SPEAKER NOTES

"Talk Therapy" in Treating Neurobiological Disorders

Summarized by Thomas T. Thomas

The current treatment of choice for neurobiological disorders seems to be medication, which was the subject of our January meeting. But is there a place as well for traditional psychological analysis and its modern variants—the regime of the so-called "talk therapies"?

Two speakers at our March 27 meeting described some of the new approaches they are taking with both clients and their families: **Bruce Burtner, LCSW,** an expert in narrative therapy who works with students in the Oakland School District; and **Simone Madan, MA,** a psychological assistant and PhD candidate from the Center for Cognitive Therapy in Oakland.

Narrative therapy, Burtner said, is an outgrowth of post-modernist theory, including some of the French ideas involved in literary deconstruction. Its basic premise is that each of us have "narratives" or stories that we tell ourselves. These stories combine our values, expectations, hopes and fears, and much of our self-perception. They are the ongoing "me" with which each of us must deal.

The goal of narrative therapy is to help the client, or the client's family members, evaluate the current story in a non-judgmental way. Rather than looking for the "right" or the "real" story, the therapist seeks the client's or family's agreement on identifying the problem that is creating his or her unhappiness, and then moving it outside the client. In other words, to start replacing the dysfunctional story that the client is telling him- or herself with an equally valid story that works better.

"Narrative therapy doesn't change everything," Burtner said. "It changes the way we construct what's meaningful."

For example, the goal with a client who is suffering from schizophrenia might be to change the story from "I am a schizophrenic"—and therefore hopelessly mentally ill—to "I have a problem with my temper" or "I have a problem with delusions." This experience can be a relief, Burtner said, because the client no longer has to identify with the problem. The problem is not the person.

Narrative therapy differs from traditional psychotherapies in that its effectiveness does not come from insight. The client does not find his or her "real self" through the process. Instead, he or she learns to choose from among several possible realities. The narrative which the client chooses is the identity he or she adopts at that moment.

This is one of the post-modernist elements: that a person is understood to have no underlying, unchanging "self," but only a series of roles and identities that may change each day, sometimes each hour. The same person can be wife, mother, supervisor, employee, and customer at different times during a single day, depending on the role, or narrative, she adopts.

Narrative therapy also changes the nature of the therapist. He or she is no longer the "smart guy" who comes up with a diagnosis, the "right answers," based on training in psychological theory and evaluation. Instead, the therapist is a helpful listener who assists the client in becoming more aware of the many forces—the values, expectations, and assumptions—which are pulling on the client and "recruiting" him or her into a particular, often negative, narrative.

The client is not "wrong" in choosing this negative narrative, but he or she may need to become more open to possible alternative patterns.

"Most of our medical people are programmed to push you into a certain pattern," Burtner said. "The trouble is, our culture doesn't deal well with problems for which solutions may not be apparent."

Narrative therapy can be relevant to cases of schizophrenia, he said, because one of the longstanding issues is non-compliance with medication protocols. Narrative therapy tries to find a story in which this non-compliance comes to mean something different. In the current story, medication may represent a negative factor: the client's fear of having an outside force manipulate his or her brain. In a different story, compliance might mean more options for the client: the chance to play sports, or have a girlfriend, or something else the client values.

Narrative therapy is not meant to be a long-term process or cause an internal change in the client's personality—because it denies that such a singular personality exists! It has not been widely embraced in part because it is antithetical to the power of therapy and the therapist.

Instead of being "smart," the therapist tries to be more open and listening. He or she helps the client develop a new meaning for the narrative of his or her experience. The client then learns to tell a more helpful story—not the "real" story, but one that works better.

Cognitive behavior therapy, by contrast, was founded in the early 1960s as a model for treating depression. Over the decades it has been expanded to treat anxiety, bipolar syndrome, eating disorders and substance abuse, and more recently schizophrenia.

"Cognitive therapy's view is that psychological problems are caused by faulty or maladaptive information processing," Madan said. "In the case of depression, the information being processed has to do with loss and failure. In the case of anxiety, with danger."

Each disorder, she said, is like a computer program. In anxiety, a survival program has been activated that screens incoming data and emphasizes signals of threat and harm while rejecting those which suggest safety and comfort. In depression, the program looks for failure and screens out signs of success.

Cognitive therapy is short-term, perhaps 15 to 25 sessions, and seeks to modify the client's expressed symptoms. The therapy is a structured, collaborative process involving both therapist and client. They work together to figure out goals, decide on "homework" which will extend therapy outside the session time, and monitor levels of depression or anxiety to see how the client is progressing.

A typical therapy program might go like this:

1. The client learns to identify maladaptive thoughts.

2. The therapist uses techniques like imaging and roleplaying to help the client learn the relationship between these thoughts and his or her moods.
3. The client learns to modify thoughts in order to change moods.
4. The client identifies and understands underlying beliefs and assumptions.
5. The client practices learned skills to reduce symptoms and enable coping.

Some of the techniques the therapist uses include:

- Pattern checking—does the client have all-or-nothing or black-and-white patterns of thinking? Does he or she engage in largely negative thoughts?
- Examining the evidence for negative thoughts—get the client to test out negative assumptions and discuss them with other people to check their validity.
- Redefining feelings—for example, turn "I'm lonely" into "I need to reach out to others."
- Introducing distractions—for example, get the client involved in physical exercise or some pleasurable activity which takes his or her mind off the negative mood.
- Practicing mood induction—through imaginal and *in vivo* exposures, get the client to experience the feared or negative event, learn what's real and what's false about it, and overcome feelings of discomfort.

Clinical applications of cognitive behavior therapy to schizophrenia and bipolar syndrome help the client understand the limits of the illness, the importance of complying with medication protocols, and the evidence for and against delusions and hallucinations. Madan did note, however, that schizophrenia can be a challenge because the client's cognitive skills and motivations are often an issue.

With obsessive-compulsive disorder, cognitive behavior therapy helps the client list his or her fears, grade them in terms of their real effect, and through exposure prevent the rituals which are the hallmarks of this disorder.

"Research has shown that cognitive behavior therapy works better with medication than either treatment works alone," Madan said. "This therapy is also useful in preventing relapses."