Introduction to Theories in Psychotherapy

Customer's Name

Academic Institution

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A single woman in modern-day society is often faced with many dilemmas leading to later psychological dysfunction. This is especially true if the young woman is a lesbian and devoid of a solid inner foundation and plagued with self-esteem issues. Lesbian women are human beings like everyone else except for the affixed label defining their sexual orientation. Society's desire and need for labels can create much psychological havoc in individuals who could lead otherwise normal lives.

Women who define themselves as lesbians encounter many of the same psychological issues as everyone else. Depression and anxiety may be more evident within some areas of this diverse group due to public ridicule, misunderstanding, and scrutiny. When members of a socially diverse group make the conscious decision to engage in psychotherapy, the therapist must take into consideration the nature in which the individual fits into the diverse grouping. Many therapeutic techniques are designed to enhance and bring forth an inner understanding and confidence which, in turn, provides the client with the ability to accept the self. Psychotherapy techniques can greatly enrich and change the quality of life experienced by the diversely grouped client, but a caring and well trained therapist will work diligently to aid the client in reaching the therapeutic goals.

Background

Personal History

Dana is a thirty-two year old, single, Caucasian, female who defines herself as a lesbian. Her parents are deceased, by natural causes, and she has one sibling, a brother, who lives in another state. She indicates having little if any contact with her brother. Dana has been single for

the past eighteen months since breaking up with her long-time partner due to an incident of infidelity. Dana reveals that her ex-partner had been involved in an affair outside of their relationship boundary for several months before discovering the infidelity. Dana has no children, biologically or through any previous relationships. She works as a cashier for a small retail business, but she is now on a leave of absence due to the recurring panic attacks.

Psychological History

Dana reports being diagnosed with Bipolar Disorder I over a year ago following a brief hospitalization for unexplained depression and a sudden burst of energy that could not be explained. She is currently on a medication regimen of 500mg of Depakote twice a day. She briefly continued with outpatient Cognitive Behavioral Therapy (CBT) and was released with only intermittent appointments to see the treating psychiatrist for medication.

Methodology

Presenting Symptoms

Dana enters the therapeutic setting with the chief complaint focusing on recurring panic attacks. She explains that sometimes the panic attacks will start and seem to dye-down before resurging and setting off another panic attack. She says the panic attacks seem to come in waves. The symptoms associated with the panic attacks include numbness in her hands, chest pains, confusion, sweating, and worrying that she is having a heart attack. After several trips to the local emergency room to confirm that she was not having a heart attack, the attending physician diagnosed Dana with having had a panic attack. She was then referred to the mental health agency for follow-up. The referral was made three months ago.

Dana has taken a voluntary leave of absence from work because she is scared of having another panic attack at work or while driving. She refers to her home as her "safe haven". It is revealed that she is reluctant to leave her home even to check the mail or go to the grocery store because of the insatiable fear of having another panic attack. The panic attacks are now reported to be occurring at home and include waking her up from sleep. Dana defines the episodes as feeling out of control. Further questioning uncovers new "habits" that Dana has now engaged in as well. Dana exposes that she now feels that she can ward off the panic attacks if keeps every door and window locked while inside her home. She also tells how repeating the word "Amen" after saying a prayer will also help to ward off the panic attacks.

Physically, Dana appears to be lacking sleep. Her eyes have darkened circles beneath them, and they appear to be puffy from either crying or from allergies. All the lab work indicates that her Depakote level is well within the safe range and that she is continuing to take her medication. While her facial appearance resembles exhaustion, her body language suggests otherwise. Her right foot is constantly bouncing, and she continually changes positions in her seat. Her hands are kept clasped together tightly, and it appears as if she is trying to wring out a washcloth.

Diagnosis

In light of the earlier diagnosis of *Bipolar Disorder I*, Dana's records were sent before this appointment. Dana was diagnosed with Bipolar Disorder I, 296.4x, with the most recent episode being manic (American Psychiatric Association, 2000). This diagnosis shows a family history, in the deceased parents, of clinical depression, alcoholism, and anxiety. No differential diagnosis was available.

