand and help clients in overcoming difficulties. Various assessments are intended for different reasons and the common ones are:

- Personality inventory.
- Projective tests.
- Ability tests.
- Cognitive assessments.
- Behavioural assessment

6.5. Summary

The lecture has been able to expose students to knowledge about various assessments in clinical psychology. These assessments in clinical psychology include interviews, behavioural assessment and mental status examination. The assessment tools available to the clinical psychologists as discussed in the lecture include personality inventories such as MMPI, EPQ; and projective techniques such as TAT, Rorschach blot test.

Post-Test

1. What are differences between the diagnostic interview and the intake interview?

2. Why are there needs for behavioural assessment in clinical psychology?

Self – assessment questions (SAQs)

1. Explain some reasons for the use of projective techniques in clinical psychology.

2. Mention and discuss steps in clinical interview.

References

Osinowo, H. O, Imhonde, H. O. and Olley, B. O. (2004). *A step into Clinical Psychology,* RYCE, Benin City

Uwaoma, N. (2002). *Clinical/Abnormal Psychology in Modern Africa.* Rescue Publishers, Abba Road Owerri.

LECTURE SEVEN

7.0. PSYCHOTHERAPIES IN CLINICAL PRACTICE

Expected duration: *1 week or 2 contact hours*

Introduction

This lecture provides a general description of psychotherapy and explains various methods of psychotherapy used for clinical intervention. These psychotherapies go by many different names: psychoanalysis, behaviour therapy, cognitive therapy, humanistic therapy, group therapy and on and on. In some ways, each of these psychotherapies has a set of unique defining characteristics or is directed toward specific kinds of problems.

7.1. Objectives

At the end of this lecture, you should be able to

1. Explain specific characteristics of different psychotherapies.

2. Explain some basic components of these psychotherapies.

7.2. Pre-Test

1. Explain the concept of psychotherapy.

2. What will be the focus of a psychoanalyst in therapy?

3. Mention some methods of having specific changes through behavior therapy.

7.3. CONTENT

7.3.1. Defining Psychotherapy

Wolberg (1967) defined psychotherapy as 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. It is basically seen as a *systematic interaction between a therapist and a client* that brings *psychological principles* to bear on influencing the *client's thoughts, feelings, or behaviour* in order to help the client *overcome abnormal behaviour, adjust to problem* in living or *develop* as an individual.

Psychotherapy is not counseling, though there may be overlap. Counseling focuses on giving advices to help an individual in terms of specific situations. This speaks of a provision of an immediate temporary relief or solutions. But psychotherapy teaches or exposes an individual to healthy and lasting patterns of coping effectively with or adjusting to his problems. It helps the patient change unhealthy living patterns by assisting him to understand his inner self and how to deal with his present and future problems. Carson, et al (1998) posit that psychotherapy is based on the assumption that even in cases where physical pathology is present, a client's perceptions, judgment, expectations and coping strategies also play a role in the development of the disorder and will probably need to be changed if maximum benefit is to be realized.

ITQ: A major factor that sets psychotherapy different from counseling is (a) the mode of delivery (b) advices about specific issues (c) psychotherapy focuses on the treatment and changing or enhancing coping in more severe illnesses.

ITA: If you pick (a) you are wrong, because the mode of delivery of both counseling and psychotherapy are the same, which is talking. If you pick (b) you're wrong, because there are situations when psychotherapy uses giving advices but it's just more than advice. If you pick (c) you're right, because psychotherapy is more on the treatment of psychopathologies.

7.3.1.1. Psychoanalytic Therapy

Psychoanalytic therapy is the foremost and most often described as the fathers of all theories developed by Sigmund Freud. The approach of psychotherapy utilizes unconscious motives and conflicts in the search for the roots of behaviour. It likewise depends heavily on the analysis of past experience. In other words, psychodynamic therapy emphasizes the role of unconscious processes in the determination of both normal and abnormal behaviours. The following are the basic techniques used in the psychoanalytic therapy:

i. *Dream Analysis:* This is built on the rule that when a person is asleep, repressive defenses are said to be lowered and forbidden desires and feelings may find an outlet in dreams. The therapist's task then, is to uncover these distinguished meanings by studying the images that appear in the manifest content of a client's dream and his preconscious association to them. Dream interpretation can be very tedious but one can develop dream symbolism. The symbolism and dream are culturally interpreted. Some believe they are prophetic while some regard dreams as patterns of thinking.

