**Psychosocial theories**

Many theories attempt to explain human behavior, health, and mental illness. Each theory suggests how normal development occurs based on the theorist’s beliefs, assumptions, and view of the world. These theories suggest strategies that the clinician can use to work with clients. Many theories discussed in this chapter were not based on empirical or research evidence; rather, they evolved from individual experiences and might more appropriately be called conceptual models or frameworks. And we are will discusses the following types of ***psychosocial Theories***:

• Psychoanalytic

• Developmental

• Interpersonal

• Humanistic

• Behavioral

• Existential

1. **Psychoanalytic**

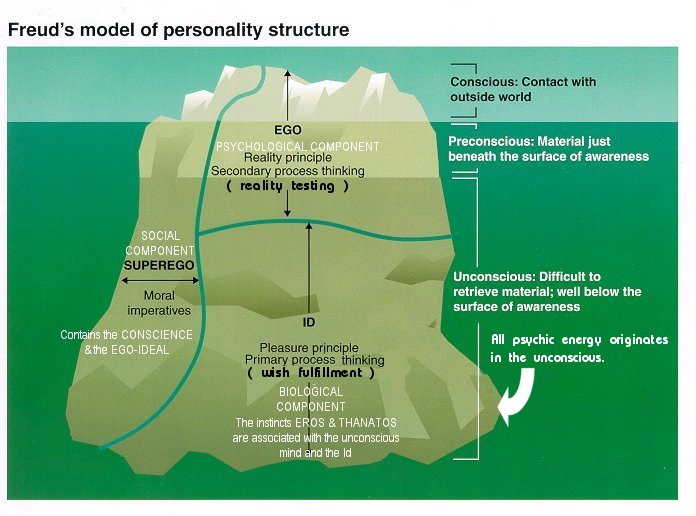
* ***Sigmund Freud: The Father of Psychoanalysis***

Psychoanalytic theory supports the notion that all human behavior is caused and can be explained (deterministic theory). Freud believed that *repressed* (driven from conscious awareness) sexual impulses and desires motivate much human behavior. He developed his initial ideas and explanations of human behavior from his experiences with a few clients, all of them women who displayed unusual behaviors such as disturbances of sight and speech, inability to eat, and paralysis of limbs. These symptoms had no physiological basis, so Freud considered them to be the “hysterical” or neurotic behavior of women. After several years of working with these women, Freud concluded that many of their problems resulted from childhood trauma or failure to complete tasks of psychosexual development. These women repressed their unmet needs and sexual feelings as well as traumatic events. The “hysterical” or neurotic behaviors resulted from these unresolved conflicts.

**Personality Components:**

Freud conceptualized personality structure as having three components: **Id, Ego, and Superego.** (Freud, 1923/1962).

* The **id** is the part of one’s nature that reflects basic or innate desires such as pleasure-seeking behavior, aggression, and sexual impulses. The id seeks instant gratification, causes impulsive unthinking behavior, and has no regard for rules or social convention.
* The **superego** is the part of a person’s nature that reflects moral and ethical concepts, values, and parental and social expectations; therefore, it is in direct opposition to the id.
* The third component, the **ego,** is the balancing or mediating force between the id and the superego. The ego represents mature and adaptive behavior that allows a person to function successfully in the world. Freud believed that anxiety resulted from the ego’s attempts to balance the impulsive instincts of the id with the stringent rules of the superego. The accompanying drawing demonstrates the relationship of these personality structures.



\*\*According to Freud the id, ego, and superego all operate across three levels of awareness in the human mind. They are the conscious, unconscious, and preconscious.  
 **The conscious:**

The conscious consists of what someone is aware of at any particular point in time. It includes what you are thinking about right now, whether it is in the front of you mind or the back. If you are aware of it then it is in the conscious mind.  
**The Preconscious:**The preconscious contains information that is just below the surface of awareness. It can be retrieved with relative ease and usually can be thought of as memory or recollection.  
**The Unconscious:**The unconscious contains thoughts, memories, and desires that are buried deep in ourselves, well below our conscious awareness. Even though we are not aware of their existence, they exert great influence on our behavior.

**EGO DEFENSE MECHANISMS**

Anxiety is a key concept in Freud's personality profile. He believed that people will try to ward of anxiety in any way possible, whether it is conscious or unconsciously. In an effort to ward off anxiety people use methods called defense mechanisms. I will discuss a variety of defense mechanisms and provide an example of each.

