one study supporting both facts: 14 in 150 murder convicts had DID, different opinions on whether memory accounts were real or wrong (confirmed by outside sources, physical examination)

THERAPIES FOR DISSOCIATIVE DISORDER
- psychoanalytic therapy, best choice of treatment as DID is from repressed memories in childhood
- goal to repress memories
- therapies similar to ones used in PTSD
- DID is highly hypnotizable so age regression (hypnosis back into childhood memories) is used
  - in hopes of easing the patients memories and letting them know that those memories don't govern their present
- goal of therapy is to integrate personalities (helping person cope with stress that can cause splitting personality: and also convincing client that they do not need to alter personality to cope with stress
- more personalities, longer treatment
- Richard Kluft, therapist, well-reported outcomes from his clinical observation
- 'conflict-free collaboration' is goal if integration is not possible
- ISSD treatment plan
  - (1) safety, stabilization and symptom reduction
  - (2) working directly and in depth with traumatic memories
  - (3) identify integration and rehabilitation
  - different for children
  - revision made
- DID is conceptualized as a failure of normal development linked primarily to traumatic events
- therapy should be neutral with respect to patients memories
- little evidence of treatment with respect to patients memories
- self-reports and clinician ratings show improvement in therapy (long therapy is crucial for DID)
- long term intervention required for patients not showing improvement within 30 months
- even with treatments, patients may show elevated levels of dissociation and associated adjustment problems

Schizophrenia
- schizophrenia, a psychotic disorder characterized by major disturbances in thought, emotion, and behaviour’ disordered thinking in which ideas are not logically related, faulty perception and attention, flat or inappropriate affect, and bizarre disturbances in motor activity
- prevalence, .87%, men>women, symptom’s prevalence vary across cultures, begins in childhood but appears in late adolescence (earlier for men than women)
  - ex. African countries have higher prevalence rates for visual and auditory hallucinations
- key factors that may vary across cultures: likelihood of experiencing adverse life events, degree of social disadvantage, and family differences across cultures in terms of reactions to interpretations of symptoms of schizophrenia
  - ex. Canada has higher rates of schizophrenia possibly due to high immigration rates and high latitude (less sunlight)
- 30.9% of psychiatric hospitalization is due to schizophrenia, 10% of schizophrenics commit suicide possible due to comorbid disorders (50% chance of developing comorbid disorders)
- about 1 in 3 have symptom remission (it depends on milder initial symptoms, better premorbid functioning, earlier treatment response, and a shorter duration of untreated psychosis
- comorbid conditions appear to play a role in development, severity and cause of schizophrenia
  - Axis I and II disorders
  - comorbid personality disorders, comorbid substance abuse (37%), comorbid anxiety disorder (specifically social anxiety disorder-14.9%)

Clinical Symptoms of Schizophrenia
- symptoms show problems in areas like thought, perception, and attention, motor behaviour, affect or emotion, and life functioning
• amphetamines release norepinephrine and dopamine
• dopamine theory could not be supported as excessive dopamine was not found in people with schizophrenia
  - research showed sensitive dopamine receptors as opposed to high levels of dopamine
  - accounts for mainly positive symptoms
    - amphetamines-worsen positive symptoms and lessen negative symptoms
    - antipsychotics-lessen positive symptoms and no clear effect on negative symptoms
  - dopamine theory
    - dopamine neuron underactive in prefrontal cortex accounts for negative symptoms of schizophrenia
    - release of mesolimbic dopamine neurons from inhibitory control account for positive symptoms of schizophrenia

Evaluation of the Dopamine Theory
• dopamine theory doesn’t fully account for schizophrenia as it takes long for antipsychotic drugs to show affect (side effect of Parkinson’s disease occurs when lack of dopamine but results should take place when dopamine levels are normal, before they get low)

Other Neurotransmitters
• glutamate (in human brain can increase dopamine activities) and serotonin (regulated by dopamine neurons in mesolimbic pathway)