ii. *Analysis of Free Association*: This is a technique developed where the therapist encourages the client to explain and record what is going on in his unconscious. This can be done through interviews and observations. For example what is normally called slip-of-tongues is often a revelation of materials in the unconscious mind.

iii. *Analysis of Resistance:* This is a technique, which the therapist can use to assess some of the factors working against the progress or recovering rate of the client, for example, Probing,

Paraphrasing etc. Resistance may manifest in terms of inconvenience to talk about certain motives, giving a too glib interpretation of som associations, coming late to appointment or forgetting it completely and such preventing painful and threatening material from entering awareness.

iv. *Analysis of Transference:* This is a technique of assessing factors responsible for a client's direction of emotional feelings toward the therapist, as if he was the original source of his /her problem. One has to interpret, clarify this point. From these you will know what to do because the patient may give an impression associating you with the cause of the illness, to show that you are not responsible in your encounter, by been empathic.

7.3.1.2. Behaviour Therapy

Modern behaviour therapy stems, in large part, from the work of Joseph Wolpe and B.F.Skinner in the 1950s. The therapy is based on the principle of *classical* and *operant conditioning*. It specifies the precise maladaptive behaviours to be modified and the adaptive behaviour to be achieved, as well as the specific learning principles or procedures to be used in producing the desired results. Behaviour therapy methods are today routinely used in all facets of mental-health treatment, and the field is continuously enriched by new contributions from research in general psychology. The following behaviour therapeutic methods are discussed.

i. Systematic Desensitization: Three steps make up systematic desensitization. The first is training in progressive relaxation, a method of inhibiting anxiety. The second is constructing a series of anxiety provoking scenes on the basis of the patient's description of the problem. Thirdly, while the patient is deeply relaxed, the therapist asks the patient to imagine being in each scene until all feelings of anxiety have disappeared. In progressive relaxation, the therapist instructs the patient in tensing and then relaxing muscles of the arms, legs, abdomen, neck, and head. By practicing at home, most patients become adept in quickly achieving a deep state of

relaxation. Thereafter, the patient and the therapist jointly develop the series of anxiety provoking scenes, known as anxiety hierarchy. The average systematic desensitization procedure takes ten to fifteen sessions. It has proven remarkably effective in the treatment of phobias and similar anxiety reactions. In vivo desensitization sometimes anxiety reactions can be corrected by exposing the patient directly to anxiety provoking situations, rather than imagined scenes. The patient is asked to stay in the situation until all feelings of discomfort subside.

ii. Extinction: This is based on the fact that behaviour patterns tend to weaken and disappear over time if they are not reinforced. Thus, the simplest way to remove a maladaptive pattern is to remove the reinforcement for it. This can be done through implosive or flooding.

iii. Modeling: In modeling, the client watches other people perform desired behaviours, thus vicariously learning skills without going through a lengthy trial and error process. For example, a therapist may show a twenty-four-year-old student with a severe spider phobia how to kill spiders with a fly swatter and had her practice this skill at home with rubber spiders. The combination of live modeling with gradual practice is called participant modeling; it is one of the most powerful treatments for fear.

iv. Assertiveness Training: Assertiveness training teaches people to express their feelings in a direct and honest way that neither humiliates nor degrades other people. Acting assertively lets other people know how you see the problem, how you feel about it, and what you would like to do about it. Assertion training has proved especially effective for patients who tend to be anxious in social situations and who react by withdrawing and feeling helpless.

v. Aversive Conditioning: Many unwanted behaviours are so habitual and temporarily rewarding that they must be made less attractive if the client is to have any chance of learning alternatives. Methods for lessening the appeal of once-desirable stimuli are known as aversive conditioning, because they employed classical conditioning principles to associate physical or

psychological discomfort with behaviours, thoughts, or situations the client wishes to stop or avoid. For example, alcoholics might be allowed to drink after taking a nausea producing drugs, so that the taste and smell of alcohol are associated with nausea rather than with the usual pleasurable feelings. Still, aversive conditioning is unpleasant and uncomfortable, and its effects are often temporary. Many therapists thus avoid this method or use it only long enough to allow the client to learn alternative behaviour.