With the presenting symptoms available, it appears that Dana is now experiencing two associated mental illnesses common in individuals with Bipolar Disorder. The first mental disorder is Panic Disorder with Agoraphobia. The DSM-IV-TR defines Panic Disorder with Agoraphobia, 300.21, as a feeling of sudden terror recurring repeatedly without explanation (American Psychiatric Association, 2000). The agoraphobia occurs when the individual limits or alters their lifestyle to accommodate the possibility of future panic attacks. The client experiences panic attacks that are unexplained and unexpected, and the client the condition has been present for at least thirty days. The client is now using avoidance to prohibit the possibility of future attacks.

The second mental disorder present is Obsessive Compulsive Disorder (OCD). OCD, 300.3, is evident in the client's need to repeat a specific word several times and keeping all the doors and windows locked as a means to respond to the obsession (American Psychiatric Association, 2000). Dana feels that these behaviors will help to ward off future panic attacks. The DSM-IV-TR by American Psychiatric Association (2000) specifies the following:

> A person with obsessive-compulsive disorder has either obsessions, or compulsions, or both. The obsessions and/or compulsions are strong enough to cause significant distress in their employment, schoolwork, or personal and social relationships. This includes: anankastic neurosis, obsessional neurosis, and obsessive-compulsive neurosis….The person feels the need to repeat physical behaviors (checking the stove to be sure it is off, hand washing) or mental behaviors (counting things, silently repeating words). These behaviors occur as a response to an obsession or in accordance with strictly applied rules. The aim of

these behaviors is to reduce or eliminate distress or prevent something that is dreaded.

OCD is often a comorbid condition appearing in conjunction with Bipolar Disorders and Panic Disorder.

Analysis

One of the most important acts that a therapist must conduct, when seeing a client for the first time, involves the explanation of informed consent. A therapist must explain to the client the following key items: a) the benefits of psychotherapy, b) the risks associated with psychotherapy, c) alternative treatments, d) cost, e) confidentiality, f) mandated reporting, and g) termination of services (Corey, 2009). The explanation of informed consent is a legal requirement of all treating therapists, clinicians, and psychiatrists. Most items are very simply explicated with the exception of the issue of confidentiality. Clients should be made aware of the fact that anything and everything said during to contextual confines of the therapy session is considered private and privileged information; however, in the instance of suicidal or homicidal statements or ideations, the therapist is mandated to report the information to the proper authorities.

Psychotherapies

There are several psychotherapies that stand to benefit Dana as she faces various, but similar, psychological problems. Cognitive Behavioral Therapy (CBT) is a form of psychotherapy used to aid the client in realizing the garbled thoughts and perceptions causing psychological anguish (Pomerantz, 2008). In humans, thoughts predetermine the actions and feelings that follow. Aaron Beck studied and researched the correlation between thought and

emotions before giving rise to the cognitive behavioral technique (Corey, 2009). In more scientific terms, a stimulus creates a thought which then produces an emotion. In some individuals, the scientific equation works differently causing psychological angst and upset. An example of the alternative pattern is evident in the following example. Dana has experienced repeated panic attacks causing her to go to the emergency room for fear of having a heart attack. The attending physician informed her of the panic disorder and referred her to an agency for mental health services. Dana has perceived the information provided from the doctor to mean that she is crazy. Her misconstrued thoughts has caused her more emotional grief as she has continued to experience more panic attacks in the months that have followed. If she had surmised what the doctor said to mean that the physical condition, the panic attacks, were not of a biological origin but rather of a psychological origin, then she could have sought the services from the mental health organization sooner and already be on the road to recovery. This therapeutic technique would serve as beneficial in treating the disorders of panic disorder, OCD, and various aspects of Bipolar Disorder.