SCHIZOPHRENIA AND THE BRAIN: STRUCTURE AND FUNCTION
• observable brain pathology

Enlarged Ventricles
• consistent findings of enlarged ventricles which implies loss of subortical or thalamic areas
  - loss of cortical grey matter in temporal and frontal regions
  - reduced basal ganglia
  - correlated with impaired neuropsychological performance (ex. poor response to drug treatment)
  - brain abnormalities might not be genetic
  - enlarged ventricles are not apparent in people with other disorders (ex. bipolar)

The Prefrontal Cortex
• schizophrenia disrupts many roles that are conducted in prefrontal cortex (speech, decision-making)
• lack of illness awareness linked to frontal lobe functioning
• reduced grey matter in prefrontal cortex
• low metabolic rates in prefrontal cortex
  - instead of showing activity, schizophrenics performed poorly
• fMRI shows cognitive control deficits in strongly contributing to episodic memory impairment in schizophrenia
• less severe frontal hypoactivation in non-schizophrenia twin of discordant MX pairs leading to dopamine underactivity
• fMRI showed the difference between violent-people with schizophrenia and comorbid anti-social personality disorder and substance use and seriously violent people with schizophrenia have different prefrontal functioning

Congential and Developmental Considerations
• presence of craniofacial/midline anomalies and/or early functional impairments that commonly occur as a symptom of CNS doubled risk of schizophrenia
• a genetic predisposition and complications at birth (ex. reduced oxygen to brain=brain damage), increase rates of schizophrenia
• exposed to influenza during second trimester may increase chances
  - cortical development and cell migration in second trimester
  - neurons in brain have defects reduced number of cells in prefrontal and temporal areas, loss of dendrites and axons
• low birth weight is a risk factor combined with influenza and hypoxia (childhood infection doubles risk for children to develop adult schizophrenia)
• focus on prevention programs
• evidence suggests that damage occurs in childhood but disorder begins later in adolescence as the prefrontal cortex plays a more pivotal role then, along with dopamine activity

Contemporary Research
• focus has shifted from specific lesions to the overall neural systems and their interactions to better understand the relationship between schizophrenia and the brain
  • meta-analysis found hippocampal volume reduction in people with schizophrenia (4%)
  • cortical dysfunction in people with schizophrenia
  • smaller white matter volumes in people with schizophrenia

PSYCHOLOGICAL STRESS AND SCHIZOPHRENIA
• there has not been a proven stress-psychosis onset relationship
• in schizophrenia, stressor that have played an important role:

Social Class and Schizophrenia
• possible correlation between low socioeconomic class and schizophrenia but difficult to interpret cause:
  (1) Sociogenic hypothesis
     the degrading treatment one receives in the lowest social class, along with a predisposition may lead to developing schizophrenia
  (2) Social Selection theory
     • people with schizophrenia may go to poverty ridden areas where the person’s cognitive and motivational problems continue to decline
     • experiment shows 26 clients in lowest social class, who only had 4 fathers in the lowest class, meaning the others started off well but brought themself to poverty
     • another experiment showed immigrants facing discrimination but they didn’t develop schizophrenia: showing that the social selection theory doesn’t account for everything (even though data is more supportive of it)

The Family and Schizophrenia
Etiology and the Role of the Family
• early theories proposed the ‘schizophrenogenic mother’ who basically introduced schizophrenia to her offspring by her cold, dominant, conflict-inducing demeanour
• no supportive evidence
• possible influence of faulty communication
• serious psychopathy in adoptees if they were reared in disturbed family
• great increase in serious psychopathy if child with biological parent with schizophrenia
• possible misinterpretation

Relapse and the Role of Family
• families have impact on person with schizophrenia
  • based on expressed emotion (EE), 10% of families showing low EE relapsed and 58% of families showing high EE returned to hospital
  • families may make critical comments that view client as being to control their symptoms
• key features of EE
  • (1) unusual thoughts expressed by client elicit higher levels of critical comments by family members who were previously characterized as high EE
  • (2) in high EE families, critical comments by family members led to increased expression of unusual thoughts
• possible sensitivity to areas of the brain that are responsive to critical comments

DEVELOPMENTAL/HIGH-RISK STUDIES OF SCHIZOPHRENIA
• before developing schizophrenia, according to their early reports, children had serious problems in their behaviour
• lower IQ, boys as disagreeable, girls as passive, both were withdrawn, poor motor skills,
ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