vi. Contingency Management: This involves the use of reinforcement to elicit and maintain effective behaviour. It employs techniques such as shaping, token economies and behavioural contracting.

vii. Self-Control Procedures: A self-control procedure is a special form of behaviour modification I which the person whose bahaviour is to be changed actively participates in designing and carrying out the behaviour modification program. For the behaviour therapist, self-control means that the person arranges cues (discriminative stimulus) and consequences (reinforcers) in his or her environment to support new forms of behaviour. Self-control procedures are especially helpful in changing ingrained habits like overeating or smoking. But they can also be used to support more effective studying, a regular program of exercise, or any other desirable goal. There are three steps involve in self-control program: *analyzing the situation*, *managing discriminative stimuli* and *managing the consequences*.

viii. Biofeedback: Biofeedback is a method of teaching patients voluntary control over their muscular and visceral responses to stress so that they can recognize and reduce body tension. The most commonly used biofeedback devices are instruments that record the electrical activity of muscles and instruments that record hand temperature. The goal of muscle biofeedback is to decrease muscular tension, while the goal of temperature biofeedback is to increase hand temperature by dilating the underlying blood vessels. Thus information about physiological

activity is fed back to the patient so he or she can learn to control it voluntarily. Biofeedback is usually accompanied by training in various types of relaxation.

7.3.1.3. Cognitive Therapy

In our daily lives, our beliefs and thoughts influence our emotional reactions. Indeed, the cognitive behaviour therapy stemmed from cognitive psychology and focuses on the effects of thought on behaviour and on the study of the very nature of our cognitive processes and behaviorism with its rigorous methodology and performance-oriented focus. According to this therapy, when the critical cognitive components are changed, the behaviour and maladaptive emotions will change. Basically, there are three approaches to cognitive therapy:

1. The rational-emotive therapy of Abert Ellis
2. The stress inoculation training of Donald Meichenbaum
3. The cognitive behaviour therapies of Beck.

The Rational-Emotive Therapy by Ellis

The Rational-Emotive therapy is one of the best-known forms of cognitive therapy. Its originator, Albert Ellis, stresses that the emotional difficulties of many patients in psychotherapy are due to what he calls the “irrational beliefs” they bring to bear on their experiences. His goal is to teach patients more effective “rational beliefs”. In rational emotive therapy, patients are first thought to recognize and then question their irrational beliefs. Patients are shown how to ask themselves questions such as “where is the evidence that I am a worthless person if not universally approved? Who say I must be perfect? Why must things go exactly the way I would like?” After recognizing their irrational beliefs, patients are taught to substitute more realistic alternatives. For example, rational alternatives such as ‘I would like to be approved, but I do not need such approval’, ‘what I do doesn’t have to be perfect to be good. I will be happier if I achieve at a realistic level rather than strive for perfection’, or ‘if I can’t change the situation, it

may be unfortunate but not catastrophic. I can make plans to make my life as enjoyable as possible', to replace their irrational beliefs.

Cognitive-behaviour Therapies by Beck

Aaron, T. Beck and his colleagues developed a cognitive therapy specifically designed for work with depressed patients (Beck, Rush, Shaw, & Emery, 1979). Beck found that depressed patients suffer from a cognitive triad of *negative beliefs about themselves, their future,* and *their experiences*. These negative beliefs, according to beck, are based on faulty information processing and faulty logic, such as ignoring positive information or over generalizing from single negative instances. Cognitive therapy for depression therefore consists of isolating, challenging, and changing erroneous patterns of information processing and thinking.

7.3.1.4. Humanistic Therapies

There are many different forms of humanistic psychotherapy. Some humanistic therapists differ only slightly from psychoanalytic therapist in their approach to treatment. They may use interpretations and analyze resistances, as does the psychoanalytic therapist. The major difference is that the humanistic therapist sees the patient's behaviour as an expression of his or her current feelings rather than as simple a cue to past conflicts or unconscious mind. Other humanistic therapists actively attempt to put the patient in touch with his or her true feelings and perceptions.