* 1. **Compensation** Overachievement in one area to offset real or perceived deficiencies in another area
  + Napoleon complex: diminutive man becoming emperor.
  + Nurse with low self-esteem working double shifts so her supervisor will like her

1. **Conversion** Expression of an emotional conflict through the development of a physical symptom, usually sensorimotor in nature
   * Teenager forbidden to see X-rated movies is tempted to do so by friends and develops blindness, and the teenager is unconcerned about the loss of sight.
2. **Denial** Failure to acknowledge an unbearable condition; failure to admit the reality of a situation or how one enables the problem to continue
   * Diabetic person eating chocolate candy
   * Spending money freely when broke
   * Waiting 3 days to seek help for severe abdominal pain
3. **Displacement** Ventilation of intense feelings toward persons less threatening than the one who aroused those feelings

* Person who is mad at the boss yells at his or her spouse.
* Child who is harassed by a bully at school mistreats a younger sibling.

1. **Dissociation** Dealing with emotional conflict by a temporary alteration in consciousness or identity

* Amnesia that prevents recall of yesterday’s auto accident
* Adult remembers nothing of childhood sexual abuse.

1. **Fixation** Immobilization of a portion of the personality resulting from unsuccessful completion of tasks in a developmental stage

* Never learning to delay gratification
* Lack of a clear sense of identity as an adult

1. **Identification** Modeling actions and opinions of influential others while searching for identity, or aspiring to reach a personal, social, or occupational goal

* Nursing student becoming a critical care nurse because this is the specialty of an instructor she admires

1. **Intellectualization** Separation of the emotions of a painful event or situation from the facts involved; acknowledging the facts but not the emotions

* Person shows no emotional expression when discussing serious car accident.

1. **Introjection** Accepting another person’s attitudes, beliefs, and values as one’s own

* Person who dislikes guns becomes an avid hunter, just like a best friend.

1. **Projection** Unconscious blaming of unacceptable inclinations or thoughts on an external object

* Man who has thought about same-gender sexual relationship, but never had one, beats a man who is gay.
* Person with many prejudices loudly identifies others as bigots.

1. **Rationalization** Excusing own behavior to avoid guilt, responsibility, conflict, anxiety, or loss of self-respect

* Student blames failure on teacher being mean.
* Man says he beats his wife because she doesn’t listen to him.

1. **Reaction formation** Acting the opposite of what one thinks or feels

* Woman who never wanted to have children becomes a supermom.
* Person who despises the boss tells everyone what a great boss she is.

1. **Regression** Moving back to a previous developmental stage to feel safe or have needs met

* Five-year-old asks for a bottle when new baby brother is being fed.
* Man pouts like a 4-year-old if he is not the center of his girlfriend’s attention.

1. **Repression** Excluding emotionally painful or anxiety-provoking thoughts and feelings from conscious awareness

* Woman has no memory of the mugging she suffered yesterday.
* Woman has no memory before age 7, when she was removed from abusive parents.

1. **Resistance** Overt or covert antagonism toward remembering or processing anxiety-producing information

* Nurse is too busy with tasks to spend time talking to a dying patient.
* Person attends court-ordered treatment for alcoholism but refuses to participate.

1. **Sublimation** Substituting a socially acceptable activity for an impulse that is unacceptable

* Person who has quit smoking sucks on hard candy when the urge to smoke arises.
* Person goes for a 15-minute walk when tempted to eat junk food.

1. **Substitution** Replacing the desired gratification with one that is more readily available

* • Woman who would like to have her own children opens a day care center.

1. **Suppression** Conscious exclusion of unacceptable thoughts and feelings from conscious awareness

* • Student decides not to think about a parent’s illness to study for a test.
* • Woman tells a friend she cannot think about her son’s death right now.

1. **Undoing** Exhibiting acceptable behavior to make up for or negate unacceptable behavior

* • Person who cheats on a spouse brings the spouse a bouquet of roses.
* • Man who is ruthless in business donates large amounts of money to charity.

**Five Stages of Psychosexual Development.**

Freud based his theory of childhood development on the belief that sexual energy, termed *libido*, was the driving force of human behavior. He proposed that children progress through five stages of psychosexual development: the accompanying developmental tasks. Psychopathology results when a person has difficulty making the transition from one stage to the next or when a person remains stalled at a particular stage or regresses to an earlier stage. Freud’s open discussion of sexual impulses, particularly in children, was considered shocking for his time (Freud, 1923/1962).

* **Oral** Birth to 18 months

Major site of tension and gratification is the mouth, lips, and tongue; includes biting and sucking activities. Id is present at birth. Ego develops gradually from rudimentary structure present at birth.

* **Anal** 18–36 months

Anus and surrounding area are major source of interest. Voluntary sphincter control (toilet training) is acquired.

* **Phallic**/oedipal 3–5 years

Genital is the focus of interest, stimulation, and excitement. Penis is organ of interest for both sexes. Masturbation is common. Penis envy (wish to possess penis) is seen in girls; oedipal complex (wish to marry opposite-sex parent and be rid of same-sex parent) is seen in boys and girls.