- hyperactive children have a hard time focusing
- Virginia Douglas, professor at McGill was credited for noting the attentional problems in ADHD which was only known as hyperactive child syndrome
- have a hard time adjusting to a classroom environment (staying still)
- unable to act properly in social situations and confronted with peer rejection
- 15-30% of ADHD kids have learning disability that impairs their IQ more than kids with ADHD alone
- 25% of children with ADHD exhibit comorbidity with anxiety disorders
- child must exhibit extreme and persistent symptoms of ADHD to qualify for a diagnosis
- early intervention was related to success rates in reduction of externalizing problem symptom, proven in a study
- ADHD vs conduct disorder
  - conduct disorder deals with acting out, ADHD deals more with cognitive deficits
  - without intervention comorbidity is 50%
- worldwide prevalence is 5.29%, boys get it more than girls but that could be because boys are referred more to clinics for anti-social behaviour found in ADHD, proven to affect women worse when it does
- cultural under-diagnosis as factors to increase likelihood was being raised in an English speaking household and access to health insurance
- studies show that most adults that had ADHD in childhood no longer satisfy the criteria for it but 50% will still exhibit ongoing impairment
  - Mayo Clinic research, disorder persisted for 29.3% of cases and 4/5 had other disorder, high mortality risk
- adult prevalence of ADHD is 4.4%
- while they still function, they live on a lower socio-economic level than most and frequently change jobs

Biological Theories of ADHD

- Nigg suggests focus for future research: prenatal events, race, and cultural factors
- no single risk factor for ADHD

Genetic factors

- 75% heritability
- ADHD was seen in twin disorders in a group that focused on genetic variations
- evidence indicates frontal striatal circuitry, reductions in volume throughout cerebrum and cerebellum, delayes in cortical maturation, and link between ADHD and dopamine deficit
- children exhibit inhibitory control deficit as well as their parents

Environmental factors

- Feingold proposed the addition of additives in diet that might increase risk of developing ADHD in children but research does not support
  - similar theory of refined sugar
- recent data supports exposure to traffic-related air pollution as a possibility only

Psychological Theories of ADHD

- Bruno Bettelheim suggest diathesis-stress theory
  - diathesis for developing ADHD coupled with parental upbringing but not enough support for research
  - findings actually show that child’s negative behaviour affects parents more

Treatment of ADHD

- consensus statement indicating that ADHD treatment is underscored
- international team concluded that best treatment is the pairing of pharmacotherapy to decrease biological symptoms and psychosocial intervention to determine life style strategies

Stimulant drugs

- increased use of Ritalin and methylphenidate
- dramatic increase in 1990 to 1996 (3 to 4.5 x)
• US study shows in 2000 to 2010, increased treatment of ADHD by psychiatrists

Psychological treatment
• effective treatment include parent training and classroom management training with operant conditioning principles
  • point and reward systems
• behavioural treatments are proven to be effective in children with ADHD, but not ‘evidence-based practice’
  • York U identified 26 studies of cognitive-behavioural, cognitive and neural-based intervention approaches are not evidence-based but show promise in treating ADHD

Stimulant medication vs. psychological treatment
• general function is enhanced by Ritalin and behaviour therapy than behaviour therapy alone
  • Ritalin showed promising improvement but with behaviour therapy, lower dose of the drug is required
• multimodality superiority effect was named after study showed success of combined treatment
• meta-analysis conducted showed that psychosocial treatment did not add value to methylphenidate
• drug treatment is only 50% successful with noting that some parents do not administer drug for their children because of loss of appetite and sleep problems side effect
• although rare, there is a link between stimulant use and sudden death among children and adolescents
• stimulant treatment has no proven effect of developing substance use disorders
• one risky side effect that has come into perspective is that children are gaining access to Ritalin through their siblings or on the street, and using it as recreational drugs, in hopes to improving focus in school or getting rid of fatigue
  • they are being snorted like cocaine

