***Flooding/Exposure Therapy***

This a form of behavior therapy and based on the principles of respondent conditioning. It is sometimes referred to as exposure therapy or prolonged exposure therapy. As a psychotherapeutic technique, it is used to treat phobia and anxiety disorders including post-traumatic stress disorder. It works by exposing the patient to their painful memories, with the goal of reintegrating their repressed emotions with their current awareness. Flooding was invented by psychologist Thomas Stampfl in 1967. It still is used in behavior therapy today.

Flooding is a psychotherapeutic method for overcoming phobias. This is a faster (yet less efficient and more traumatic) method of ridding fears when compared with systematic desensitization. In order to demonstrate the irrationality of the fear, a psychologist would put a person in a situation where they would face their phobia at its worst. Under controlled conditions and using psychologically-proven relaxation techniques, the subject attempts to replace their fear with relaxation. The experience can often be traumatic for a person, but may be necessary if the phobia is causing them significant life disturbances. The advantage to flooding is that it is quick and usually effective. There is, however, a possibility that a fear may spontaneously recur. This can be made less likely with systematic desensitization, another form of a classical condition procedure for the elimination of phobias

"Flooding" is an effective form of treatment for phobias amongst other psychopathologies. It works on the principles of classical conditioning or respondent conditioning—a form of Pavlov's classical conditioning—where patients change their behaviors to avoid negative stimuli. According to Pavlov, we learn through associations, so if we have a phobia it is because we associate the feared object or stimulus with something negative.

Flooding uses a technique based on Pavlov's classical conditioning that uses exposure. There are different forms of exposure, such as imaginal exposure, virtual reality exposure, and in vivo exposure.[4] While systematic desensitization may use these other types of exposure, flooding uses in vivo exposure, actual exposure to the feared stimulus. A patient is confronted with a situation in which the stimulus that provoked the original trauma is present. The psychiatrist there usually offers very little assistance or reassurance other than to help the patient to use relaxation techniques in order to calm themselves. Relaxation techniques such as progressive muscle relaxation are common in these kinds of classical conditioning procedures. As the adrenaline and fear response has a time limit, theoretically a person will eventually have to calm down and realize that their phobia is unwarranted. Flooding can be done through the use of virtual reality and is fairly effective.

Psychiatrist Joseph Wolpe (1973) carried out an experiment which demonstrated flooding. He took a girl who was scared of cars, and drove her around for hours. Initially the girl was hysterical but she eventually calmed down when she realized that her situation was safe. From then on she associated a sense of ease with cars.

Flooding therapy is not for every individual, and the therapist will discuss with the patient the levels of anxiety they are prepared to endure during the session. It may also be true that exposure is not for every therapist and therapists seem to shy away from use of the technique.

Why flooding is necessary?

Phobias by definition are irrational fears, and these phobias can get in the way of everyday life. For example, a person with a phobia of cars would have a hard time crossing the street or even walking around town. For some reason this person has developed the belief that all cars are dangerous and need to be avoided. Often, a person who has developed a phobia of a particular thing or situation will go to extreme lengths to avoid that situation. As long as they avoid exposure to the thing that they fear, they have no way of knowing that it can't hurt them.

***Systematic desensitization***

This a type of behavioral therapy used in the field of psychology to help effectively overcome phobias and other anxiety disorders. More specifically, it is a type of Pavlovian therapy / classical conditioning therapy developed by a South African psychiatrist, Joseph Wolpe. To begin the process of systematic desensitization, one must first be taught relaxation skills in order to extinguish fear and anxiety responses to specific phobias. Once the individual has been taught these skills, he or she must use them to react towards and overcome situations in an established hierarchy of fears. The goal of this process is that an individual will learn to cope and overcome the fear in each step of the hierarchy, which will lead to overcoming the last step of the fear in the hierarchy. Systematic desensitization is sometimes called graduated exposure therapy.

