PSYCHOLOGICAL DISORDERS

AND TREATMENTS

Disorders & Treatment Unit Guide

Essential Questions

- How should we draw the line between normality and disorder?
- How do the medical model and the biopsychosocial approach understand psychological disorders?
- How and why do clinicians classify psychological disorders?
- Why do some psychologists criticize the use of diagnostic labels?
- What are the different anxiety disorders?
- What are OCD and PTSD?
- What are mood disorders? How does major depressive disorder differ from bipolar disorder?
- How do the biological and social-cognitive perspectives explain mood disorders?
- What patterns of thinking, perceiving, and feeling characterize schizophrenia?
- How do brain abnormalities, viral infections, and genetics contribute to a person developing schizophrenia?
- What are somatic and related disorders?
- What are dissociative disorders, and why are they controversial?
- What are the three clusters of personality disorders? What behavioral symptoms occur for each disorder?
- How do psychotherapy, biomedical therapy, and an eclectic approach to therapy differ?
- What are the goals and techniques of psychoanalysis, and how have they been adapted to psychodynamic therapy?
- What are the basic themes of humanistic therapy? What are the specific goals and techniques of Rogers' client-centered approach?
- How does the basic assumptions of behavior therapy differ from other therapies? What techniques are used in exposure therapies and aversive conditioning?
- What are the goals and techniques of cognitive therapy and of cognitive-behavioral therapy?
- What are the aims and benefits of group and family therapy?
- Are some psychotherapies more effective than others for specific disorders?
- What three elements are shared by all psychotherapies?
- What are the drug therapies?

Key Terms, Concepts and Contributors

MODULE 65:
Psychological disorder
Unjustifiable
Maladaptive
Atypical
Disturbing
Attention-Deficit/Hyperactivity Disorder (ADHD)
Medical model
Diathesis-stress model
Biopsychosocial model
DSM-5

MODULE 66:
Anxiety disorders
Generalized anxiety disorder
Panic disorder
Phobia
Social anxiety disorder
Agoraphobia
Obsessive-compulsive disorder
Obsession
Compulsion
Posttraumatic stress disorder
Posttraumatic growth

MODULE 68:
Schizophrenia
Psychosis
Delusions
Hallucinations

MODULE 67:
Mood disorders
Major depressive disorder
Dysthymia
Bipolar disorder
Mania
Rumination

MODULE 69:
Somatic symptom disorder
Conversion disorder
Illness anxiety disorder
Dissociative disorders
Dissociative amnesia
Dissociative identity disorder
Anorexia nervosa
Bulimia nervosa
Binge-eating disorder
Paranoid personality disorder
Schizoid personality disorder
Schizotypal personality disorder
Antisocial personality disorder
Histrionic personality disorder
Borderline personality disorder
Narcissistic personality disorder
Dependent personality disorder
Avoidant personality disorder
Obsessive-compulsive personality disorder

MODULE 70:
Psychotherapy
Biomedical therapy
Eclectic approach
Psychoanalysis
Resistance
Interpretation
Transference
Countertransference
Psychodynamic therapy
Insight therapies
Client-centered therapy
Active listening
Unconditional positive regard

MODULE 71:
Behavior therapy
Counterconditioning
Exposure therapies
Systematic desensitization
Virtual reality exposure therapy
Aversive conditioning
Flooding
Token economy
Cognitive therapies
Rational-emotive behavioral therapy (REBT)
Cognitive-behavioral therapy
Group therapy
Family therapy

MODULE 72:
Meta-analysis
Evidence-based practice
Therapeutic alliance
Resilience

MODULE 73:
Psychopharmacology
Antipsychotic drugs
Antianxiety drugs
Antidepressant drugs
Lithium
Electroconvulsive therapy
Repetitive transcranial magnetic stimulation
Psychosurgery
Lobotomy

Key contributors:
David Rosenhan
Sigmund Freud
Carl Rogers
Mary Cover Jones
Joseph Wolpe
Aaron Beck
Albert Ellis

Rosenhan Study – AP Psychology

Question: Suppose someone were committed to a psychiatric hospital by accident. Would the staff notice? Would the person be able to get out?

