<PsychInfo:http://huie.hsu.edu:2266/ehost/search?vid=5&hid=105&sid=521c8a88-4997-4eb0-a0cf-c909dddo6667%40sessionmgr107>.

Zillman, Dolf. “Cinematic Creation of Emotion.” *Moving Image Theory. Ecological Considerations.* Ed. Joseph D. Anderson and Barbara Fisher Anderson. Carbondale. Southern Illinois University Press. 2005.

Biographical Sketch

Paul Glover received a B.A. in Communication and Information Sciences from the University of Alabama in 2001. From 2002-2004 he completed an M.A. in Communication Systems Management. Currently, he teaches Radio and Television production courses at Henderson State University and is finishing an M.F.A. in Digital Filmmaking from the University of Central Arkansas. He has also produced several documentaries for the Hot Springs Documentary Film Festival.

The Role of Psychotherapy in Mental Illness: Comparing and Evaluating Perspectives

Kristen N. Wade, B.S.
Graduate Student in Clinical Mental Health Counseling

Mentor: Linda English, Ph.D.
Associate Professor of Counselor Education

Abstract:
Throughout the course of the past several decades, we saw a change in the way both psychotherapy and mental illness is perceived. Research is needed to continue to gain insight into the benefits of psychotherapy. In this article, the role of psychotherapy in treating mental illness is evaluated in various scenarios over time (Arean & Alexopoulos, 2007; Coursey, Keller, & Farrell, 1995; Rogers, 1942, 1961; Winokur, 1973). Also examined are the roles of therapeutic alliance (Dinger, Strack, Sachsse, & Schauenburg, 2009; Marcus, Kashy, & Baldwin, 2009), counter transference issues (Horowitz, 2002), and client perspectives (Coursey et al., 1995; Pesale & Hilsenroth, 2009). Over the years, we have developed a better understanding of treatment options for the mentally ill. Many therapeutic professionals have adopted a recovery principle (Beeble & Salem, 2009). There are high hopes for the future of psychotherapy in the treatment of mental illness.

Over the course of many generations, the perspectives of therapists, clients, and society in general expanded as a deeper understanding emerged of the role psychotherapy plays in the treatment of mental illness. Although emerging research suggests mental health clients can greatly benefit from psychotherapy (Cuijpers, van Straten, Warmerdam, & Andersson, 2009; Hien, Cohen, & Campbell, 2009; Pesale & Hilsenroth, 2009), controversial research has left and continues to leave many questions indefinite. Does anyone really “need” psychotherapy, or can we at best say that an individual will

simply “benefit” from therapy? Is recovery really an option for those suffering from chronic mental illness, and if so, what defines “recovery”? Can those with co-occurring mental illness and substance abuse disorders benefit from psychotherapy? Is psychotherapy as effective as psychopharmacology? How can counter transference affect a client/therapist relationship? How do the clients themselves feel about psychotherapy? These are all questions that are of interest and need further research to contribute to the development of the profession and a greater understanding of the treatment of the mentally ill.

I expect that we have all heard, at some point in our lives, “This individual needs therapy,” a description of someone’s need for treatment (Winokur, 1973). After all, this is a rather commonly used phrase. Winkour explains that if we are to define needs as physiological by nature, e.g. needs for water, food, and oxygen, then we cannot justify a need for psychotherapy. However, if we also examine psychological needs, we would need to examine the result if these needs are not met. If we make the assumption that someone “needs” psychotherapy, this implies that the person is ill in some way, that they must receive treatment that can only be provided by a therapist. With this notion, it seems more sensible to say that there are people who may benefit from psychotherapy, rather than saying there are people who need it. Winokur suggests that we must give individuals the power to make their own choices, without imposing our own values. He also suggests that talking to clients in basic English, without using all the psychiatric jargon, would alter the hierarchy that exists within the mental health structure. Winokur makes an excellent point, and although these are all things we may have already realized, at the time these were even more controversial issues, as society’s ideas and perceptions were changing and developing.

