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Modalities of Practice: Application and Brief History

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Abstract

Modalities of psychotherapeutic practice intersect, and while they can often complement one another, adapting interventions tailored to meet individual needs is fluid. In considering the human condition, diversity, and the plethora of parts that amalgamate to make one a whole being, it becomes clear that a one-size-fits-all model could never suffice. Clinical practice, thus the modalities employed, must identify, and accommodate one's environmental upbringing, socio-economic status, family dynamics, religion/spirituality, and ethnicity; how the stated impacted and created an identity as a holistic being. It is hypothesized that a positive therapeutic alliance serves as the defining criterion as to what will be the most critical component of the therapeutic process- one's ability to be vulnerable hinging on the trust endowed to the clinician. Contributing to that attunement is the clinician's ability to apply the goodness of fit treatment interventions; an eclectic blend is often employed. Furthermore, in delivering services to an individual or group different from our own, an awareness of our value systems, culture, and implicit biases must be at the forefront of awareness, to circumvent limitations and barriers that can create an impediment in service delivery. This body of work will explore a collection of premier modalities, with a brief highlight of their historical background.

Key words: Psychotherapy, Treatment Theories, Mental Health, Clinical Practice, Brain-Body Alliance, Psychotherapeutic Treatment Modalities

1. Animal Behavior Therapy

1.1 Theory Construction

Although a younger model and still developing, animal behavior therapy has grown in popularity because of its ability to elicit a sense of healing and calm during the treatment process. Animal-assisted therapy (AAT) brings animals into the treatment plan to enhance the process and promote a sense of connection for an individual as attunement and connection can be facets of therapy an individual new to the therapeutic process might struggle with; AAT can help bridge the gap between client and clinician. For example, for someone who has a complex trauma history or takes time to open up and be vulnerable, AAT provides an alternate way of connecting. Additionally, current meta-analyses support a positive effect and improved well-being for teens with certain behavioral issues. In parts of the country where geography allows, equine therapy is becoming one of the most successful interventions for both PTSD and adolescents with acute behavioral problems- there is a healthy amount of overlap between the two. Not limited to the more common horses and canines, AAT employs the aid of several animal types. If the respective animal can withstand training protocols and be deemed safe and adequate for therapeutic purposes- there are no restrictions regarding the animal type or breed [1]. As with most other interventions it is person-centered, the type of animal used is weighted on the type of therapy being facilitated, and the client's needs.

2. Brief History of the Theory

AAT informally began in the early 1960s when Dr. Boris Levinson, a psychotherapist, began bringing his dog with him to work when he would be working with younger children struggling with mental health/behavioral problems [2]. He noticed how at ease they were with his dog and how much more effectively they socialized and interacted with the animal by comparison to people. Levinson published the first manuscript oriented to AAT titled 'Pet-Oriented Child Psychotherapy', and from here other tranches of animal use grew. Founded in 1969, The North American Riding for the Handicapped Association used horses as an integral part of treating certain types of physical disabilities and led the charge in developing guidelines outlining safety protocols and techniques used to treat disabilities such as cerebral palsy, and muscular dystrophy. Whereas the earliest practice of animals used to lift the spirits of those infirmed dates back to ancient Greek practices, concrete research

is still young. However, a growing number of independent clinicians and facilities are integrating AAT practices because of how well the human-animal connection complements the therapeutic process as well as the alliance between client and clinician [1].

3. Cognitive Behavior Therapy/Dialectical Behavior Therapy

3.1 Theory Construction

3.1.1 Cognitive Behavior Therapy (CBT)

Cognitive Behavioral Therapy (CBT), a talk-oriented intervention, has been a long-favored practice among clinicians in successfully treating a broad spectrum of mental health disorders. Through Socratic questioning and the guidance of a skilled clinician, one explores the relationship between distorted cognitions and intrusive thoughts, the feelings they elicit, and the behaviors tertiary to thoughts and feelings. CBT is a model designed to challenge distorted cognitions, the irrational behaviors attached to distorted cognitions, and self-regulate uncomfortable feelings by providing tools to better manage said intrusive thoughts and distorted cognitions [3].

3.1.2 Dialectical Behavioral Therapy (DBT)

A hybridization of humanism with dialectics and CBT, Dialectical Behavior Therapy (DBT) was the first talk-oriented psychotherapy to integrate mindfulness practices into the therapeutic process [4]. DBT orients to the here and now, i.e., mindfulness practices, and teaches adaptive coping strategies to replace maladaptive self-destructive ones. A primary intervention to treat borderline personality disorder (BPD), a chronic and complicated Cluster B Personality Disorder, DBT, is successful at reducing high suicidal ideations, substance misuse disorders, and mood dysregulation [5,6]. Like CBT's Socratic method of challenging distorted cognitions, the mindfulness practices germane to DBT such as self-reflection, distress tolerance, and validation/positive reinforcement provide one with new, more adaptive/productive coping skills to manage the impulsive behaviors attached to intrusive thoughts [4].