David Rosenhan of Stanford University set out to answer these questions and another "How accurately to psychiatric hospitals distinguish between people who are psychotic and those who are healthy?"

To find out, Rosenhan and several colleagues had themselves committed (Rosenhan, 1973). Entrance to mental hospitals was gained by faking only one symptom. Rosenhan and the others complained of hearing voices, which said "empty," "hollow," and "thud." In 11 out of 12 tries, they were admitted with a diagnosis of "schizophrenia."

Pseudo-patients After being admitted these "pseudo-patients" dropped all pretense of mental illness. Yet, even though they acted completely normal, none of the researchers was ever recognized by the hospital staff as a phony patient. Other patients were not so easily fooled. It was not unusual for a real patient to say to one of the researchers "You're not crazy, you're checking up on the hospital!" or "You're a journalist."

Rosenhan and the others spent from one to seven weeks in hospitals before being discharged. The hospitals ranged from very modern and plush to ancient and shoddy. No matter how good the facilities or how good the hospital's reputation, Rosenhan found some disturbing conditions.

Contact between staff and a patient was very limited and sometimes marked by fear or hostility. It was found that attendants and staff only spent an average of 11.3 percent of their time out of the "cage," the glassed-in central compartment in the ward.

It was not unusual for the morning attendants to wake patients with a hostile call of: "Come on you m----- f-----s, out of bed!" When patients tried to talk with staff, they were often ignored or received strange replies. One pseudo – patient approached a psychiatrist and politely asked when he might get grounds privileges. The doctor's reply was, "Good morning Dave. How are you today?"

Rosenhan found that therapy other than drugs was very limited. Daily contact of patients with psychiatrists, psychologists, or physicians averaged about 7 minutes. On the other hand, the researchers were given a total of 2,100 pills to swallow. (Only 2 of these were actually taken, the rest being pocketed or flushed down the toilet.)

Nonpersons Patients tended to be treated as nonpersons. A nurse unbuttoned her uniform to adjust her bra in front of a room of male patients. She was not being sexy, she just didn't consider the patients as men. Patients would often be discussed by the staff while the patient was standing near by. It was as if patients were invisible.

A situation that sums up Rosenhan's findings better than any other is his note – taking. Rosenhan began taking notes by carefully jotting things on a small piece of paper hidden in his hand. He learned quickly that hiding was totally unnecessary. He was soon walking around with a clipboard and note pads, recording observations and collecting data.

No one questioned this behavior. Note – taking was simply seen as a symptom of his "illness". As a matter of fact Rosenhan found that anything he did was ignored. When a staff member manhandles a patient (as happened occasionally) Rosenhan would be right there – taking notes on the whole incident.

Labels These observations clarify the failure of staff members to detect the fake patients. Because they were seen in the context of a mental ward and because they had been labeled schizophrenic, anything the pseudo – patients did was seen as a symptom of their "illness."

To return to the original hypothetical question about talking your way out of an accidental commitment, it should be clear that it would be quite futile to say, "Look, this is all a mistake. I'm not

crazy. You've got to let me out." The response might very well be, "Have you had these paranoid delusions for long?'

Many mental health professionals found Rosenhan's findings hard to believe. This led to a follow - up study in which the staff of another hospital was warned that 1 or more pseudo – patients were going to try to gain admission over the next 3 months. Thus alerted, the staff at this hospital tried to identify fake incoming patients. Among 193 candidates, 41 were labeled fakes by at least 1 staff member, and 19 more were labeled "suspicious." This only serves to confirm Rosenhan's original findings since he never sent any patients – fake or otherwise – to this hospital!