The second psychotherapy technique chosen is the Client-Centered Therapy (CCT) developed by renowned psychologist Carl Rogers (Pomerantz, 2008). The CCT technique regards each client as being in possession of the necessary tools to aid in their own recovery. This technique uses the therapist as a guide for the client to discover the hidden answers to many problems and issues plaguing or disrupting their life. CCT focuses on three guidelines that must be adhered to by the therapist. These factors are an unconditional positive regard, empathetic listening and understanding, and congruence (Corey, 2009). When implementing unconditional positive regard, the therapist allows the client free will to survey every thought and feeling without the fear of rejection. This may prove tricky in some instances in lieu of mandated

reporting issues within the regulated informed consent. Second, therapists should exercise empathetic listening and understanding. This is accomplished with reflective listening. It is a form of communication used to relay to the speaker that he is being understood. Third, congruence is expressed in the client speaking as a real person. The therapist should refrain from using words or phrases that cannot be intellectually understood by the client, and the therapist should develop a personable rapport with the client to ensure a level of comfort in which the client can effectively communicate and convey their feelings. This therapy is especially helpful for clients with low self-esteem, depression, and anxiety.

The final choice of psychotherapy to be used is Exposure Therapy. Exposure therapy has proven to be very successful in illnesses such as OCD and panic disorder. Exposure therapy is a sub-type of CBT as it forces the client to face their fears in order to psychologically move forward and make progress (Corey, 2009). The therapy teaches the client how to use relaxation techniques as a means for creating relaxation at-will when necessary. Visual and actual exposures are used to aid the client to face their fears which increases the level of anxiety within the client (Burns, 2006). The client receives encouragement from the therapist to resonate the feelings of anxiety until the apprehensive or fearful emotions pass. Exposures are repeated in subsequent sessions as a way to desensitize the client to the origin of the anxiety.

Mock Therapy Session

Dana will be treated using a combination of CBT coupled with Exposure Therapy. The CCT approach will be used to develop congruence between the client and the therapist. This is Dana's third session with the client.

Therapist: Hello Dana.

Dana: Hello _____.

Therapist: So, how was your week?

Dana: Long. I've been really tired lately, but every time I try to take a nap or go to sleep it seems like the phone rings. I don't have caller i.d., so I answer it every time in case it is your office calling to reschedule or something. (Sighs)

Therapist: Have you thought about getting an answering machine? Some models let you screen the calls, which would let you decide who you wanted to talk to. I don't think they are very expensive either.

Dana: Oh, they aren't. I sell them where I work…. (long pause) or worked.

Therapist: Have you talked to your supervisor or someone from work lately?

Dana: No, but I know they aren't going to give me much more time to get my act together before the bring down the gavel on me and tell me to either come to work or be fired. (She starts wringing hands and tapping foot)

Therapist: Dana, on a scale of 1-10, where is your anxiety level at right now when we were talking about your job?

Dana: About 6, or maybe 7'ish.

Therapist: Okay, I think this is a good place for us to start today. Today we are going to concentrate on learning a relaxation technique that will allow you to enter a relaxed state when you start to feel anxious and worked up. Then, we are going to talk more about your work and the panic attacks and try to use the new technique. Okay?

Dana: Okay.

Therapist: Alright. Now I would like for you to get comfortable and close your eyes. I want you to concentrate on the sound of my voice.

Dana: (sitting upright, eyes closed)

Therapist: Now, I want you to concentrate on breathing. Breathe in through your nose and out through your mouth. Take in long, deep, and slow breaths through your nose, and expel the used air through your mouth. In….and…..out. As you continue breathing, I want you to begin to relax your feet. Now start to relax your ankles, and knees working your way up to your thighs. Let your lower body go limp. As you continue breathing, let the air passing out of your mouth expel all the tension. In….and….out…..slowly.

Dana: (visual appearance of paced breathing)

Therapist: Now, let your abdomen relax…..and continue the relaxation to your fingers, your hands, your arms, and now your shoulders. Feel the tension and stress leave your body through your mouth. Breathe it away. Blow it out and far away from your body. Let your shoulders go, feel the tension release from your neck. Let your face relax. Allow your jaw to unclench and drop. Feel the frown lines leaving your forehead. You are in a complete state of relaxation. Keep breathing slowly in through your nose, and out through your mouth.