CONDUCT DISORDER
• conduct disorder involves a variety of undercontrolled behaviour with DSM-5’s focus on behaviour that violates the rights of others
• usually identified by legal authorities, prevalence 3.2%
• longitudinal study showed a link between substance use and delinquent acts in conduct disorder
• studies show that conduct behaviour in childhood does not mean it will continue in adulthood
  • but still show pre conducts problems even without adult diagnosis
• different from prank or childish behaviour, involves callousness and one of the criteria for anti-social personality disorder
• Moffitt described two categories:
  • life-course persistent: conduct disorder begins by age 3 and continues into adulthood
  • adolescence-limited: conduct disorder thrives in childhood and child goes onto adulthood without it
• different onsets for conduct disorder:
  • childhood-onset type is (prior to age 10, showing at least one criteria) persistent and more likely to develop into adulthood anti-social PD
  • adolescent-onset type (no criteria prior to age 10)
• rarer disorder is oppositional defiant disorder (ODD) which was earlier thought to be a manifestation of conduct disorder but its proven not to be
  • diagnostic criteria: anger/irritable mood, argumentative/defiant behaviour, vindictiveness
  • prevalence 3.3%
• association between callousness-unemotional traits and the more severe pattern of aggressive/ anti-social behaviour

Etiology of Conduct Disorder

Biological factors
• aggressive behaviour seems to be heritable
• neuropsychological deficits have been found in children with conduct disorder (executive functioning)
  • Catherine Cappadocia at York University found:
• PACFOLD is a funded research study that studies learning problems in early childhood, including direct and indirect costs of learning disability
• learning disabilities, inadequate development in a specific area of academic, language, speech, or motor skills that is not due to mental retardation, autism spectrum disorder, a demonstrable physical disorder, or deficient educational opportunities
• children with learning disabilities have difficulty learning specific skills

SPECIFIC LEARNING DISORDER
• learning disorders in the DSM-IV-TR involved three categories but in the DSM-5 they are categorized under specific learning disorder, difficulties learning and using academic skills with symptoms that persist six months or more despite interventions targeting these difficulties
• children with reading disorder, aka dyslexia (this term is not used in DSM-5 despite efforts to have it changed), difficulty with word recognition, reading comprehension and written spelling with problems persisting in adulthood
• mathematics disorder, aka dyscalculia (again international use), difficulty rapidly and accurately recalling arithmetic facts, counting objects correctly and quickly, or aligning numbers in a column
• disorder of written expression, impairment in the ability to compose the written word
• efforts to remove disorder due to lack of evidence that is occurs separate from dyslexia
• children with learning disabilities show signs of psychosocial dysfunction (increased depression, low self worth)

COMMUNICATION DISORDER
• language disorder, child has difficulty expressing themself in speech, unable for remember words when new ones are learned, with grammatical structures below average
• known early as phonological disorder, able to use speech but unable to pronounce or recall letters (tothla)
• stuttering, (child onset fluency disorder in DSM-5), disturbance in verbal fluency, characterized by one or more of the following speech patterns: frequent repitition or prolongation of sounds, long pauses between words, substituting easy words for those that are difficult to pronounce and repeating words
• social (pragmatic) communication disorder, new to DSM-5, difficulty in social and non-social forms of communication
• language deficits a stronger predictors than ADHD diagnosis
• language impairment may cause more problems in adulthood, important for early intervention

MOTOR DISORDER
• developmental coordination disorder, children have impairment in motor function which is not linked to mental retardation or physical disorder

ETIOLOGY OF LEARNING DISORDERS AND COMMUNICATION DISORDERS
• most research is done on dyslexia
• no distinct causal factors but genetic and biological factors can increase risk
• chromosome 13 involved in dyslexia
• biological factors: deficits in perceptual systems, perceptual-motor functioning, oculomotor functioning, neuroogical organization leading to abnormal cognitive processing
• prenatal and perinatal complications linked to learning disability
• children with learning disabilities show deficits in language processing
• lack of activation of temporoparietal cortex (important for language-phonological awareness)
• structural anomalies and anomalous activation in critical language areas in temporal and frontal lobes with people with dyslexia
• no single cause but variables in a complex interaction play a role in learning disability