It is an important final note that all of the normal people who served as pseudo – patients in the original studies were discharged as schizophrenics "in remission" (temporarily free of symptoms). In other words, the label that prevented hospital staff from seeing the normality of the researchers stayed with them when they left. Psychiatrist Karl Menninger (1964) has commented on a similar situation:

A label can blight the life of a person even after his recovery from mental illness. A young doctor I knew suffered for a time from some anxiety and indecision. He consulted a psychiatrist and soon recovered. Unfortunately, a "tentative" diagnosis of schizophrenia got abroad – I don't know how – and the young doctor's professional career was seriously impaired. He was injured, not by mental illness but by a word.

Observations such as these are not a total condemnation of psychiatrist hospitals. Many of the conditions Rosenhan encountered will be found in any hospital or other large institution. But Rosenhan's findings do carry an important message for professionals and nonprofessionals alike: labels can be dangerous. As Stoller (1967) said,

"When a person is labeled – neurotic, psychotic, executive, teacher, salesman, psychologist – either by himself or by others. He restricts his behavior to the role and even may rely upon the role for security. This diminishes the kind of experiences he is likely to have. Indeed, it is those groups whose members have shared labels – be it schizophrenic or executive – which are hardest to help move into intimate contact.

Implications The terms in the Rosenhan Study can cause problems. If used carelessly, they may do great damage. Everyone has felt or acted "crazy" during brief periods of stress or high emotion. The person whose adjustment problems extend over a longer period of time is different from you or me only is the severity of his or her difficulty.

It is therefore more productive to label problems than to label people. Think of the difference in impact between saying, "He is experiencing a serious emotional disturbance" and saying "He is a psychotic." Which statement would you choose to have said about yourself.

It is also important to realize that a severely disturbed person will appreciate being treated normally. Rosenhan's research makes it clear that the person is not helped by being thrust into the role of a "patient." One former patient's comments clarify this last point:

"After I got back from the hospital, my friends tried to act like nothing had changed. But I could tell they weren't being honest. For instance, a friend invited me to dinner and everything went fine until I dropped my fork. Both my friend and his wife jumped up and stared at me like they thought I might explode. I was quite embarrassed."

A CASE OF ADOELESCENT SHYNESS

Nadine was a 15-year-old girl whose mother brought her for a psychiatric evaluation to help her with her long-standing shyness.

Although Nadine was initially reluctant to say much about herself, she said she felt constantly tense. She added that the anxiety was "really bad" for several years and was often accompanied by episodes of dizziness and crying. She was generally unable to speak in any situation outside of her home or school classes. She refused to leave her house alone for fear of being forced to interact with someone. She was especially anxious around other teenagers, but she had also become "too nervous" to speak to adult neighbors she had known for years. She felt it impossible to walk into a restaurant and order from "a stranger at the counter" for fear of being humiliated. She also felt constantly on her guard, needing to avoid the possibility of getting attacked, a strategy that really only worked when she was alone in her home.

Nadine tried to conceal her crippling anxiety from her parents, typically telling them that she "just didn't feel like" going out. Feeling trapped and incompetent, Nadine said she contemplated suicide "all the time."

Nadine had always been "shy" and had been teased at recess since she started kindergarten. The teasing had escalated to outright bullying y the time shew as in seventh grade. For two years, day after difficult day, Nadine's peers turned on her "like a snarling wolf pack," calling her "stupid," "ugly," and "crazy." Not infrequently, one of them would stare at her and tell her she would be better of committing suicide. One girl (the ringleader, as well as a former elementary school friend) hit Nadine on one occasion, giving her a black eye. Nadine denied it, saying she had "fallen" on the street. She did, however, mention to her mother "in passing" that she wanted to switch schools, but her delivery was so offhand that at the time, her mother casually advised against the switch. Nadine suffered on, sobbing herself to sleep most nights.