Dana: (looks to be falling asleep)

Therapist: Now, I want you to think of a place where you have felt like this before. Dana, where is that place?

Dana: My bathtub.

Therapist: Great! Tell me about it.

Dana: My bathroom is remodeled. I have a big garden tub. It's full of warm water. The bubbles are fuzzy and tingly. I have my radio playing by the sink. I'm tired and relaxed.

Therapist: Okay. I want you to remember the bathtub, the relaxed feeling, the peaceful

feeling within you right now. Whenever you begin to feel worried or anxious, I want you to close your eyes and return to this place. You are safe here. You can relax here….regroup here….and calm down. Now I want you to open your eyes.

Dana: (opens eyes and smiles) I feel like I could have gone to sleep for a week.

Therapist: (smiles and laughs) Dana, on a scale of 1-10, where is your anxiety level right now?

Dana: Ha! About a -3. I haven't felt this good in ages.

Therapist: That's wonderful! I want you to remember where and how to get to your safe place as we continue working here in therapy. You can also use this technique of relaxation in the outside world, too, or even at home. Now, let's talk a little. Tell me what made you decided to leave your job temporarily.

Dana: Well, I was ringing up a customer, like I always do. I had taken the customer's money and I felt my heart start pounding. I handed the customer her change, and she said that my hands felt like ice. I tried to smile, but inside I was just hoping she'd hurry and leave. Then I felt hot and I could feel sweat on my forehead. (hands starting to clench and breathing becoming more erratic) The customer

asked me if I was feeling okay. When I tried to answer her, my words were all jumbled and I was confused. Then I …..

Therapist: Okay Dana, on a scale of 1-10, where is your anxiety level right now?

Dana: Oh God….about a 7…I just….

Therapist: Dana, I want you to think of your safe place…..go there right now….breathe. Remember, you are telling me about a memory. Memories are things stored in our mind that have already happened. A memory cannot hurt you. Breathe slowly, in through your nose and out through your mouth.

Dana: (pacing her breathing with eyes wide open)

Therapist: What are you feeling right now?

Dana: My heart is pounding really fast and my hands are sweaty.

Therapist: Dana, I want you to stay with this feeling. (offering calm reassurance) Now, after the customer asked you if you were alright, what did you do?

Dana: I couldn't talk right and I was really confused. I ran from my register back to the break room.

Therapist: Why?

Dana: I just had to get away. I got my purse and my keys cause I wanted to go to the hospital. It felt like a heart attack.

Therapist: Have you ever had a heart attack?

Dana: No, but this doctor on TV. told about it once and I was having the same symptoms.

Therapist: On a scale of 1-10, where is your anxiety level right now?

Dana: About a 4 or 5.

Therapist: So it's coming down?

Dana: Yeah, it is.

Therapist: Can you finish telling….

Dana: Can you tell me something?

Therapist: I can try.

Dana: What makes a panic attack happen?

Therapist: Well, the human brain runs on different chemicals which each have a specific job. A panic attack occurs when there is too much of the adrenaline chemical released. Adrenaline puts the brain into a "fight or flight" mode. After the chemical is released, the brain puts all the bodily systems on "red alert", so to speak. The extra chemical in the brain essentially puts your body into a

state of emergency for no reason.

Dana: Like a false alarm?

Therapist: Very much so.

Dana: But it feels like I'm going to die.

Therapist: Well, that's one of the misconceptions about panic attacks. You aren't going to die, even though it might feel inevitable at that moment. Once you understand that you will be okay, then you will be better equipped for using the relaxation technique like you learned today to get on top of an unpredicted episode of panic. The best way to combat a panic episode therapeutically is through distraction. If you can divert your thinking to something, other than the current physical feelings and worry, like the birds outside or a television program, then the "false alarm" will stop going off and the adrenaline will stop being released. In the end, the panic attack will cease.

Dana: Will I always have this problem?

Therapist: Maybe less frequently, or the panic attacks may even stop altogether. It is not for me to determine. I have great confidence that you will be able to

overcome this issue and be able to regain your whole life back as you have indicated to me that you want to do.