TREATMENT OF LEARNING DISORDERS
• treatment fads (teaching your child to crawl at a young age will make them smarter-yeah no!)
• treatment programs exist in school
• more emphasis on keeping special needs children in regular classrooms
• special education programs involve
• instructional interventions (maximize learning with different teaching methods)
**ETIOLOGY OF INTELLECTUAL DISABILITY**

No Clear Etiology (Approximately 30-40% of cases)
- despite extensive evaluation, 30-40% don't have a known cause

Hereditary Disorders (5%)
- autosomal recessive mechanisms
  - phenylketonuria, infant born normal soon suffers from deficiency of liver enzyme which is required for production of hormones like epinephrine
  - neurons in frontal lobe affected, producing mental retardation
- other single-gene abnormalities with variable expression
- chromosomal aberrations

Early Alterations of Embryonic Development (Approximately 30%)
- factors include chromosomal changes (Down’s) or prenatal damage due to toxins (substance use during pregnancy)
  - Down’s syndrome (trisomy 21) occurs when gene count is 47 instead of normal 46
    - 1 in 800 to 1200 live births
  - cytomegalovirus, toxoplasmosis, rubella, herpes simplex and syphilis can cause mental retardation in fetus
    - 85% of women are immune to rubella, the other should get tested and vaccinated
  - possible link between Down’s syndrome and Alzheimer’s

Later Pregnancy and Prenatal Problems (Approximately 10%
- fetal malnutrition, placental insufficiency, prematurity, hypoxia, low birth weight, intracranial hemorrhage, trauma, viral and other infections are facts that could account for diminished intellectual functioning

Medical Conditions Acquired During Childhood and Accidents (Approximately 5%)
- factors that cause mental retardation, encephalitis, meningococcal meningitis, childhood meningitis, environmental toxins like lead poisoning, Singh (drowning, accidents-encouraged to wear seat belts to reduce mental retardation from car accidents)

Environmental Influences and Other Mental Disorders (Approximately 15-20%)
- possible factor of social conditions deprivation leading to deficits in intellectual and behavioural development

**PREVENTION AND TREATMENT OF INTELLECTUAL DISABILITY**

- America forced sterilization for mentally retarded individuals
  - first in Indiana in 1907
  - 1930, 28 states passed these laws
  - countries like Russia continue to encourage parents to give up their disabled children

Environmental Interventions and Enrichment Programs
- mainstreaming children with intellectual disabilities has shown greater improvement in psychological functioning that the ones confined

Behavioural Interventions Based on Operant Conditioning
- applied behaviour analysis (ABA), children with severe intellectual disability usually need intensive instruction provided by this approach, reduces inappropriate and self-injurious behaviour
- improvements in motor skills, communication skills and vocational techniques

Cognitive Interventions
- intellectually disable children are unable to apply problem solving techniques effectively so self instructional training, first developed by Meichenbaum and Goodman in 1971, teach children problem-solving through speech
• believes suicide can be understood in sociological terms, theory does not account for other features
  • **egoistic suicide**, committed by people who have few ties to family, society, or community. They cut off from support which is important for them to function adaptively
  • **altruistic suicide**, response to social demands, suicide as part of a group (cults)
  • **anomic suicide**, triggered by a sudden change in a person’s relationship to society (bankruptcy)

Psychological Theories
• key feature in suicide is that individual is ambivalent (uncertain) about suicide, good for prevention
• suicide is complex, in a suicidal state and individual is unable to think of a better way to cope with stress

A Risk Factor Model
• causes of suicidal behaviour include: **predisposing factors** (early loss or abuse), **precipitating factors** (rejection, unemployment), **contributing factors** (physical illness, isolation) and **protective factors** (adaptive coping skills, perceived social support)
• childhood sexual abuse is a potent predisposing risk factor

Baumeister’s Escape Theory
• suicide arises from a strong desire to escape from aversive self-awareness, one’s shortcomings and failures cause high expectation which individual is unable to meet causing depression and ultimately suicide

The Perfectionism Social Disconnection Model
• high levels of self-criticism and trait perfectionism might be implicated in suicidal acts
• Perfectionism Social Disconnection Model (PDSM) found that interpersonal perfectionism especially in the form of perfectionistic self-presentation (need to seem perfect in public) is associated with a measure of suicide potential especially following public humiliation or bullying