* **Latency** 5–11 or 13 years

Resolution of oedipal complex Sexual drive channeled into socially appropriate activities such as school work and sports Formation of the superego Final stage of psychosexual development

* **Genital** 11–13 years

Begins with puberty and the biologic capacity for orgasm; involves the capacity for true intimacy.

**Transference and Countertransference.** Freud developed the concepts of transference and countertransference.

* **Transference** occurs when the client displaces onto the therapist attitudes and feelings that the client originally experienced in other relationships (Freud, 1923/1962).
* **Countertransference** occurs when the therapist displaces onto the client attitudes or feelings from his or her past. For example, a female nurse who has teenage children and who is experiencing extreme frustration with an adolescent client may respond by adopting a parental or chastising tone.

**Developmental theorirs:**

* ***Erik Erikson and Psychosocial Stages of Development***

**Erik Erikson** (1902–1994) was a German-born psychoanalyst who extended Freud’s work on personality development, across the life span while focusing on social and psychological development in the life stages. In 1950, Erikson published *Childhood and Society*, in which he described eight psychosocial stages of development. In each stage, the person must complete a life task that is essential to his or her well-being and mental health. These tasks allow the person to achieve life’s virtues: hope, purpose, fidelity, love, caring, and wisdom. Each stage is dependent on completion of the previous stage and life task

**ERIKSON’S STAGES OF PSYCHOSOCIAL DEVELOPMENT**

|  |  |  |
| --- | --- | --- |
| **Stage** | **Virtue** | **Task** |
| Trust vs. mistrust (infant**)** | Hope | Viewing the world as safe and reliable; relationships as nurturing, stabled, and dependable |
| Autonomy vs. shame and doubt (toddler) | **will** | Will Achieving a sense of control and free will |
| Initiative vs. guilt(preschool) | **purpose** | Purpose Beginning development of a conscience; learning to manage conflict and anxiety |
| Industry vs. inferiority (school age) | Competence | Emerging confidence in own abilities; taking pleasure in accomplishments |
| Identity vs. role confusion  (adolescence) | Fidelity | Formulating a sense of self and belonging |
| Intimacy vs. isolation (young  adult) | Love | Forming adult, loving relationships and meaningful attachments  to others |
| Generativity vs. stagnation  (middle adult) | Care | Being creative and productive; establishing the next generation |
| Ego integrity vs. despair (maturity) | Wisdom | Accepting responsibility for one’s self and life |

* ***Jean Piaget and Cognitive Stages of Development***

Jean Piaget (1896–1980) explored how intelligence and cognitive functioning develop in children. He believed that human intelligence progresses through a series of stages based on age, with the child at each successive stage demonstrating a higher level of functioning than at previous stages. In his schema, Piaget strongly believed that biologic changes and maturation were responsible for cognitive development. Piaget’s four stages of cognitive development are as follows:

* 1. ***Sensorimotor***—birth to 2 years: The child develops a sense of self as separate from the environment and the concept of object permanence; that is, tangible objects do not cease to exist just because they are out of sight. He or she begins to form mental images.
  2. ***Preoperational***—2 to 6 years: The child develops the ability to express self with language, understands the meaning of symbolic gestures, and begins to classify objects.
  3. ***Concrete operations***—6 to 12 years: The child begins to apply logic to thinking, understands spatiality and reversibility, and is increasingly social and able to apply rules; however, thinking is still concrete.
  4. ***Formal operations***—12 to 15 years and beyond: The child learns to think and reason in abstract terms, further develops logical thinking and reasoning, and achieves cognitive maturity.

**Interpersonal theories:**

* ***Harry Stack Sullivan: Interpersonal Relationships and Milieu Therapy***

Harry Stack Sullivan (1892–1949) was an American psychiatrist who extended the theory of personality development to include the significance of interpersonal relationships. Sullivan believed that one’s personality involves more than individual characteristics, particularly how one interacts with others. He thought that inadequate or no satisfying relationships produce anxiety, which he saw as the basis for all emotional problems (Sullivan, 1953). The importance and significance of interpersonal relationships in one’s life is probably Sullivan’s greatest contribution to the field of mental health.

**Five Life Stages.**

Sullivan established five life stages of development—infancy, childhood, juvenile, preadolescence, and adolescence, each focusing on various interpersonal relationships (Table 3.4). He also described three developmental cognitive modes of experience and believed that mental disorders are related to the persistence of one of the early modes.