Full of hope, Nadine transferred to a specialty arts high school for ninth grade. Although the bullying ceased, her anxiety symptoms worsened. She felt even more unable to venture into public spaces and felt increasingly embarrassed by her inability to develop the sort of independence typical of a 15-year-old. She said she had begun to spend whole weekends "trapped" in her home and had become scared to even read by herself in the local park. She had nightly nightmares about the bullies in her old school. Her preoccupation with suicide grew.

Her parents had thought she would outgrow being shy and sought psychiatric help for her only after a teacher remarked that her anxiety and social isolation were keeping her from making the sorts of grades and doing the sort of extracurricular activities that were necessary to get into a good college.

Nadine described her mother as loud, excitable, aggressive, and "a little frightening." Her father was a successful tax attorney who worked long hours. Nadine described him as shy in social situations ("he's more like me"). Nadine said that she and her father sometimes joked that the goal of the evening was to avoid tipping the mother into a rage. Nadine added that she "never wanted to be anything like her mother."

Name(s)_____

MOOD DISORDER CASE STUDY ANALYSIS

Case Study #_____

Which disorder do you believe your patient is suffering from?

List at least 3 symptoms that support your diagnosis:

How might **negative thoughts** have contributed to her development of this disorder?

How might **genetics** have contributed to her development of this disorder?

Personality Disorders Party

Ian decided to throw a party for his birthday and invited some of his new coworkers. . .

Hillary arrived early to the party; she tried to impress the host by being very helpful. She insisted on staying to help clean up after the host told her that it would be better for her to leave because it was late. She also asked the host if she could return at another time so she could get to know him better. She and her ex-fiancé' just broke off their engagement two days prior to the party.

Annie danced into the party and immediately became the center of attention. With sweeping gestures of her arms and dramatic displays of emotion, she boated about her career as an actress in a local theater. During a private conversation, a friend inquired about the rumors that she was having some difficulties in her marriage. In an outburst of anger, she denied any problems and claimed her marriage was "as wonderful and charming as ever". Shortly thereafter, while drinking her second martini, she fainted and had to be taken home.

Vincent wandered into the party, but didn't stay long. The "negative forces" in the room were unsettling and to his "psychic soul-spot". The few guests he spoke to felt somewhat uneasy being with this aloof "space cadet".

Jean paraded into the party drunk and continued to drink throughout the night. Laughing and giggling, she flirted with many of the men and to two of them expressed her "deep affection". Twice during th evening she disappeared for almost half an hour, each time with a different man. After a violent argument with one of them, because he took "too long" to get her a drink, she locked herself into the bathroom and attempted to swallow a bottle of aspirin. Her friends encouraged her to go home, but she was afraid to be alone in her apartment.

Mac spends most of the time talking about his trip to Europe, his new Mercedes, and his favorite French restaurants. People seemed bored being around him, but he kept right on talking. When he made a critical remark about how one of the women was dressed – hurt her feelings – he could not apologize for his obvious blunder. He tried to talk his way around it, and even seemed to be blaming her for being upset.

Sam arrived at the party exactly on time. He made a point of speaking to every guest for five minutes. He talked mostly about technology and finance, and avoided any inquiries about his feelings or personal life. He left precisely at 10 PM because he had work to do at home.

Sue watched the party for several minutes from outside through the window before entering. Once she went in, she seemed very uncomfortable. When people tried to be nice to her, she looked guarded and distrustful. People quickly became uncomfortable with her habit of finding fault with every little thing you said or did. She seemed to be picking fights with people. She didn't stay very long at the party.

Ulysses wasn't invited to the party. No one really knows him very well because he rarely talks. In fact, he spends most of his time alone at home reading.

Ericka didn't come to the party, even though she received an invitation and told the host she really wanted to attend. The host did not know why she failed to attend.