Joiner’s Interpersonal Theory of Suicide
• Joiner is leading authorities on suicide, his father committed suicide
• Joiner’s model includes two interpersonal constructs: a thwarted need to belong and perceived burdensome
• greater capability to commit suicide depends on physical capability (ability to withstand physical pain) and ability to get equipment
• research found higher capability in students high in sensation seeking and high level of distress tolerance

Schneidman’s Approach
• emphasized that mentally ill people usually do not commit suicide
• **psychache**, Schneidman’s regard that suicide is a conscious effort to seek a solution to a problem that is causing intense and intolerable psychological suffering and pain
• other psychological illnesses only matter in their relationship to psychache
• Psychache Scale reflect profound psychological pain
• psychache predicts susceptibility to depression and stronger predictor of hopelessness

Additional Psychological Factors
• about 20% of those that complete programs, actually quit smoking in the long run

**BIOLOGICAL TREATMENTS**
- substituting nicotine through form on gum
- study emphasizes educational information and environment changes in addition to nicotine substitution
- gum reduces withdrawal but withdrawal is minimally linked to success of stopping smoking
- STOP Study targets about 50,000 smokers that combines nicotine replacement therapy with other forms of intervention
  - UofT found CYP2A6 genotype associated with slow metabolism of nicotine explaining why some may not benefit from nicotine replacement therapy
- nicotine patches are taped to the arm and serves as a transdermal (through the skin) nicotine delivery system
  - patch becomes smaller over course of treatment
  - like the gum, patch success rates over time are lower than 40%
- Varenicline, nicotine receptor partial agonist that is effective in reducing smoking when used over a period of three months, possible side effects are depression and suicidal tendencies
- depression may reappear, best to combine treatments with Willburtin
- antidepressants are usually administered before the person stops smoking and continued through the recovery course of cessation of smoking
  - study found 35% abstinence rate
  - high short term success rates and low long term success rates

**PSYCHOLOGICAL TREATMENT**
- many techniques try to make smoking unpleasant, have high relapse rates at follow ups
- relapse is a major issue despite therapy given
- cognitive therapies encourage gaining control over smoker’s life (counseling and pharmacotherapy best)
- most common and effective is advice given from physician

**RELAPSE PREVENTION**
- ex smokers who live with non-smokers feel better when in recovery than with smokers
- increased social support for smoking
- one technique to prevent relapse is to focus on changing the smokers cognition by distracting them or showing them ways to cope
- relapse prevention has not proven to be too successful

**Prevention of Substance Abuse**
- prevention efforts come in two forms: school-based prevention and specific policies and procedures enacted at the community level
- most prevention programs are targeted to adolescents because drug abuse starts there
  - programs try to enhance adolescent's self esteem, teach social skills and encourage youngsters to refuse peer pressure
  - Project DARE (Drug Abuse Resistance Education), bringing police officers to give lectures to 6th and 7th graders, low success rate
• (4) family doctors were as effective as mental health professionals in the short term but not in long term
• (5) AA was rated better than mental health professionals
• (6) active participants had better outcomes than passive participants
• (7) no particular psychotherapy showed superior effectiveness than another
  • research had no control group, more subjective than research
  • research though confirmed dodo bird effect, tendency for various therapies to achieve similar results
  • criticized that support (Alice in Wonderland) for dodo bird effect is overstated
• 75% of people entering psychotherapy achieve some improvement that cannot be achieved from family support or no intervention

Focus on Discovery 17.3: Consensus Beliefs Involving Psychotherapy Research
• study conducted on 12 experts found that:
  • therapy is helpful to the majority of clients
  • most people achieve some change relatively quickly in therapy
  • in general, therapies achieve similar outcomes
  • people change more due to common factors than due to specific factors associated with therapies
  • client-therapist relationships is the best predictor of treatment change
  • most therapists learn more about effective therapy techniques from their experience than from research
  • about 10% of clients get worse as a result of therapy
  • can be avoided by making potential clients aware of potential risks