Although as stated earlier that to begin the process of systematic desensitization, the individual must be first taught relaxation skills, it is not the only factor. A study of the contribution and importance of muscle relaxation to systematic desensitization therapy in four different phobic patients. The study proved that during a control phase of therapy if relaxation was taken away it made no or so little difference to the patients' improvement ability to perform in their case. In two cases, when measured by self-rating by removing relaxation it slowed the progress through the hierarchy and therapeutic progress; however it was overall small effects if any. Concluding that other variables than relaxation are highly responsible for the therapeutic effectiveness of desensitization. Putting together visualization and relaxation of feared scenes helps certain individuals to attack their feared object or scenario in imagination, and may push them to attack it in reality as well.

Specific phobias are one class of mental illness often treated through the behavior therapy or cognitive–behavioral process of systematic desensitization. When individuals possess irrational fears of an object, such as height, dogs, snakes, and close spaces, they tend to avoid it. Since escaping from the phobic object reduces their anxiety, patients' behavior to reduce fear is reinforced through negative reinforcement, a concept defined in operant conditioning. The goal of systematic desensitization is to overcome this avoidance pattern by gradually exposing patients to the phobic object until it can be tolerated. In classical and operant conditioning terms the elicitation of the fear response is extinguished to the stimulus (or class of stimuli).

*Coping strategies*

Prior to exposure, the therapist teaches the patient cognitive strategies to cope with anxiety. This is necessary because it provides the patient with a means of controlling their fear, rather than letting it build until it becomes unbearable. Relaxation training, such as meditation, is one type of coping strategy. Administration of an anti-anxiety medicine prior to exposure to the phobia-inducing stimuli is another type of coping strategy. Patients who have serious anxiety that leads to breathing problems might be taught to focus on their breathing or to think about happy situations. Another means of relaxation is cognitive reappraisal of imagined outcomes. The therapist might encourage subjects to examine what they imagine happening when exposed to the phobic object, allowing them to recognize their catastrophic visions and contrast them with the actual outcome. For example, a patient with a snake phobia might realize that they imagine any snake they encounter would coil itself around their neck and strangle them, when this would not actually occur. These patients need to see that not all snakes are large and that most snakes are completely harmless so that they can get over their fear. Research has demonstrated the effectiveness of this technique in helping subjects reduce similar animal phobias.

*Progressive exposure*

The second component of systematic desensitization is gradual exposure to the feared objects or situations. Continuing with the snake example, the therapist would begin by asking their patient to develop a fear hierarchy, listing the relative unpleasantness of various types of exposure. For example, seeing a picture of a snake in a newspaper might be rated 5 of 100, while having several live snakes crawling on one's neck would be the most fearful experience possible. Once the patient had practiced their relaxation technique, the therapist would then present them with the photograph, and help them calm down. They would then present increasingly unpleasant situations: a poster of a snake, a small snake in a box in the other room, a snake in a clear box in view, touching the snake, etc. At each step in the progression, the patient is desensitized to the phobia through the use of the coping technique. They realize that nothing bad happens to them, and the fear gradually extinguishes.

***Client-Centered Therapy***

Client-centered therapy is a therapeutic approach that was introduced in the 1940s by an American psychologist named Carl Rogers.

As its name implies, client-centered therapy places significant focus on the client. According to Rogers’s view of client-centered therapy, the client-centered therapist refrains from asking questions, making diagnoses, providing reassurance, or assigning blame during his or her interactions with the client.

According to a client-centered therapy article in the *Harvard Mental Health Letter*, “The [client-centered] therapist must create an atmosphere in which clients can communicate their feelings with certainty that they are being understood rather than judged.”

A core tenet of client-centered therapy is that people are inclined to move toward healing and growth; thus, the role of the client-centered therapist is to establish an atmosphere in which the client can discover the answers and solutions that he or she has been looking for.

**What are the Benefits of Client-Centered Therapy?**

The benefits of client-centered therapy are centered on the ability of the client-centered therapist to establish and maintain an open and non-judgmental environment in which the client has the time and space to make the discoveries that are necessary for progress to occur.

Research has shown that the effectiveness of client-centered therapy is associated with the empathetic and unconditional relationship between the client-centered therapist and the client.