7.3.1.5. *Gestalt Therapy:*

Gestalt is a German word meaning Whole. Gestalt therapist often challenge patients to give up their facades, resistances, and phony games in order to experience underlying feelings directly. The gestalt therapist may ask the patient to act out a dream of a problem with another person in order to increase the patient's awareness of his or her immediate feelings. For example, a man who tapped the table while other people spoke was asked by a gestalt therapist if others

talking annoyed him. When he denied, the therapist asked him to experience the feeling behind his habit by tapping more vigorously, as he did his anger mounted until he was pounding the table. The exercise made him aware of his anger, when others are talking as well as his inhibited and unassertive response to it.

The best-known and most widely practiced humanistic therapy is that of Carl Rogers' client-centered therapy.

7.3.1.6. *Client-Centered Therapy:*

The term client-centered implies a focus on the client's conscious experience rather than on the therapist's theory or techniques. The therapy is also client-centered in that clients are treated as fully responsible individuals capable of understanding and directing their own lives. Rogers (1966) regards a warm, trusting, and accepting relationship between therapist and client as the chief ingredient of therapeutic change. Such a relationship helps the client become conscious of those aspects of experience that have been denied or distorted in the past. In coming to recognize and then accept his or her individuality, the client sets the stage for continued growth as a person. In order to facilitate these changes, the therapist must adopt and communicate three interrelated attitudes: *unconditional positive regard, empathy,* and *congruence*.

According to Rogers, the therapist's attitudes of unconditional positive regard, empathy, and congruence initiate a process of growth in the client. As the client realizes someone is listening and understanding, perhaps for the first time in any real sense, the client becomes aware of long denied feelings and thoughts. The client finds that these feelings and thoughts are accepted by the therapist, and moves toward accepting them also. Gradually, the client becomes

a more fully functioning person, able to change and grow in ways that express his or her true personality.

7.3.1.7.. Group Therapy

A group can powerfully influence the behaviour, attitudes, and feelings of its members. Group therapy is a way of harnessing this influence to help people overcome psychological difficulties and achieve more fulfilling lives. Therapeutic groups have several advantages over individual therapy. First, in individual therapy there is no guarantee that the patient's newly acquired insights or behaviour patterns will transfer from therapy sessions to daily interactions in the outside world. A therapeutic group gives the person an opportunity to test out new attitudes and behaviours in a relatively sheltered and supportive social situation. With feedback from the therapist and other group members, the person can further modify and strengthen new ways of interacting. Second, the group participant can learn new ways of behaving by observing other group members as they work to become more effective people. Thirdly, group members can facilitate new behaviour by pooling information and experience and by reinforcing individual attempts to change. Fourthly, group therapy is less expensive and a more efficient use of the therapist's time.

Some therapeutic groups are extensions of well-developed individual therapies. Groups may be conducted, for example, on psychoanalytic, behavioural, or humanistic principles. Psychoanalytic group therapy, with goals of insight and working through, were among the earliest of therapeutic groups. Certain behaviour therapies, especially systematic desensitization and assertion training, are often conducted in-group settings. Encounter groups, discussed below, grew partly out of humanistic therapies. Other forms of group therapy have their own theoretical rationales that are independent of any associated individual therapy. The concept and methods of

family therapy, couple therapy and transactional analysis grew largely out of attempts to understand and help troubled families and couples.

7.3.1.8. ***Family therapy:*** family therapists regard the family as a powerful system that both causes and sustain psychological disorders. Symptoms in one family member are often taken as a sign that the family as a whole is in disarray. The solution is to change the often rigid and destructive ways in which family members interact. The family itself literally becomes the patient. Like behaviour therapists, family therapists are often less interested in uncovering the reasons behind a particular style of interaction than in directly intervening to modify it. To increase awareness of troubling styles of interaction, the therapist might ask the family to reenact a particular incident they have been discussing abstractly. Following the reenactment, the therapist might ask questions such as, how did that make you feel? Why does daddy always stay in the background? How would you prefer to see your parents to each other? At other times the therapist might ask the family to practice new ways of interacting. With a family that has difficulty expressing affection, for example, the therapist might ask Mom and Dad to hold hands in front of their children or ask each member to say something affectionate to the others. As rigid rules are broken, a flood of emotion often occurs. Family members become aware of the unacknowledged styles of interaction responsible for their problems. With the therapist's guidance, they are then able to adopt more open, flexible, and mutually supportive styles of interactions.