Focus on Discovery 17.4: Stepped Care Models and the Treatment Process: Can We Do More with Less?
• step cares, notion that clinicians should match the level of required treatment to the seriousness of the adjustment problem being addressed, but they should begin with less involved and less costly interventions, followed by more complex interventions if the initial interventions are not successful
• step approach does not account for small procedural steps that are implemented with little notice
• some therapies may need to start with an intense approach (like anorexia)
• ideal in situations where minimal resources are available

THE CHALLENGE OF MANAGED CARE
• managed-care organizations operate to provide clients with least expensive health care (US)
• Canada provides free health care as a right to reach individual
• empirically supported therapies (ESTs), demonstrated therapies that are effective in research studies with appropriate scientific controls in a specific population
  • suggestions on ESTs: require longitudinal research that includes process of change, client factors, chronic mental illness
  • current suggestion is to provide clients with knowledge on treatment success based on support not empirical data
• discrepancy between treatments identified as effective and treatments done in practice
• empirically informed therapies, therapies more focused on intervention strategies and change processes that are guided by the clinician’s insights rather than a rigidly invoked manualized approach
• Barlow’s exposure treatment has been helpful in treating couples with agoraphobia and couples problems attached with agoraphobia
• therapy is more positive in younger couples who have not considered divorce yet
• poor outcome is determined by emotional disengagement (poor communication), rigid traditional and gender views, depression in one partner
• prevention is encouraged for young couples, brief training in improving communication skills
• not much research is done on homosexual or unmarried heterosexual couples, research is done only on married couples

Psychotherapy Integration
• CBT interventions are too overused (4 out of 5 studies employed this intervention)
• graph shows the superior use of CBT interventions over other therapies, graph does not study integrated approach, more research needs to be done

ECLECTICISM AND THEORETICAL INTEGRATION IN PSYCHOTHERAPY
• no significant increase in earlier use of eclectic approach
• research conducted on 127 therapy techniques found that most therapists used techniques outside their therapeutic orientation
• techniques used were: trying to understand the world from clients point of view, providing unconditional positive regard, challenging maladaptive or distorted belief, being congruent and genuine, and reflecting feeling
• investigation of 24 expert psychotherapists found strong allegiance to their main theoretical orientation but to some degree were influenced by other four orientations
• many famous therapies like Young’s schema therapy or the emotion-focused therapy are actually integrated therapies

THREE TYPES OF PSYCHOTHERAPY INTEGRATION
• (1) technical eclecticism, therapists work within a particular theoretical framework but sometimes may use techniques found in other orientations. use whatever works
• (2) common factorism, seeks strategies that all therapy schools might share
  • does not work within a particular framework, free to adopt any technique to help client
• (3) theoretical integration, tries to synthesixe not only techniques but also theories (modifying a theory into the framework of another psychological orientation

Contemporary Developments in Treatment and Intervention
• psychotechnologies, refers to the deliever of psychotherapy and trelated services by incorporating modes involving Skype, Twitter, Facebook and curious other alternatives such as mobile phones.
  • helps during therapy and for prevention
• current effective treatment is internet based delievery used in treatment found results to be successful with clinical improvement
• geographical distances may impose a practical problem
  • Alberta employed a telemental health service, which many found was quite effective, 9 out of 10 were satisfied, felt the the doctor listened to them, felt supported and encouraged, and felt the sessions would provide the same info as face to face sessions would
• research was confirmed by larger investigations, but methodology was flawed and that stopped the implementation of telemental health approaches
• research done on virtual reality therapy (*in virtuo*) found it to be effective in treating social anxiety disorder
• new innovation: computerized CBT, needs to be studied more, high dropouts and more staff time required
• key issues at present include ways to safeguard clients’ confidentiality and right to anonymity and ways to maximize the safety of these individuals

Student Perspectives 17.1: Computerized CBT for Depressed and Anxious Students
• famous cCBT program called *Beating the Blues* consisted of eight 50-minute sessions over an eight-week period: identified and challenged negative automatic thoughts, beliefs and negative attributions; exposure; problem-solving training; and sleep management
• program gave homework assignments
• mixed results: those who completed found clinical improvement (got better results on Beck Depression Inventory), low completion rate: only 12% completed with only 3.2 session completed on average
• reminders did not help with session completion or attendance
• although many indicated moderate to high satisfaction with cCBT program