4. Brief History of the Theory

4.1 Cognitive Behavior Therapy (CBT)

The initial wave of Cognitive Behavior Therapy began in the 1950s with Albert Ellis' emphasis on the importance of recognizing the correlation between thoughts, feelings, and their subsequent behaviors. He developed the first theory from which CBT would grow- Rational Emotive Behavior Therapy (REBT) [7]. By the 19060s, Aaron Beck expanded upon Ellis' work, that is, the basis on emotional distress presenting secondary to one's thoughts about an event rather than the actual event itself, e.g., the employment of Socratic Questions. Beck noticed a trend among his clients suffering from acute anxiety and depression- regardless of how much time was spent exploring the past, the intrusive/negative thoughts attached to explored events did not dissipate [3]. The expansion of REBT, i.e., the foundation of CBT was developed from here [7].

4.2 Dialectical Behavioral Therapy (DBT)

Developed in the 1970s by Marsha Linehan, a Ph.D., and pioneer in researching suicidality, she found the tenets of behavioral and humanistic approaches not just ineffective, but aversive. Having been challenged by mental health setbacks in her late teens, what she came to know as borderline personality disorder, Marsha Linehan held a personal interest in wanting to, as she has been cited, 'Get her patients out of hell' [4]. She did so by hybridizing the models of humanism and behaviorism- in turn creating a third model. Linehan's background with Zen teachings also influenced the model as she vacillated between approaches. What appeared to help balance the two models was dialectics, giving this third model its name and own identity, Dialectical Behavior Therapy [7].

5. Group Work

5.1 Theory Construction

As its title suggests, group therapy, a type of psychotherapy, is an intervention that services a group as opposed to a 1:1 session. Oftentimes participants working in a group dynamic are working in tandem with a psychotherapist individually. The group dynamic provides an opportunity to connect with other individuals whose lives have been impacted by a common theme, or individuals working toward a shared goal [8]. Group sessions are facilitated by one clinician; however, it is not uncommon for a co-facilitator to be present. The duration of a group session is consistent with that of an individual session- 45 minutes/one hour. Groups provide members with a network of peer support as group members frequently assist one another in developing plans or ideas to improve a challenging life circumstance while holding one another accountable throughout the process. Consistently talking to other people managing similar circumstances also helps group members to understand their experiences from different perspectives. For example, an overwhelming amount of people experience mental health difficulties, or have family that do; addiction as well. Because talking openly about mental health carries a stigma, people are hesitant to disclose their challenges. These personal barriers then lead to isolation and withdrawal [9]. Group work provides the opportunity to hear other individuals open up about their backgrounds which can provide comfort to those who were feeling alone and are now part of a group dynamic.

5.2 Brief History of the Theory

After receiving what was called "Section Status", at the time, a means of discerning the psychotherapy type, the National Conference of Social Work (NCSW), began recognizing group work as a credible practice to use as a therapeutic approach. The year of its advent was 1934. Henceforth, several presentations on the topic of group work were included during conference meetings which were beginning to have a significant global impact, thus leading to the necessity of funding for empirical research that would cement group work as an evidence-based practice. The language "social group work" became widely used as did the growth of interest organizations concentrating on group practice. Findings from early research also identified the theme of all groups having a network of relationships between their members and the facilitators, as well as the agency in which the group was being hosted, its neighbor-

hood, and the neighborhood of the members. These social connections were in addition to the activities in which the group engaged. This network of connections and interactions was subsequently languaged "the group process" [8].

6. Narrative Therapy

6.1 Theory Construction

Individuals assign meaning to experiences. The meaning one assigns to experience, positive or negative, impacts how one will view oneself, future interactions/events, and the general world. Narratives, i.e., the stories we tell ourselves about ourselves, in turn, affect relationships, self-esteem, and self-efficacy [10]. Narrative therapy is an intervention style that encourages one to be the narrator of their story by retelling i.e., narrating, emotionally charged life events without assigning blame [11]. It is a therapeutic intervention that underscores an individual's experience in such a way that allows for a more robust perception. The pursuit of narrative therapy is to destabilize the negative perceptions one has attached to events through exploring alternate possibilities. Through techniques employed, individuals can identify how their internal narratives influence their relationships and lives. Techniques such as externalization, a style of storytelling that promotes separation between the narrator and the experience, and deconstruction, breaking down a highlighted story into parts to better compartmentalize the experience and detach emotion, are thought to help with situations such as moving on from a high conflict life event [10]. Narrative therapy is theorized to have an empowering effect, as a narrative therapist will often encourage their clients to not just challenge the narratives, they have attached to their life difficulties and experiences, but to expand their perspective by considering alternative narratives [11].