1. The prototaxic mode**,** characteristic o infancy and childhood, involves brief, unconnected experiences that have no relationship to one another. Adults with Schizophrenia exhibit persistent prototaxic experiences.
2. The parataxic modebegins in early childhood as the child begins to connect experiences in sequence. The child may not make logical sense of the experiences and may see them as coincidence or chance events. The child seeks to relieve anxiety by repeating familiar experiences, although he or she may not understand what he or she is doing. Sullivan explained paranoid ideas and slips of the tongue as a person operating in the parataxic mode.
3. In the syntaxic mode, which begins to appear in school-aged children and becomes more predominant in preadolescence, the person begins to perceive himself or herself and the world within the context of the environment and can analyze experiences in a variety of settings. Maturity may be defined as predominance of the syntaxic mode (Sullivan, 1953).

**SULLIVAN’S five LIFE STAGES**

|  |  |  |
| --- | --- | --- |
| **Stage** | **Ages** | **Focus** |
| Infancy | Birth to onset of language | 1. Primary need exists for bodily contact and tenderness. 2. Prototaxic mode dominates (no relation between experiences). 3. Primary zones are oral and anal. 4. If needs are met, infant has sense of well-being; unmet needs lead to dread and anxiety. |
| Childhood | Language to 5 years | 1. Parents are viewed as source of praise and acceptance. 2. Shift to parataxic mode: experiences are connected in sequence to each other. 3. Primary zone is anal. 4. Gratification leads to positive self-esteem. 5. Moderate anxiety leads to uncertainty and insecurity; severe anxiety results in self-defeating patterns of behavior. |
| Juvenile | 5–8 years | 1. Shift to the syntaxic mode begins (thinking about self and others based on 2. analysis of experiences in a variety of situations). 3. Opportunities for approval and acceptance of others Learn to negotiate own needs. 4. Severe anxiety may result in a need to control or in restrictive, prejudicial attitudes. |
| Preadolescence | 8–12 years | 1. Move to genuine intimacy with friend of the same sex. 2. Move away from family as source of satisfaction in relationships. 3. Major shift to syntaxic mode occurs. 4. Capacity for attachment, love, and collaboration emerges or fails to develop. |
| Adolescence | Puberty to  adulthood | 1. Lust is added to interpersonal equation. 2. Need for special sharing relationship shifts to the opposite sex. 3. New opportunities for social experimentation lead to consolidation of self-esteem or self-ridicule. 4. If the self-system is intact, areas of concern expand to include values, ideals, career decisions, and social concerns. |

## Therapeutic Community or Milieu.

*Sullivan envisioned the:*

* Goal of treatment as the establishment of satisfying interpersonal relationships.
* The therapist provides a corrective interpersonal relationship for the client.
* Sullivan created the term **participant observer** for the therapist’s role, meaning that the therapist **both participates in and observes** the progress of the relationship.
* Sullivan is also credited with developing the first **therapeutic community or milieu** with young men with schizophrenia in 1929
* In the concept of therapeutic community or milieu, the interaction among clients is seen as beneficial, and **treatment emphasizes the role of this client-to-client interaction.**
* Until this time, it was believed that the interaction between the client and the psychiatrist was the one essential component to the client’s treatment.
* The concept of **milieu therapy,** originally developed by Sullivan, involved clients’ interactions with one another **including**:

1. **Practicing interpersonal relationship skills**
2. **Giving one another feedback about behavior**
3. **Working cooperatively as a group to solve day-to-day problems.**

* Management of the milieu, or environment, is still a primary role for the nurse in terms of providing safety and protection for all clients and promoting social interaction.

***Hildegard Peplau: Therapeutic Nurse–Patient Relationship***

Hildegard Peplau was a nursing theoristand clinician who built on Sullivan’s interpersonal**.**

* Hildegard Peplau, who developed the phases ofthe nurse–client therapeutic relationship, which has madegreat contributions to the foundation of nursing practicetoday.
* Theories and also saw the role of the nurse as a participant observer.
* Peplau developed the concept of the **therapeutic** **nurse– patient relationship,** which includes four phases: *orientation, identification, exploitation, and resolution*

During these phases, the client accomplishes certain tasks and makes relationship changes that help the healing process (Peplau, 1952).

**PEPLAU’S STAGES AND TASKS OF RELATIONSHIPS**

|  |  |
| --- | --- |
| **Stage** | * **Tasks** |
| Orientation | * Patient’s problems and needs are clarified. * Patient asks questions. * Hospital routines and expectations are explained. * Patient harnesses energy toward meeting problems. * Patient’s full participation is elicited. |
| Identification | * Patient responds to persons he or she perceives as helpful. * Patient feels stronger. * Patient expresses feelings. * Interdependent work with the nurse occurs. * Roles of both patient and nurse are clarified. |
| Exploitation | * Patient makes full use of available services. * Goals such as going home and returning to work emerge. * Patient’s behaviors fluctuate between dependence and independence. |
| Resolution | * Patient gives up dependent behavior. * Services are no longer needed by patient. * Patient assumes power to meet own needs, set new goals, and so forth. |

Peplau’s concept of the nurse–client relationship, with tasks and behaviors characteristic of each stage, has been modified but remains in use today (see Chapter 5).