ITQ: if a client walks into therapy with a strong fear of spiders which had hindered her ability to live a normal life. Which of the following therapies will be the most appropriate to overcome the phobia? (a) Humanistic therapy (b) behavior therapy (c) psychoanalysis

ITA: if you pick (a) humanistic therapy, you're wrong because to treat phobia effectively you require more than accepting the expressions of the individual. If you pick (b) behavior therapy

you're right, why? Because this psychopathology rests on behavioural responses and altering this process through conditioning, systematic desensitization etc can cure the disorder. If you pick (c) psychoanalysis, you're wrong because exploring the subconscious conflicts might help this disorder but definitely not cure on the short term.

Box 7.3: Behavior therapy

In mental health treatment of patients most times behavior are modified with behavioral therapy which is a n off shoot of the works of Joseph Wolpe and B.F. Skinner. There are various steps and modalities under behavior therapy, however, common ones are :

- Systematic desensitization.
- Extinction.
- Modeling.
- Biofeedback.
- Aversive conditioning
- Contingency management .etc

7.4. Summary

In the lecture, it has shown that professional psychotherapy no doubt, has come to stay and has become the greatest weapon in the hands of practicing clinical psychologists. Though, there are variations in the field, including psychoanalytic therapy, behaviour therapy, cognitive behavioural therapy, humanistic therapies and group therapy, all are aimed at understanding man's problem and how to assist him make a better living using different therapeutic techniques.

Post-Test

1. Explain the concept of psychotherapy.
2. What will be the focus of a psychoanalyst in therapy?
3. Mention some methods of having specific changes through behavior therapy.

Self – assessment questions (SAQs)

1. Explain the major characteristics of humanistic therapy.

2. Mention the major techniques in behavioural therapy

References

Carson, R. C. et al (1998). *Abnormal Psychology and Modern Life.* (10th ed.), Longman, England.

Rogers, C. P. (1966). Client-centered therapy. In S. Arieti, et al (eds.), *American Handbook of Psychiatry, Vol 3. Basic books, New York.*

Wolberg, L. R. (1967). *The Technique of psychotherapy* (2nd ed.), New York: Grune and Statton.

LECTURE EIGHT

8.0. DRUG THERAPIES

Expected duration: *1 week or 2 contact hours*

Introduction

In this lecture, you would be intimated with the various drugs used in treating some peculiar mental disorders. Similarly, it is expected that you will become familiar with certain side effects associated with the use of some drugs in treating mental disorders.

8.1. Objectives

At the end of this lecture, you should be able to

1. Understand various categories of drug therapies in treating mental disorders.
2. Identify some of the side effects of certain drugs used in the treatment of psychological disorders.

8.2. Pre-Test

1. Why drug therapies in treatment of mental disorders?
2. Mention any three antidepressant drugs in the treatment of mental disorders?

8.3. CONTENT

Biological Treatment

You might imagine that most drugs used to treat psychopathology were discovered through a perfectly rational and systematic application of basic sciences, however, most drugs in the treatment of mental illness were by error i.e. looking for cure of something else stumble on

cure of a form of mental illness . Also, some clever scientists did the basic research to discover which systems of the body and brain were responsible for a particular type mental disorder, and then using their understanding of the basic biology, developed a drug that would reverse the bodily processes known to cause the disorder. Human's brain is akin to the word "life", and it plays a major role in our survival. It can be referred to what is called "central network" in the life of a man. This implies that if the brain is damaged, it is much likely to affect the person. It is based on this that paying attention to the brain may be useful in treating psychological disorders. Past effort in altering the brain has however appeared drastic, recent efforts on the use of psychotropic drugs, have served as breakthroughs in treating psychological disorders. The term "psychotropic" suggests affecting mental experience or behaviour. Psychotropic drugs are drugs that have such effects in a person's mental functioning. Even with its numerous advantages, drug therapies are not without negative effects such as harmful side effects. We will now look at some of the psychotropic drugs that are frequently administered in the treatment of psychological disorders.