In an optimal client-centered therapy environment, the client learns to play an active role in his or her recovery, and to take responsibility for making the discoveries and decisions that will allow for the greatest degree of growth and progress.

**What Conditions/Disorders Does Client-Centered Therapy Treat?**

Client-centered therapy may be used as a treatment component for individuals with any type of condition or disorder that would benefit from traditional talk therapy or psychotherapy.

Both outpatient and residential treatment programs for myriad addictions, compulsions, and other behavioral and mental health challenges typically incorporate some form of talk therapy into the comprehensive treatment plan. Though client-centered therapy does not address any specific disorder or diagnosis, this therapeutic approach may have value in a wide range of treatment milieus.

***Free Association***

Psychoanalysis was founded by Sigmund Freud (1856-1939). Freud believed that people could be cured by making conscious their unconscious thoughts and motivations, thus gaining “insight”. Particularly in psychoanalytical therapy, patients are asked to say whatever pops into their minds, which may also include dream interpretations.

The aim of psychoanalysis therapy is to release repressed emotions and experiences, i.e. make the unconscious conscious.

Psychoanalysis is most effective for treating personality disorders, neuroses and depression.

***Cognitive Therapy***

The premise of this therapy is that patients have negative thoughts throughout the day, which leads to unwanted behaviors and feelings. This habitual negative thinking must be altered in order for the patient to get well. First, the cognitive therapist helps the patient become aware of the negative thoughts and the habit of thinking this way and then he or she is asked to replace these thoughts with more positive, reinforcing feelings or behaviors. Gradually the patient is able to stop his or her negative pattern of thinking and use positive imagery to feel better. Cognitive therapists typically treat mild depression, anxiety and eating disorders.

***Cognitive-Behavioral Therapy***

CBT is exactly as it sounds. It is the combination of identifying negative thoughts and processes, as well as modifying negative feelings and behaviors. Cognitive-behaviorists believe that what has been learned can be unlearned. The cognitive-behavioral therapist will be very specific about what the problems are and provide specific homework assignments for the patient to practice in order to overcome ways of thinking and behaving. Cognitive behaviorists treat mild depression, anxiety, eating disorders, specific phobias (e.g., claustrophobia) and sexual disorders (e.g., premature ejaculation).

***Group Therapy***

Like individual psychotherapy, is intended to help people who would like to improve their ability to cope with problems in their lives. However, instead of a one-on-one meeting with a mental health professional, group therapy involves several individuals (usually six to eight) and a therapist or facilitator. The aim of group psychotherapy is to help solve emotional difficulties and to encourage the personal development of the participants in the group. One of the advantages of group therapy over individual therapy is that patients are able to develop more effective ways of relating interpersonally with others and to share their experiences with more than one person.

Group therapy also gives individuals a sense of hope and universality. The realization that one is not alone in dealing with the emotional upheavals of binge eating and then vomiting can be a relief for many eating disorder patients. Seeing those in the group who have learned to cope with their problems also provides hope and encouragement for participants. In addition, group therapy provides a means of getting direct advice from a "peer" or group member. Some people find that this is less threatening and more practical. By engaging in group therapy, many participants also develop socializing techniques by imitating behaviors of other group members which may help them better deal with their own, individual problems. Knowing that one belongs to a group or social network can be a powerful, confidence-building characteristic and offers the type of group togetherness that cannot be found in individual treatments.

There are different types of group therapy which include family therapy and psychodrama. Family therapy is usually used in the treatment of children, adolescents or young adults and is used when a patient's difficulties come from disturbed relationships within their family. Psychodrama is a form of group therapy originated by J.L. Moreno in which patients act out roles and characterizations in dramatic form on a stage. It encourages patients to communicate inner tensions, conflicts and feelings.