Antisocial Personality Disorder:
- Be able to act witty and charming
- Be good at flattery and manipulating other people's emotions
- Break the law repeatedly
- Disregard the safety of self and others
- Have problems with substance abuse
- Lie, steal, and fight often
- Not show guilt or remorse
- Often be angry or arrogant

Obsessive-Compulsive Personality Disorder:
- Excess devotion to work
- Inability to throw things away, even when the objects have no value
- Lack of flexibility and generosity
- Not wanting to allow other people to do things
- Not willing to show affection
- Preoccupation with details, rules, and lists

Dependent Personality Disorder:
- Avoiding being alone
- Avoiding personal responsibility
- Becoming easily hurt by criticism or disapproval
- Becoming overly focused on fears of being abandoned
- Becoming very passive in relationships
- Feeling very upset or helpless when relationships end
- Having difficulty making decisions without support
- Having problems expressing disagreements

Avoidant Personality Disorder:
- Be easily hurt when people criticize or disapprove of them
- Hold back too much in intimate relationships
- Be reluctant to become involved with people
- Avoid activities or jobs that involve contact with others
- Be shy in social situations out of fear of doing something wrong
- Make potential difficulties seem worse than they are
- Hold the view they are not good socially, not as good as other people, or unappealing

Borderline Personality Disorder:
- Frantic efforts to avoid real or imagined abandonment
- Unstable, intense interpersonal relationships
- Recurrent suicidal behavior
- Emotional instability
- Impulsivity
- Transient, stress-related paranoid thoughts

Paranoid Personality Disorder:
- Concern that other people have hidden motives
- Expectation that they will be exploited by others
- Inability to work together with others
- Social isolation
- Detachment
- Hostility

Schizoid Personality Disorder:
- Appears aloof and detached
- Avoids social activities that involve emotional intimacy with other people
- Does not want or enjoy close relationships, even with family members

Schizotypal Personality Disorder:
- Discomfort in social situations
- Inappropriate displays of feelings
- No close friends
- Odd behavior or appearance
- Odd beliefs, fantasies, or preoccupations
- Odd speech

Histrionic Personality Disorder:
- Acting or looking overly seductive
- Being easily influenced by other people
- Being overly concerned with their looks
- Being overly dramatic and emotional
- Being overly sensitive to criticism or disapproval
- Believing that relationships are more intimate than they actually are
- Blaming failure or disappointment on others
- Constantly seeking reassurance or approval
- Having a low tolerance for frustration or delayed gratification
- Needing to be the center of attention
- Quickly changing emotions, which may seem shallow to others

Narcissistic Personality Disorder:
- React to criticism with rage, shame, or humiliation
- Take advantage of other people to achieve his or her own goals
- Have excessive feelings of self-importance
- Exaggerate achievements and talents
- Be preoccupied with fantasies of success, power, beauty, intelligence, or ideal love
- Have unreasonable expectations of favorable treatment
- Need constant attention and admiration
- Disregard the feelings of others, and have little ability to feel empathy
- Have obsessive self-interest
- Pursue mainly selfish goals

Disorders Case Studies

Read each of the following case studies and diagnose the type of neurosis you feel each best exemplifies. Be sure you support your diagnosis by stating specific phrases and examples from the case study that support your view.

CASE STUDY 1

Edna; age 20, a sophomore in college, had a pronounced fear of being left alone with a man, whether fellow student, professor, relative, or acquaintance. She refused all dates and never allowed herself to be placed in situations where it was necessary for her to go home with someone of the opposite sex. She could give no good reason for this fear but recognized her problem; yet there seemed to be nothing she could do about it. Recently when it appeared inevitable that she must go home from a party with a boy, she trembled, her hands became clammy, and she became very faint. As a result, her hostess invited her to remain for the night.

CASE STUDY 2

George T., age 35, an auto mechanic, on serval occasions found himself in a movie theater after having left home to report for work. He would "come to" in a bewildered fashion and would go to a bar for a few drinks. Eventually he would go home.

As a child, George had a pattern of wandering away from home. He came from a very unhappy family; his parents were divorced, and he was left at home without housekeepers. His father was very hard on him and on several occasions gave him such severe whippings that the neighbors called the police. His mother was a highly emotional person and tried to discipline George by screaming at him and threatening to place him in a boarding home.