**Roles of the Nurse in the Therapeutic Relationship.**

Peplau also wrote about the roles of the nurse in the therapeutic relationship and how these roles help meet the client’s needs. The primary roles she identified are as follows:

1. ***Stranger****––*offering the client the same acceptance and courtesy that the nurse would to any stranger;
2. ***Resource person****––*providing specific answers to questions within a larger context
3. ***Teacher****––*helping the client to learn formally or informally;
4. ***Leader****––*offering direction to the client or group;
5. ***Surrogate****––*serving as a substitute for another such as a parent or sibling;
6. ***Counselor****––*promoting experiences leading to health for the client such as expression of feelings.

Peplau also believed that the nurse could take on many other roles, including ***(consultant, tutor, safety agent, mediator, administrator, observer, and researcher)***. These were not defined in detail but were “left to the intelligence and imagination of the readers” (Peplau, 1952, p. 70).

**Four Levels of Anxiety.**

Peplau defined anxiety as the initial response to a psychic threat. She described four levels of anxiety: mild, moderate, severe, and panic (Table 3.6).

These serve as the foundation for working with clients with anxiety in a variety of contexts (see Chapter 13).

1. *Mild anxiety* is a positive state of heightened awareness and sharpened senses, allowing the person to learn new behaviors and solve problems. The person can take in all available stimuli (perceptual field).
2. *Moderate anxiety* involves a decreased perceptual field (focus on immediate task only); the person can learn new behavior or solve problems only with assistance. Another person can redirect the person to the task.
3. *Severe anxiety* involves feelings of dread or terror. The person cannot be redirected to a task; he or she focuses only on scattered details and has physiological symptoms of tachycardia, diaphoresis, and chest pain. A person with severe anxiety may go to an emergency department, believing he or she is having a heart attack.
4. *Panic anxiety* can involve loss of rational thought, delusions, hallucinations, and complete physical immobility and muteness. The person may bolt and run aimlessly, often exposing himself or herself to injury

|  |  |  |  |
| --- | --- | --- | --- |
| **Mild** | **Moderate** | **Severe** | **Panic** |
| * Sharpened senses * Increased motivation * Alert * Enlarged perceptual field * Can solve problems * Learning is effective * Restless * Gastrointestinal “butterflies” * Sleepless * Irritable * Hypersensitive to noise | * Selectively attentive * Perceptual field limited to the immediate task * Can be redirected * Cannot connect thoughts or events independently * Muscle tension * Diaphoresis * Pounding pulse * Headache * Dry mouth * Higher voice pitch * Increased rate of speech * Gastrointestinal upset * Frequent urination * increased automatisms   (nervous mannerisms) | * Perceptual field reduced to one detail or scattered details * Cannot complete tasks * Cannot solve problems or learn effectively * Behavior geared toward * anxiety relief and is usually ineffective * Feels awe, dread, or horror * Doesn’t respond to redirection * Severe headache * Nausea, vomiting, diarrhea * Trembling * Rigid stance * Vertigo * Pale * Tachycardia * Chest pain * Crying * Ritualistic (purposeless, repetitive) behavior | * Perceptual field reduced to focus on self * Cannot process environmental stimuli * Distorted perceptions * Loss of rational thought * Personality disorganization * Doesn’t recognize danger * Possibly suicidal * Delusions or hallucination possible * Can’t communicate verbally * Cannot sit (may bolt and run) or is totally mute and immobile |

**Humanistic theories:**

Humanism represents a significant shift away from the psychoanalytic view of the individual as a neurotic, impulse-driven person with repressed psychic problems and away from the focus on and examination of the client’s past experiences.

**Humanism** focuses on a person’s positive qualities, his or her capacity to change (human potential), and the promotion of self-esteem. Humanists do consider the person’s past experiences, but they direct more attention toward the present and future.

* ***Abraham Maslow: Hierarchy of Needs***

Abraham Maslow (1921–1970) was an American psychologist who:

* Studied the needs or motivations of the individual.
* He differed from previous theorists in that he focused on **the total person**, not just on one facet of the person
* Emphasized health instead of simply illness and problems.
* Maslow (1954) formulated the **hierarchy** **of needs**, in which he used a pyramid to arrange and illustrate the basic drives or needs that motivate people.