8.3.1. Drug Therapies

Most drugs affect neurotransmitter levels and thus can have a prominent role in treating psychological disorders (Davis & Palladino, 1997). Neurotransmitters have powerful effects on behaviour, emotions, and thinking.

i. Antianxiety Drugs: Antianxiety drugs can reduce the severity of many of the symptoms of anxiety, such as worry, tension, and fearfulness; especially through the physiological ones such as increased heart rate. These drugs are often prescribed to treat generalized anxiety disorder; they are also regularly used to treat agitation, alcohol withdrawal, insomnia, and muscle spasms. Benzodiazepines are the major class of minor tranquilizers. Xanas, Valium and Librium are among the frequently prescribed benzodiazepines. These drugs increase the ability of Gamma-

Amino butyric Acid (GABA), an inhibitory neurotransmitter, to bind to receptor sites at synapses in the brain. The resulting increase in the firing of inhibitory neurons lowers levels of the neurological activity that produces anxiety.

Antianxiety drugs may be relatively safe because a lethal overdose requires a very large amount of the drug. However, combining antianxiety drugs with alcohol or other drugs may produce severe depression and may sometimes lead to suicide. The most common side effects of antianxiety drugs are drowsiness and impaired ability to acquire or store information, which are usually temporary. Antianxiety drugs are quite addictive, and withdrawal from them can cause life-threatening symptoms such as increased heart rate, delirium and convulsion. This addiction could be in form of being tolerance to the drugs, which means that they need larger dose to maintain the initial effect.

ii. Antidepressant Drugs: In the treatment of depression, three classes of drugs are generally administered: *tricyclic antidepressants, monoamine oxidase inhibitors or MAOIs* and *selective serotonin reuptake inhibitors or SSRIs*. Examples of tricyclic antidepressants include Elavil and sinequan being used to reduce the uptake of the neurotransmitters serotonin and norepinephrine. Although changes takes place at the synapses it takes upward of 10 to 14 days before any reduction in the symptoms of depression takes place. Side effects noticed with the antidepressants include constipation, dizziness, and dry mouth. The MAO is blocked, the levels of these neurotransmitters increase. MAO inhibitors prevent MAO from breaking down norepinephrin and serotonin and thus increasing their effective levels in the brain. The possible side effects of MAO inhibitors are similar to those of the tricyclic antidepressants; however they can be more serious. The third class of drugs use to treat depression is the selective serotonin reuptake inhibitors (SSRIs). This has little or if any effect on norepinephrin levels. Drugs in this group include Prozac (Fluoxetine), which is the most widely prescribed drug for the treatment of

depression. One of the reasons for its popularity is a low rate of short-term side effects. Prozac is prescribed for a growing number of problems including anorexia, bulimia, obesity, obsessive-compulsive disorder, panic disorder, and phobias (Gram, 1994).

iii. Lithium as a Mood Stabilizer

Although lithium was found by an Australian physician, John F. Cade in 1949 to reduce the symptoms of mania, it was however, not approved for use by the Food and Drug Administration until 1970. Lithium is a natural mineral salt, and is the drug of choice for treating the acute manic episodes of bipolar disorder and tend to reduce the wide mood swings associated with this disorder. Some of the side effects of lithium include hand tremour, excessive thirst and urination. Vomiting, nausea, unsteadiness, and even death are symptoms of lithium when in the toxic level. A number of mechanisms have been proposed to explain how lithium reduces wild mood swings. For example, lithium influences the passage of ions in and out of cell membranes. It may also regulate levels of norepinephrine and perhaps other neurotransmitters.