In adolescents, he twice found himself going off to school and eventually "coming to" in a park about 2 miles from home. In school, George got along well with the teachers and other students. He was a poor student and failed both the 2nd and 7th grades. He quit school at 16.

CASE STUDY 3

An 11- year-old boy instituted the following ceremony before going to bed: He did not sleep until he had told his mother in great detail all the events of the day; there must be no scraps of paper or other rubbish on the carpet of the bedroom; the bed must be pushed right to the wall; three chairs must stand by it and the pillows must lie in a particular way. To get to sleep he must first kick out a certain number of times with both legs and then lie on his side.

CASE STUDY 4

A married woman, whose life was complicated by her mother's living in the home, complained that she felt tense and irritable most of the time. She was apprehensive about something happening to her mother, her husband, her children, or herself. She had no definite idea what it was that she feared might happen. She suffered from occasional attacks in which her heart pound and was irregular, she could not seem to get her breath. Often, she broke out in a profuse perspiration. Her mouth seemed always dry, even though she drank a great deal of water, and because of this and her anxiety she could not sleep.

CASE STUDY 5

During an interview, the 50-year-old year female patient expressed beliefs covering almost the entire range of delusions. She felt that her niece was in on a plot with other relatives to take away the property she owned in 106 countries, which she was planning to use, after training religious missionaries, to establish missions to convert heathens. Although her husband was alive and visited her weekly, she maintained that her husband was dead and that he had been killed by the FBI. The FBI had 6 agents assigned to her alone and had killed her husband. She had leaned of their spying and talking about her from the television where they were portraying her life in several of the TV shows. She was convinced that the hospital attendants were in on the conspiracy and that poison was being placed in her food. She was also concerned about the electrical waves that were "messing up" her mind.

CASE STUDY 6

Mrs. K was first admitted to a state hospital at the age of 38, although since childhood she had been characterized by having mood swings, some of which had been so extreme that they had been psychotic in degree. At one point she became depressed and asked to return to the hospital where she had been a patient. She then becomes overactive and exuberant in spirits and visited her friends, purchased many clothes, bought furniture, pawned her rings, and wrote checks without funds. For a period thereafter, she was mildly depressed. In a little less than a year Mrs. K again became overactive, played her radio until late in the night, smoked excessively, took out insurance on a car and snot not yet bought. Contrary to her usual habits, she swore frequently and loudly, created a disturbance in a club to which she did not belong, and instituted divorce proceedings. On the day prior to her second admission to the hospital she purchased 57 hats.

Name:_____

DISORDERS & DRUG USE/ADDICTION

Drug use, abuse, and addiction is strongly connected with people suffering from psychological disorders. Today we will be looking at different drugs and how they affect human behavior. Psychiatrists believe that people with different psychological problems are more likely to use different types of drugs in order to deal with the negative aspects of their disorders. Your task is to help these psychiatrists identify which drugs would be used by people suffering from the different disorders we've discussed in class. Go to the following website to get started: http://learn.genetics.utah.edu/content/addiction/mouse/.

DRUG NAME	HOW DOES THE DRUG AFFECT A USER'S BEHAVIORS?	WHY MIGHT A PERSON USE THIS DRUG?	WHICH DISORDER WOULD BEST BE "SELF-MEDICATED" WITH THIS DRUG?	WHY?

1. Psychiatrists removed substance addiction from being an actual psychological disorder. Do you agree with this or not? Why?

2. If people are diagnosed with a substance use disorder, should they be allowed to use these drugs? Why or why not?

Metea Valley Psychology Group, LLC

Diagnostic and Treatment Protocol

Congratulations on your new position as a clinical psychologist intern! Your first client has a specific problem and has come to **you** for your help. As a psychologist, you and your team must diagnose and treat the individual with an eclectic approach appropriate to your client's diagnosis.