6.2 Brief History of the Theory

Developed by Michael White, an Australian-born social worker, and David Epston a New Zealand-born family therapist, narrative therapy rose to prominence in the late 1970s and further expanded throughout the 1980s [12]. Although narrative therapy was inspired by different philosophies, it was thought by early developers that demand dictated the need for a more person-centered, empowering approach to treatment. Narrative therapy was also the answer to a more social justice-oriented model of treatment, as it sought to contest dominant discourses that destructively shape an individual's life. Wanting to be part of the solution, colleagues White & Epston authored Narrative Means to Therapeutic Ends. Published in 1990, it was the first text specifically oriented to narrative therapy [10].

7. Solution-Focused Therapy

7.1 Theory Construction

As its title suggests, Solution Focused Therapy (SFT) is goal-directed and future-focused; its core tenet is targeted to finding a realistic solution/solutions to what is being presented by the individual seeking therapy. In addition to collaboratively brainstorming solutions, the principles of SFT also focus on the client's existing successful coping practices and strengths, i.e., highlighting the importance of these already existing coping resources and protective factors. SFT is a future-focused conduit for formulating and sustaining behavioral change by incorporating practices from positive psychology and narrative therapy as it highlights the positive in one's life while generating a comprehensive outline of who the client is while exploring how the client's life could be different in the absence of the problem that brought them into therapy [13]. An additional development introduced by SFT was the shift in the work's emphasis from the client spending time focusing on issues in the past over which they have no control to change, to an emphasis on their hopes for the future. This type of approach makes SFT not only, 'solution focused', but empowering and person-centered.

7.2 Brief History of the Theory

Solution Focused Therapy first emerged during the early 1980s within the Short Family Therapy Center. Located in Milwaukee, clinicians Steve de Shazer and Insoo Kim Berg led a research team investing in the most effective ways to promote real and measurable change in people's lives. Through observational research, the team carefully noted the questions, both open and closed-ended, and the client responses that helped them most effectively experience real-life change while maintaining their self-determination [13]. The team noticed that there were frequent outliers to abnormal behavior patterns, for example, occurrences in which the behavior being measured was either minimally noticed or completely nonexistent. The exploration of these exceptions through the therapeutic process seemed to help clients see potential paths forward, i.e., solutions to what ailed them. Subsequent to this model, the team facilitated early research and began to notice the frequency of patient sessions decreased because their challenges were being resolved [14].

8. Structural Family Therapy

8.1 Theory Construction

A premier therapeutic intervention employed by social workers, structural family therapy highlights the interaction between family members, oftentimes in live time, to gain insight into the organization and structure within a family system. It is during this time that covert indicators of family dynamics such as individual communication styles, who speaks for who/who speaks over whom, and who simply does not speak are noted by the treating clinician [15]. The core concept of the theory is to restructure family dynamics such that there is a pecking order dynamic, with parents or otherwise primary caretakers in dominant/authoritative roles, and with boundaries being flexible though clear. Endorsed by structural family theory is the wholeness and intersectional functioning of both the nuclear family system and its subsystems, e.g., those not part of the nuclear family but whose relationships with impact members of the nuclear family and how they interact with one another have an impact. As touted by Dallos & Vetere, the family must 'function in conjunction' [11]. In clinical practice, a clinician might ask to see a scenario role played by families, to intercept and

provide family members with objective insight and offer new strategies to better manage conflict consequently promoting harmony within the family system. Theoretically, it is thought that because families are relieved of their maladaptive patterns, individuals within the family will be relieved of their maladaptive behaviors within the family dynamic [15].

8.2 Brief History of the Theory

Led by the initiative of Salvador Minuchin, a family therapist, the constructs of structural family therapy were developed. The 1960s saw a growing interest and need for research in the systemic ways in which the distress endured by one's nuclear family system impacted behavior and how an individual experienced interactions with other individuals and other systems, e.g., work or school settings, etc. With the support of colleagues, Minuchin developed the core beliefs of the theory positing the significance of boundaries, structure, power dynamics, and enmeshment, while identifying the subsystems that impact the nuclear family [16]. The core beliefs outlined during the advent of structural family theory remain relevant. Understanding the family dynamic through observation and feedback remains a fundamental method for eliciting constructive change within the family system [17,18].

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