***Rational-emotive Therapy***

Rational emotive behaviour therapy (‘REBT’) views human beings as ‘responsibly hedonistic’ in the sense that they strive to remain alive and to achieve some degree of happiness. However, it also holds that humans are prone to adopting irrational beliefs and behaviours which stand in the way of their achieving their goals and purposes. Often, these irrational attitudes or philosophies take the form of extreme or dogmatic ‘musts’, ‘shoulds’, or ‘oughts’; they contrast with rational and flexible desires, wishes, preferences and wants. The presence of extreme philosophies can make all the difference between healthy negative emotions (such as sadness or regret or concern) and unhealthy negative emotions (such as depression or guilt or anxiety). For example, one person’s philosophy after experiencing a loss might take the form: “It is unfortunate that this loss has occurred, although there is no actual reason why it should not have occurred. It is sad that it has happened, but it is not awful, and I can continue to function.” Another’s might take the form: “This absolutely should not have happened, and it is horrific that it did. These circumstances are now intolerable, and I cannot continue to function.” The first person’s response is apt to lead to sadness, while the second person may be well on their way to depression. Most importantly of all, REBT maintains that individuals have it within their power to change their beliefs and philosophies profoundly, and thereby to change radically their state of psychological health.

The main purpose of REBT is to help clients to replace absolutist philosophies, full of ‘musts’ and ‘shoulds’, with more flexible ones; part of this includes learning to accept that all human beings (including themselves) are fallible and learning to increase their tolerance for frustration while aiming to achieve their goals. Although emphasizing the same ‘core conditions’ as person-centred counselling — namely, empathy, unconditional positive regard, and counsellor genuineness — in the counselling relationship, REBT views these conditions as neither necessary nor sufficient for therapeutic change to occur.

The basic process of change which REBT attempts to foster begins with the client acknowledging the existence of a problem and identifying any ‘meta-disturbances’ about that problem (i.e., problems about the problem, such as feeling guilty about being depressed). The client then identifies the underlying irrational belief which caused the original problem and comes to understand both why it is irrational and why a rational alternative would be preferable. The client challenges their irrational belief and employs a variety of cognitive, behavioural, emotive and imagery techniques to strengthen their conviction in a rational alternative. (For example, rational emotive imagery, or REI, helps clients practice changing unhealthy negative emotions into healthy ones at (C) while imagining the negative event at (A), as a way of changing their underlying philosophy at (B); this is designed to help clients move from an intellectual insight about which of their beliefs are rational and which irrational to a stronger ‘gut’ instinct about the same.) They identify impediments to progress and overcome them, and they work continuously to consolidate their gains and to prevent relapse.

To further this process, REBT advocates ‘selective eclecticism’, which means that REBT counsellors are encouraged to make use of techniques from other approaches, while still working specifically within the theoretical framework of REBT. In other words, REBT maintains theoretical coherence while pragmatically employing techniques that work.

Throughout, the counsellor may take a very directive role, actively disputing the client’s irrational beliefs, agreeing homework assignments which help the client to overcome their irrational beliefs, and in general ‘pushing’ the client to challenge themselves and to accept the discomfort which may accompany the change process.

***Electroconvulsive Therapy***

Electroconvulsive therapy (ECT) is a procedure in which electric currents are passed through the brain, intentionally triggering a brief seizure. ECT seems to cause changes in brain chemistry that can quickly reverse symptoms of certain mental illnesses. It often works when other treatments are unsuccessful.

Much of the stigma attached to ECT is based on early treatments in which high doses of electricity were administered without anesthesia, leading to memory loss, fractured bones and other serious side effects.

ECT is much safer today and is given to people while they're under general anesthesia. Although ECT still causes some side effects, it now uses electrical currents given in a controlled setting to achieve the most benefit with the fewest possible risks.

Electroconvulsive therapy (ECT) can provide rapid, significant improvements in severe symptoms of a number of mental health conditions. It may be an effective treatment in someone who is suicidal, for instance, or end an episode of severe mania. ECT is used to treat:

* **Severe depression,** particularly when accompanied by detachment from reality (psychosis), a desire to commit suicide or refusal to eat.
* **Treatment-resistant depression,** a severe depression that doesn't improve with medications or other treatments.
* **Severe mania,** a state of intense euphoria, agitation or hyperactivity that occurs as part of bipolar disorder. Other signs of mania include impaired decision making, impulsive or risky behavior, substance abuse, and psychosis.
* **Catatonia,** characterized by lack of movement, fast or strange movements, lack of speech, and other symptoms. It's associated with schizophrenia and some other psychiatric disorders. In some cases, catatonia is caused by a medical illness.
* **Agitation and aggression in people with dementia,** which can be difficult to treat and negatively affect quality of life.