In today’s society, there is much controversy as to whether a chronically mentally ill individual can truly recover from their illness. There is a new vision of hope for recovery that counters previous beliefs that those plagued would lead a life of hopelessness (Beeble & Salem, 2009). Beeble and Salem point out that through the years, the concept of what “recovery” means has changed a great deal. Whereas recovery used to be viewed as a cure, it is now understood as a process that does not always result in a return to prior functioning. However, it is understood to be process of “changing one’s attitudes, values, feelings, goals, skills, and/or roles”; ”a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness” according to Anthony (p. 250), as cited in Beeble and Salem’s (2009) study. Beeble and Salem’s study suggests that there are multiple phases of the recovery process, e.g., “the experiences that enable an individual to move past feelings of despair and accept that they have a mental illness, may be quite different from those that enable them to cope more effectively with their illness or redefine their goals” (p. 250-251). This is a new and exciting perception on the conceptualization of recovery.

Inconsistency in various research findings constitutes a need for deeper, more specific research. For example, one controversial issue is the debate of psychotherapy vs. pharmacotherapy in the treatment of mental disorders; whether one treatment is more beneficial alone, or both together. There have been a great number of studies about the various treatments of depression. However, there have not been satisfactory significance levels in recent statistical meta-analyses (Cuijpers et al., 2009). The Cuijpers et al. study found clear evidence that the combination of psychological and pharmacological

treatment of depression surpasses psychological treatment alone in short-term treatment options. The study found a trend showing that the difference between psychological treatment alone and combined treatments is much smaller when cognitive behavior therapy is used, compared to other psychological treatments. There is a need for further research to examine effectiveness of long-term treatment options. There has been an increased need for empirical support of psychotherapy treatments, especially for clients with co-occurring mental health and substance use disorders (Hien et al., 2009). In an eagerness to discover which treatment methods are most effective, clinicians yearn for more research. Despite research into the effectiveness of psychotherapy for older adults suffering from mental illness, considerably more research is needed to understand the benefits (Arean & Alexopoulos, 2007). Arean and Alexopoulos' article suggests that psychotherapy has "a valuable role for late-life mental illness" (p. 99) and "can be effective even in the face of significant psychiatric and cognitive co morbidity" (p. 99). All of the aforementioned studies are of clinical importance and should be a focus of upcoming research.

Another topic of interest is therapeutic alliance. A recent study (Marcus et al., 2009) found trends of reciprocity in therapist and client ratings of therapeutic alliance, i.e. if a therapist reported an exceptional alliance with a particular client, then the client was also more likely to report and exceptional alliance with the therapist (compared to those of other clients). The Marcus et al. research study suggests that some clients are more likely to improve in therapy than others, but the therapeutic outcome could also be a function of the special pairing of client and therapist. Therapeutic alliance happens to be one of the most intently-researched process factors with its relation to outcomes of therapy and has been examined in numerous studies (Dinger, Strack, Sachsse, & Schauenburg, 2009). The recent study by Dinger et al. (2009) in inpatient psychotherapy found that higher preoccupation of attachment of therapists was correlated with lower levels of overall alliance with interpersonally distressed patients. This brings up the issue of counter transference and problematic counter transference behaviors: being overly supportive, talking too much, etc. It seems that therapists must strive for a balance of conveying empathy to the client without letting their own issues affect their counseling role.

A look into the relationship between psychotherapy and serious mental illness, such as schizophrenia, proves that beneficial changes have occurred throughout the years. In addition, psychiatric medication has led to incredible breakthroughs that may have overshadowed the function of psychotherapy in mental illness (Horowitz, 2002). In Horowitz's article, the matters of counter transference are examined in the relationship of client and clinician.

> Clients living with mental illness all too commonly find their thoughts and feelings discounted, regarded merely as symptoms, rather than as expressions of subjective experiences of a world gone awry. They become exquisitely sensitive to a feeling of not being listened to, an experience that replicates their profound sense of separation and estrangement. (Horowitz, 2002, p. 236).

Often times, therapists may become discouraged working with seriously mentally ill clients, feeling as though little to no progress is made. Horowitz suggests that the grief that these clients experience is likely to bring about remembrances of a therapist's own sorrow and anguish, which could either lead to emotional distancing or greater empathetic understanding. Empathy is extremely important when working with clients with serious mental illness. We must try to comprehend the unimaginable losses (of vocations, friends, family, and sometimes almost everything) some of these clients endure. Horowitz suggests that exploring counter transference can offer a path to a more essential empathetic bond. In Horowitz's reflection of one of his own personal experiences with a mentally ill client he expresses the importance of utilizing counter transference:

> And yet we must never relent in our search, never surrender hope that change can come. Some time ago Steven said, "Coming here is the best part of my week…I've probably lost more than most people could ever imagine." Perhaps he was saying that my recognition of the magnitude of his losses assuaged his grief. Steven lives in constant mourning, a mourning that knows no end. I have chosen to travel this road with him and ours has become a journey marked by the shared endurance of existential struggles. We know the part but not the destination. If in some small way I can ease his burden, if I can impart even the smallest measure of hope, if I can rekindle even the beginnings of faith, then I will feel privileged indeed. (Horowitz, 2002, p. 240).