1. The most basic needs—the physiological needs of (food, water, sleep, shelter, sexual expression, and freedom from pain)—must be met first.
2. The second level involves safety and security needs, which include (protection, security, and freedom from harm or threatened deprivation).
3. The third level is love and belonging needs, which include (enduring intimacy, friendship, and acceptance).
4. The fourth level involves esteem needs, which include the (need for self-respect and esteem from others).
5. The highest level is self-actualization, the need for (beauty, truth, and justice).

* Maslow hypothesized that the basic needs at the bottom of the pyramid would dominate the person’s behavior until those needs were met, at which time the next level of needs would become dominant. For example, if needs for food and shelter are not met, they become the overriding concern in life: the hungry person risks danger and social ostracism to find food.
* Maslow used the term **self-actualization** to describe a person who has achieved all the needs of the hierarchy and has developed his or her fullest potential in life. Few people ever become fully self-actualized.
* Maslow’s theory explains individual differences in terms of a person’s motivation, which is not necessarily stable throughout life.
* Traumatic life circumstances or compromised health can cause a person to regress to a lower level of motivation. For example, if a 35-year-old woman who is functioning at the “love and belonging” level discovers she has cancer, she may regress to the “safety” level to undergo treatment for the cancer and preserve her own health.
* This theory helps nurses understand how clients’ motivations and behaviors change during life crises (see Chapter 7).
* ***Carl Rogers: Client-Centered Therapy***

Carl Rogers (1902–1987) was a humanistic American psychologist who focused on the therapeutic relationship and developed a new method of client-centered therapy.

* Rogers was one of the first to use the term *client* rather than *patient.*
* **Client-centered therapy** focuses on the role of the client, rather than the therapist, as the key to the healing process.
* Rogers believed that each person experiences the world differently and knows his or her own experience best (Rogers, 1961).
* According to Rogers, clients do “the work of healing,” and within a supportive and nurturing client–therapist relationship, clients can cure themselves.
* Clients are in the best position to know their own experiences and make sense of them, to regain their self-esteem, and to progress toward self-actualization.
* The therapist takes a person-centered approach, a supportive role, rather than a directive or expert role, because Rogers viewed the client as the expert on his or her life.
* The therapist must promote the client’s self-esteem as much as possible through three central concepts:

• ***Unconditional positive regard***—a nonjudgmental caring for the client that is not dependent on the client’s behavior

• ***Genuineness***—realness or congruence between what the therapist feels and what he or she says to the client

• ***Empathetic understanding***—in which the therapist senses the feelings and personal meaning from the client and communicates this understanding to the client.

* Unconditional positive regard promotes the client’s self-esteem and decreases his or her need for defensive behavior.
* As the client’s self-acceptance grows, the natural self-actualization process can continue. Rogers also believed that the basic nature of humans is to become self-actualized, or to move toward self-improvement and constructive change.
* We are all born with a positive self-regard and a natural inclination to become self-actualized. If relationships with others are supportive and nurturing, the person retains feelings of self-worth and progresses toward self-actualization, which is healthy.
* If the person encounters repeated conflicts with others or is in non-supportive relationships, he or she loses self-esteem, becomes defensive, and is no longer inclined toward self-actualization; this is not healthy.

**Behavioral theories:**

* ***Ivan Pavlov: Classical Conditioning***

Laboratory experiments with dogs provided the basis for the development of Ivan Pavlov’s theory of classical conditioning:

* Behavior can be changed through conditioning with external or environmental conditions or stimuli.
* Pavlov’s experiment with dogs involved his observation that dogs naturally began to salivate (response) when they saw or smelled food (stimulus).
* Pavlov (1849–1936) set out to change this salivating response or behavior through conditioning.
* He would ring a bell (new stimulus), then produce the food, and the dogs would salivate (the desired response).
* Pavlov repeated this ringing of the bell along with the presentation of food many times.
* Eventually he could ring the bell and the dogs would salivate without seeing or smelling food. The dogs had been “conditioned,” or had learned a new response—to salivate when they heard the bell.
* Their behavior had been modified through classical conditioning, or a conditioned response.

***B. F. Skinner: Operant Conditioning***

One of the most influential behaviorists was B. F. Skinner (1904–1990), an American psychologist.

* He developed the theory of **operant conditioning,** which says people learn their behavior from their history or past experiences, particularly those experiences that were repeatedly reinforced.
* Although some criticize his theories for not considering the role that thoughts, feelings, or needs play in motivating behavior, his work has provided several important principles still used today.
* *Skinner did not deny the existence of feelings and needs in motivation; however, he viewed behavior as only that which could be observed, studied, and learned or unlearned.*
* He maintained that if the behavior could be changed, then so too could the accompanying thoughts or feelings.
* Changing the behavior was what was important.