ECT may be a good treatment option when medications aren't tolerated or other forms of therapy haven't worked. In some cases ECT is used:

* During pregnancy, when medications can't be taken because they might harm the developing fetus
* In older adults who can't tolerate drug side effects
* In people who prefer ECT treatments over taking medications
* When ECT has been successful in the past

***Aversion therapy***

A form of behavior therapy in which an aversive (causing a strong feeling of dislike or disgust) stimulus is paired with an undesirable behavior in order to reduce or eliminate that behavior.

As with other behavior therapies, aversion therapy is a treatment grounded in learning theory—one of its basic principles being that all behavior is learned and that undesirable behaviors can be unlearned under the right circumstances. Aversion therapy is an application of the branch of learning theory called classical conditioning. Within this model of learning, an undesirable behavior, such as a deviant sexual act, is matched with an unpleasant (aversive) stimulus. The unpleasant feelings or sensations become associated with that behavior, and the behavior will decrease in frequency or stop altogether. Aversion therapy differs from those types of behavior therapy based on principles of operant conditioning. In operant therapy, the aversive stimulus, usually called punishment, is presented after the behavior rather than together with it.

The goal of aversion therapy is to decrease or eliminate undesirable behaviors. Treatment focuses on changing a specific behavior itself, unlike insight-oriented approaches that focus on uncovering unconscious motives in order to produce change. The behaviors that have been treated with aversion therapy include such addictions as alcohol abuse, drug abuse, and smoking; pathological gambling; sexual deviations; and more benign habits—including writer's cramp. Both the type of behavior to be changed and the characteristics of the aversive stimulus influence the treatment—which may be administered in either outpatient or inpatient settings as a self-sufficient intervention or as part of a multimodal program. Under some circumstances, aversion therapy may be self-administered.

***Drug Therapy***

Medications may play an important role in the treatment of a mental illness, particularly when the symptoms are severe or do not adequately respond to psychotherapy. For example, treatment of bipolar disorder with medications tends to address two aspects: relieving already existing symptoms of mania or depression and preventing symptoms from returning. Medications that are thought to be particularly effective in treating manic and mixed symptoms include [olanzapine](http://www.medicinenet.com/olanzapine/article.htm) (Zyprexa), [risperidone](http://www.medicinenet.com/risperidone/article.htm) (Risperdal), and [aripiprazole](http://www.medicinenet.com/aripiprazole/article.htm) (Abilify). These medications belong to a group of medications called neuroleptics and are known for having the ability to work quickly compared to many other psychiatric medications. As a group of medications, side effects that occur most often include sleepiness, [dizziness](http://www.medicinenet.com/dizziness/symptoms.htm), and [increased appetite](http://www.medicinenet.com/increased_appetite/symptoms.htm). Weight gain, which may be associated with higher blood sugar, higher lipid levels, and sometimes increased levels of a hormone called prolactin may also occur. Although older medications in this class that were not mentioned here are more likely to cause muscle stiffness, shakiness, and very rarely uncoordinated muscle twitches (tardive dyskinesia) that can be permanent, health-care practitioners appropriately monitor the people they treat for these potential side effects as well. Mood-stabilizer medications like [lithium](http://www.medicinenet.com/lithium/article.htm), divalproex ([Depakote](http://www.medicinenet.com/valproic_acid/article.htm), and lamotrigine (Lamictal) can be useful in treating active (acute) symptoms of manic or mixed episodes. These medications may take a bit longer to work compared to the neuroleptic medications, and some (for example, lithium, divalproex, and carbamazepine) require monitoring of medication blood levels. Further, some of these medications can be associated with [birth defects](http://www.medicinenet.com/birth_defects/article.htm) when taken by pregnant women.