iv. Antipsychotic Drugs

Thorazine (Chlorpromazine) was first discovered in France by a surgeon, Henri Laborit in 1952). The drug is used for the treatment of schizophrenia; although presently there are more potent drugs in use it is still very much in use in the Nigerian hospitals. Chlorpromazine belongs to a group of chemical compounds called *phenothiazines.* The discovery of antipsychotic drugs was a major factor in the deinstitutionalization of mental patients, and that this drug also became the principal method for treating schizophrenia. Antipsychotic drugs seem to work by occupying receptor sites in neurons that respond to dopamine, a neurotransmitter that has been implicated in the development of schizophrenia. When these receptor sites are occupied, nerve condition is reduced. Antipsychotic drugs are very effective at decreasing positive symptoms such as delusions and hallucinations; they are less effective at reducing negative symptoms such as

apathy, flat affect, and poverty of speech. Although antipsychotic drugs do not cure schizophrenia and other psychotic disorders, they are effective in controlling many of the symptoms. Side effects of the antipsychotic drugs include movement disorders such as restlessness, agitation, tremours, and shuffling gait and this account so much for the reasons many patient stop taking their medications.

Other antipsychotic drugs include clozapine which produces low rate of tardive dyskinesia, restlessness, and agitation. Clozapine affects serotonin receptors rather than dopamine receptors and this is the reason for the low rate of motor effect as compared to most antipsychotic drugs. However the side effects of clozapine include impairment of the ability of the borne marrow to produce white blood cells for the immune system, which leaves individuals highly vulnerable to infections. This problem, which occurs in about 1 percent of the patients, develops rapidly and can be lethal. Patients are only advice to take clozapine when they fail to respond adequately to standard antipsychotic drugs. When on the drug patients must undergo blood test to monitor their white blood count.

ITQ: A client is highly disruptive with high level of physical and verbal aggression to family members believing they are out to kill him without any prove of this fear. Therefore, moves around with knife and he explains to you that he hears voices and sees people which others cannot see. Finally, says he was using a medication before which took away all these people but since he finished his drug pile for about six months the feelings are back. What type of medication will he most probably be using which took away these symptoms. (a) clozapine (b) lithium (c) tricyclic antidepressant

ITA: if you pick (a) Clozapine you are right, because the symptoms seem more like a psychotic episode. If you pick (b) lithium , you're wrong because this is a mood stabilizer and this description does not look like a mood disorder episode and if you pick (c) tricyclic

antidepressant, you're wrong because this is not a depressive episode and the medication would not have been this.

8.4 Professional limitation

Clinical psychologists are not licensed to prescribe medication despite their knowledge in assessment and diagnosis, because this training is done only by psychiatrists in Nigeria .Though some part of North America and South America are already licensed to do but this is with extra training and some aspects of prescription.

It is imperative for students to know that clinical psychologists are not licensed to prescribe drugs as the psychiatrists in Nigeria; this knowledge on drug therapy is however required to facilitate your treatment plan for the patients. In view of the drugs that were reviewed above, none of them seems to be free of risk. Much as clinical psychologist believes in the use of drugs, we lay more emphases on psychotherapy, as they are more percent risk free.

Box 8.4: Lithium

Lithium is a common treatment for mood disorder, especially bipolar disorder and it stabilizes a number of neurotransmitters including serotonin, dopamine and glutamate. However, it can come with some problems such as :

- Blurred vision.
- Kidney dysfunction.
- Problems with attention and concentration.
- Tremors, nausea, vomiting and twitches .

8.5. Summary

The lecture focused on biological treatment of mental disorders through the use of drugs. Categories of various drug therapies include antianxiety drugs, antidepressant drugs, antipsychotic drugs being administered to patient with specific mental disorders.

8.6. Post-Test

1. Why drug therapies in treatment of mental disorders?

2. Mention any three antidepressant drugs in the treatment of mental disorders?

8.7. Self – assessment questions (SAQs)

1. Name and discuss the use of any three antianxiety drugs.

2. How does the use of lithium function as a mood stabilizer?

3. When will it be appropriate to use biological treatment rather than psychological treatment?

References

Davis, S. F., & Palladino, J. J. (1997). *Psychology* (2nd ed.). prentice Hall, New Jersey.

Nolen-Hoeksema, S. (2001). *Abnormal Psychology*, (2nd Ed), New York.

Osinowo, H. O, Imhonde, H. O. and Olley, B. O. (2004). *A step into Clinical Psychology*, RYCE, Benin City