***The following principles of operant conditioning described by Skinner (1974) form the basis for behavior techniques in use today:***

* 1. All behavior is learned.
  2. Consequences result from behavior—broadly speaking, reward and punishment.
  3. Behavior that is rewarded with reinforcers tends to recur.

1. Positive reinforcers that follow a behavior increase the likelihood that the behavior will recur.
2. Negative reinforcers that are removed after a behavior increase the likelihood that the behavior will recur.
3. Continuous reinforcement (a reward every time the behavior occurs) is the fastest way to increase that behavior, but the behavior will not last long after the reward ceases.
4. Random intermittent reinforcement (an occasional reward for the desired behavior) is slower to produce an increase in behavior, but the behavior continues after the reward ceases.

* These behavioral principles of rewarding or reinforcing behaviors are used to help people change their behaviors in a therapy known as **behavior modification,** which is a method of attempting to strengthen a desired behavior or response by reinforcement, either positive or negative.
* For example, if the desired behavior is assertiveness, whenever the client uses assertiveness skills in a communication group, the group leader provides **positive reinforcement** by giving the client attention and positive feedback.
* **Negative** **reinforcement** involves removing a stimulus immediately after a behavior occurs so that the behavior is more likely to occur again.
* For example, if a client becomes anxious when waiting to talk in a group, he or she may volunteer to speak first to avoid the anxiety.
* In a group home setting, operant principles may come into play in a token economy, a way to involve residents in performing activities of daily living.
* A chart of desired behaviors, such as getting up on time, taking a shower, and getting dressed, is kept for each resident.
* Each day the chart is marked when the desired behavior occurs.
* At the end of the day or the week, the resident gets a reward or token for each time each of the desired behaviors occurred.
* The resident can redeem the tokens for items such as snacks, TV time, or a relaxed curfew.
* Conditioned responses, such as fears or phobias, can be treated with behavioral techniques.
* **Systematic desensitization** can be used to help clients overcome irrational fears and anxiety associated with phobias.
* The client is asked to make a list of situations involving the phobic object, from the least to the most anxiety provoking.
* The client learns and practices relaxation techniques to decrease and manage anxiety. He or she is then exposed to the least anxiety provoking situation and uses the relaxation techniques to manage the resulting anxiety.
* The client is gradually exposed to more and more anxiety-provoking situations until he or she can manage the most anxiety-provoking situation.
* Behavioral techniques can be used for a variety of problems. In the treatment of anorexia nervosa, the goal is weight gain.
* A behavioral contract between the client and the therapist or physician is initiated when treatment begins.
* When working with children with attention deficit hyperactivity disorder, goals include task completion for homework, hygiene tasks, turn-taking when talking, and so forth.
* The child is given a “star” or sticker when tasks are completed.
* Upon reaching a specified numbers of stars, the child receives a reward.

**Existential Theories:**

Existential theorists believe that behavioral deviations result when a person is out of touch with himself or herself or the environment.

* The person who is self-alienated is lonely and sad and feels helpless.
* Lack of self-awareness, coupled with harsh self-criticism, prevents the person from participating in satisfying relationships.
* The person is not free to choose from all possible alternatives because of self-imposed restrictions. Existential theorists believe that the person is avoiding personal responsibility and giving in to the wishes or demands of others.
* All existential therapies have the goal of helping the person discover an authentic sense of self. They emphasize personal responsibility for one’s self, feelings, behaviors, and choices.
* These therapies encourage the person to live fully in the present and to look forward to the future.
* Carl Rogers is sometimes grouped with existential therapists. Table 3.7 summarizes existential therapies.

**\*Existential therapies.**

* ***Cognitive Therapy***

Many existential therapists use **cognitive therapy**, which focuses on immediate thought processing—how a person perceives or interprets his or her experience and determines how he or she feels and behaves. For example, if a person interprets a situation as dangerous, he or she experiences anxiety and tries to escape. Basic emotions of sadness, elation , anxiety, and anger are reactions to perceptions of loss, gain, danger, and wrongdoing by others (Beck & Newman, 2005). Aaron Beck is credited with pioneering cognitive

therapy in persons with depression.

* ***Rational Emotive Therapy***

Albert Ellis, founder of rational emotive therapy, identified 11 “irrational beliefs” that people use to make themselves unhappy. An example of an irrational belief is “If I love someone, he or she must love me back just as much.” Ellis claimed that continuing to believe this patently untrue statement will make the person utterly unhappy, but he or she will blame it on the person who does not return his or her love. Ellis also believes that people have “automatic thoughts” that cause them unhappiness in certain situations. He used the ABC technique to help people identify these automatic thoughts: A is the activating stimulus or event, C is the excessive inappropriate response, and B is the blank in the person’s mind that he or she must fill in by identifying the automatic thought.