DIAGNOSTICS:

1. Read the history of your client.
2. Discuss the client's problem in your group. Identify the category of disorders in which your patient's symptoms might best fit (i.e. mood, anxiety, personality, etc.).
3. Narrow your diagnosis to one specific disorder.
4. Detail your patient's diagnosis using specific symptoms to back up your diagnosis.

DEVELOPING A TREATMENT PLAN:

1. Together, you must decide on an ending goal for the therapeutic process.
   - Do you want an absence of symptoms?
   - If that's not realistic, what would give your client the best quality of life?
   - It **MUST** be measurable/observable!!
2. Decide on an eclectic approach that includes at least **two treatment options** from different psychological perspectives (i.e. cognitive, humanistic, psychoanalytic, behavioral, biological, etc.)

PRESENTATION TO YOUR CLINIC REVIEW BOARD:

1. Design a typed report (in ***outline form***- with only small paragraphs) that addresses the following:
   a. Introduction to client – name, demographics, symptoms
   b. Diagnosis – **briefly** explain the disorder
   c. Rationale – you must provide at least three pieces of evidence from their history to support your diagnostic claim
   d. Describe your treatment approach with the board – what is your overall goal?
   e. Define **&** describe the two different methods you will be using to treat your patient. Be sure to explain how each technique would apply to your client's situation.
2. The review board will be evaluating your diagnosis and treatment plan.

CHANGE MY CLIENT RUBRIC

/ 5	**Client Introduction & History** – name, demographics, symptoms
/ 4	**Diagnosis Explanation**
/ 6	**Diagnosis Rationale** - must include 3 pieces of evidence from history to support diagnosis
/ 3	**Treatment Approach #1** - definition
/ 7	**Treatment Approach #1** - application
/ 3	**Treatment Approach #2** - definition
/ 7	**Treatment Approach #2** - application
/ 35	**Total**

THERAPUTIC TECHNIQUES

BIOLOGICAL THERAPY TECHNIQUES

Drug Therapy

Goal:

How it works:

Which drug options/categories are available for the following disorders? Underline the most effective.

Schizophrenia

Depression

Bipolar Disorder

Anxiety Disorders

Electroconvulsive Therapy

Goal:

How it works:

Best for treating:

COGNITIVE THERAPY TECHNIQUES

Cognitive Therapy

Theorist:

Goal:

How it works:

Best for treating:

Rational-Emotive Therapy

Theorist:

Goal:

How it works:

Best for treating:

Cognitive-Behavioral Therapy

Goal:

How it works:

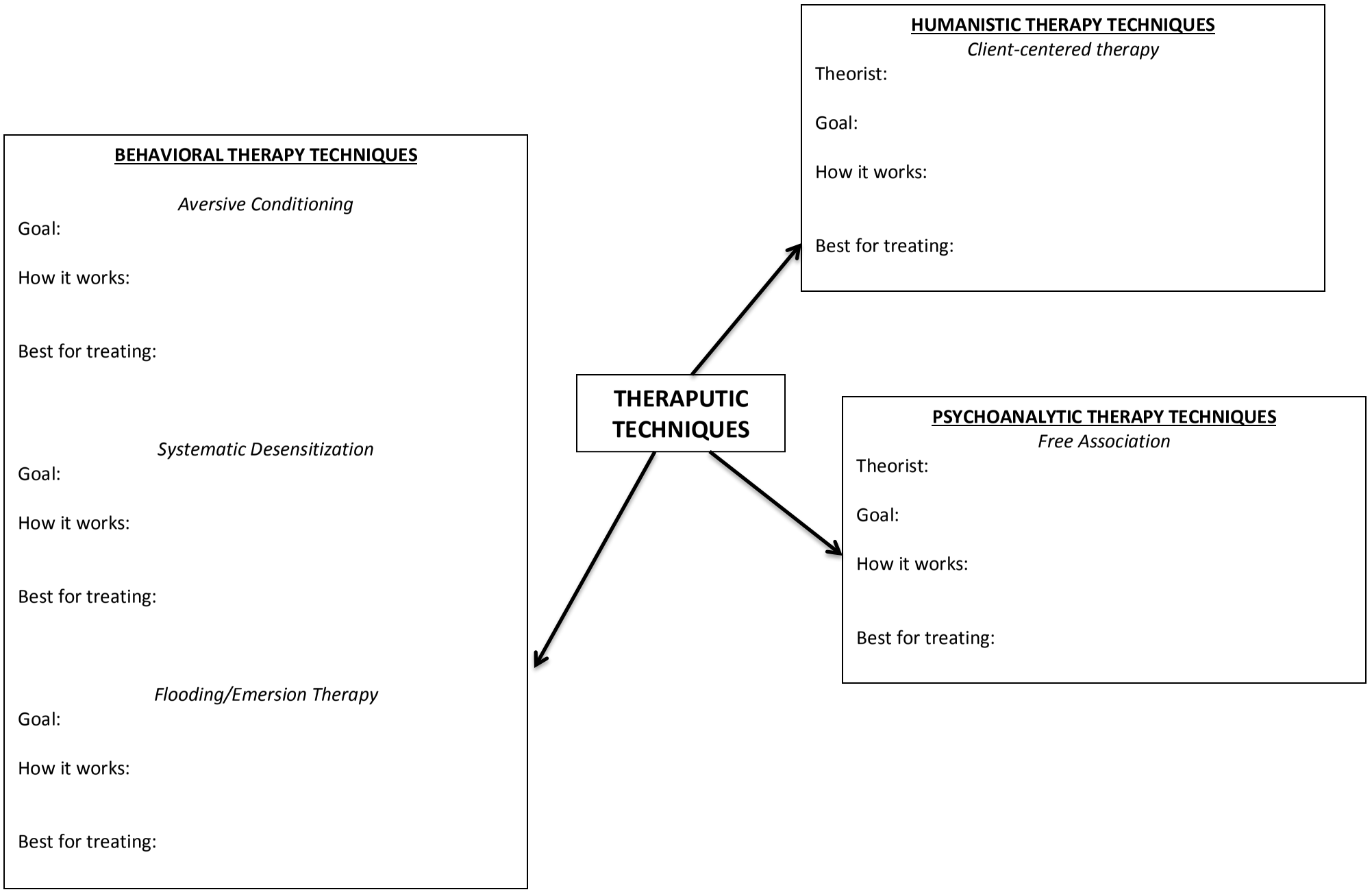
Best for treating:

GROUP & FAMILY THERAPY TECHNIQUES

Goal:

How it works:

Best for treating:


THERAPUTIC TECHNIQUES
BEHAVIORAL THERAPY TECHNIQUES
Aversive Conditioning
Goal:
How it works:
Best for treating:
Systematic Desensitization
Goal:
How it works:
Best for treating:
Flooding/Emersion Therapy
Goal:
How it works:
Best for treating:
HUMANISTIC THERAPY TECHNIQUES
Client-centered therapy
Theorist:
Goal:
How it works:
Best for treating:
PSYCHOANALYTIC THERAPY TECHNIQUES
Free Association
Theorist:
Goal:
How it works:
Best for treating:

CLINICAL REVIEW BOARD

Team up for review:	
Diagnosis evaluation: *(Accuracy? Possible other diagnoses?)*	
Why do you agree or disagree with diagnosis? *(refer to specific symptoms)*	
Treatment plan evaluation: *(Do you agree their plan would be most effective? Why or why not?)*	
Third treatment option: create a third plan using a different perspective	

Team up for review:	
Diagnosis evaluation: *(Accuracy? Possible other diagnoses?)*	
Why do you agree or disagree with diagnosis? *(refer to specific symptoms)*	
Treatment plan evaluation: *(Do you agree their plan would be most effective? Why or why not?)*	
Third treatment option: create a third plan using a different perspective	