Dana: I just hate feeling like I'm in a prison because of this. I feel so confined.

Therapist: Fortunately, that is only true metaphorically. My job is to help you find the right keys in order for you to release and free yourself.

Discussion

Treatment Goals

The treatment goals for Dana focus on aiding her to develop a better understanding of her diagnosed conditions. Psycho-education can be helpful during psychotherapy. Sometimes, fear is generated simply because something is unknown or foreign to an individual. Dana can gain much knowledge from the Exposure Therapy and the CBT sessions. As she makes significant progress, Dana can move into a more CCT process allowing her to express her feelings and emotions with regard to her psychological health and Bipolar Disorder illness.

In a therapeutic position, it would not be farfetched to hope to see Dana become self-sufficient again through being able to return to work. It is essential that Dana grow and nurture her level of self-esteem as it appears that she possesses some residual guilt for her psychological flaws. The issue of infidelity in her previous relationship should be explored more effectively to ensure that Dana has been allowed to put closure onto a painful and emotionally traumatizing experience. Dana should be encouraged to seek out future a future relationship which would give her a supportive environment in her isolated world. She should also be supported in finding

friends with whom she can talk, spend leisure time, and pursue fun activities. Dana has a bright future ahead of her so long as she continues to be cooperative and functional within the psychotherapy treatment.

Criticisms of Psychotherapy Techniques

Every topic has a critic. This is also true in the psychotherapy spectrum. Cognitive Behavioral Therapy (CBT), Client-Centered Therapy (CCT), and Exposure Therapy have all encountered skeptics along the way. Critics of CBT contend that a therapist's views and ideas are not always right, and the therapist should not thrust their views onto a vulnerable client (Corey, 2009). Some participants in CBT have reported feeling lead by certain questions and dictated over by the treating therapist. Truthfully, CBT is not about criticizing the thought or emotion, but rather it is a method by which a structurally unsound equation is being tested and redeveloped.

Critics of CCT feel that this method is one whereby all therapist should function regardless. Some suggest that this form of therapy turns the therapist into a liar by demanding the therapist to withhold opinions from the client. Some psychologists feel that CCT gives the client too much ground too fast. Psychological boundaries are needed within any given therapy session, but the CCT sessions seem to be without a peripheral guideline (Pomerantz, 2008). There is also the ethical dilemma concerning the client's free will and expression when faced with the issues of mandated reported under the informed consent. Some clients may feel betrayed or lied to if certain information were relayed to a third party due to the mandated reporting laws. Consequently, this would leave the client psychologically traumatized and less likely to trust a therapist again.

Finally, the critics of Exposure therapy suggest that the therapy moves too far too fast. They feel that it pushes the clients into emotional situations that they may not be psychologically ready to handle. Trained psychotherapists are taught and educated as to the readiness of each individual client. Therapists are also consciously aware of their client's history before undertaking an exposure session. If at any time the client feels that he, or she, cannot endure any further exposure, then the client is free to halt and cease the exposure (Burns, 2006). No one is forcing the clients to do anything that they are not willing to try. Facing one's fears can be scary and produce anxiety, but with the encouragement and accompaniment of a specially trained therapist, the experience can prove to be successful.

Conclusion

Various psychotherapies are designed to help aid and treat clients with an assortment of mental disorders. Upon making contact with a therapist, a client must provide a detailed history including family, physical health, and psychological history. This information better enables the therapist to help the client address the problematic areas and to define the problem areas. Lesbian women are categorized as a diverse group, but in actuality, they are as much a human being as anyone else. Treating agencies must inform the clients of the laws concerning informed consent before any therapeutic sessions can commence. This serves to protect the therapist, the client, and society. Psychotherapies such as Cognitive Behavioral Therapy, Client-Centered Therapy, and Exposure Therapy are known for their effectiveness in treating illnesses like panic disorder, Obsessive-compulsive Disorder, and some aspects of Bipolar Disorder. Psychotherapy techniques can greatly enrich and change the quality of life experienced by the diversely grouped client, but a caring and well trained therapist will work diligently to aid the client in reaching the therapeutic goals.