* ***Viktor Frankl and Logotherapy***

Viktor Frankl based his beliefs in his observations of people in Nazi concentration camps during World War II. His curiosity about why some survived and others did not led him to conclude that survivors were able to find meaning in their lives even under miserable conditions. Hence, the search for meaning (*logos*) is the central theme in logotherapy. Counselors and therapists who work with clients in spirituality and grief counseling often use the concepts that Frankl developed.

* ***Gestalt Therapy***

Gestalt therapy, founded by Frederick “Fritz” Perls, emphasizes identifying the person’s feelings and thoughts in the here and now. Perls believed that self-awareness leads to self-acceptance and responsibility for one’s own thoughts and feelings. Therapists often use gestalt therapy to increase clients’ self-awareness by having them write and read letters, keep journals, and perform other activities designed to put the past to rest and focus on the present.

* ***Reality Therapy***

William Glasser devised an approach called reality therapy that focuses on the person’s behavior and how that behavior keeps him or her from achieving life goals. He developed this approach while working with persons with delinquent behavior, unsuccessful school performance, and emotional problems. He believed that persons who were unsuccessful often blamed their problems on other people, the system, or the society. He believed they needed to find their own identities through responsible behavior. Reality therapy challenges clients to examine the ways in which their own behavior thwarts their attempts to achieve life goals.

* ***Crisis intervention:***

A crisis is a turning point in an individual’s life that produces an overwhelming emotional response. Individuals experience a crisis when they confront some life circumstance or stressor that they cannot effectively manage through use of their habitual coping skills.

*Caplan (1964) identified the stages of crisis:*

* + 1. The person is exposed to a stressor, experiences anxiety, and tries to cope in a habitual fashion
    2. Anxiety increases when habitual coping skills are ineffective
    3. The person makes all possible efforts to deal with the stressor, including attempts at new methods of coping
    4. When coping attempts fail, the person experiences disequilibrium and significant distress. Crises occur in response to a variety of life situations and events and fall into three categories

• ***Maturational crises****,* sometimes called ***developmental***

***crises****,* are predictable events in the normal course of life, such as leaving home for the first time, getting married, having a baby, and beginning a career.

• ***Situational crises***are unanticipated or sudden events that threaten the individual’s integrity, such as the death of a loved one, loss of a job, and physical or emotional illness in the individual or family member.

• ***Adventitious crises*,** sometimes called *social crises*, include natural disasters like floods, earthquakes, or hurricanes; war; terrorist attacks; riots; and violent crimes such as rape or murder.

* Note that not all events that result in crisis are “negative” in nature.
* Events like marriage, retirement, and childbirth are often desirable for the individual but may still present overwhelming challenges.
* Aguilera (1998) identified three factors that influence whether or not an individual experiences a crisis: the individual’s perception of the event, the availability of emotional supports, and the availability of adequate coping mechanisms.
* When the person in crisis seeks assistance, these three factors represent a guide for effective intervention.
* The person can be assisted to view the event or issue from a different perspective, for example, as an opportunity for growth or change rather than as a threat.
* Assisting the person to use existing supports or helping the individual find new sources of support can decrease the feelings of being alone or overwhelmed.
* Finally, assisting the person to learn new methods of coping will help to resolve the current crisis and give him or her new coping skills to use in the future.
* Crisis is described as self-limiting; that is, the crisis does not last indefinitely but usually exists for 4 to 6 weeks.
* At the end of that time, the crisis is resolved in one of three ways.
* In the **first two**, the person either returns to his or her pre-crisis level of functioning or begins to function at a higher level; both are positive outcomes for the individual.
* The **third** resolution is that the person’s functioning stabilizes at a level lower than pre-crisis functioning, which is a negative outcome for the individual.
* Positive outcomes are more likely when the problem (crisis response and precipitating event or issue) is clearly and thoroughly defined.
* Likewise, early intervention is associated with better outcomes.
* Persons experiencing a crisis usually are distressed and likely to seek help for their distress.
* They are ready to learn and even eager to try new coping skills as a way to relieve their distress. This is an ideal time for intervention that is likely to be successful.

**Crisis intervention** includes:

A variety of techniques based on the assessment of the individual.

1. ***Directive interventions***are designed to assess the person’s health status and promote problem-solving, such as offering the person new information, knowledge, or meaning; raising the person’s self-awareness by providing feedback about behavior; and directing the person’s behavior by offering suggestions or courses of action.
2. ***Supportive* *interventions***aim at dealing with the person’s needs for empathetic understanding, such as encouraging the person to identify and discuss feelings, serving as a sounding board for the person, and affirming the person’s self-worth. Techniques and strategies that include a balance of these different types of intervention are the most effective.