Horowitz refers to counter transference as either becoming a wall or a window, either creating a barrier between client and clinician internal experiences, or opening up the therapist's own experiences to deepen the connection to the client's own reality. Clients with serious mental illnesses, such as schizophrenia, can be challenging to therapists. Therapists must "…manage expectations, seek out strengths, and convey hope sometimes rooted more in faith than in reason," according to Horowitz (p. 241). We must share a journey with those afflicted with mental illness, and provide authentic support.

We must realize that it is important to understand the world of someone afflicted with serious mental illness in order to provide supportive services; therefore we must take into account the client's perspective. A study by Coursey et al. (1995) found that seventy-two percent of the clients in the study with serious mental illness thought that individual psychotherapy had positive effects. As the Coursey et al. study points out, it is important to find out the specific benefits of psychotherapy, because the benefits identified by the clients may differ from therapists' goals, and sometimes even those originally set by clients themselves. This 1995 study was extremely important because it had many significant findings regarding psychotherapy with those with serious mental illness. The Coursey et al. study looked at two different types of therapy, more practical (shorter sessions meeting less frequently) vs. deeper (longer, more insight-oriented sessions meeting more frequently). The study found that only 16 percent of clients with schizophrenia chose the deeper sessions as opposed to 47-60 percent of those with mood disorders. Also, it was discovered in the study that clients who preferred deeper sessions also preferred a combination of medication and therapy, and were more interested in gaining insight into their illness. This study also suggested something that we are more

aware of now than we were fifteen years ago, that an eclectic approach is sometimes best, and that therapists should at times suggest an ongoing relationship and be available to the client, with periods of more frequent interventions targeting particular issues. We must always take into account the client's specific needs and motivational goals.

A recent study by Pesale and Hilsenroth (2009) examined client and therapist perspectives regarding session depth in relation to psychotherapy technique. The Pesale and Hilsenroth study found that clients rated sessions as being more deep, valuable, powerful, and special when therapists used psychodynamic techniques in therapy and the techniques seemed to be related to more positive treatment outcomes. So how has the view of "optimal" therapy changed over the years? Carl Rogers (1961) said "I have endeavored to check my clinical experience with reality, but not without some philosophical puzzlement as to which 'reality' is most valid" (p. 197). Also in his book, *On Becoming a Person*, Rogers describes his views on optimal therapy:

> If therapy were optimal, intensive as well as extensive, then it would mean that the therapist has been able to enter into an intensely personal and subjective relationship with the client – relating not as a scientist to an object of study, not as a physician expecting to diagnose and cure, but as a person to a person. It would mean that the therapist feels this client to be a person of unconditional self-worth: of value no matter what his condition, his behavior, or his feelings. It would mean that the therapist is genuine, hiding behind no defensive façade, but meeting the client with the feelings which organically he is experiencing. It would mean that the therapist is able to let himself go in understanding the client; that no inner barrier keeps him from sensing what it feels like to be the client at each moment of the relationship; and that he can convey something of his empathetic understanding to the client. It means that the therapist has been comfortable in entering this relationship fully, without knowing cognitively where it will lead, satisfied with providing a climate which will permit the client the utmost freedom to become himself. For the client, this optimal therapy would mean an exploration of increasingly strange and unknown and dangerous feelings in himself, the exploration proving possible only because he is gradually realizing that he is accepted unconditionally. (Rogers, 1961, p. 185).

In an even older account of *Counseling and Psychotherapy* (1942), Rogers identifies that the problem(s) are not the focus, but rather the individual himself. Rogers states that the goal of psychotherapy is to assist the person to grow, not to solve one particular or a set of problems. Rogers suggests that if an individual can first learn to handle a problem in "more independent, more responsible, less confused, better-organized ways" (p. 28-29) then the individual will have the capability to handle other problems in that same manner. Rogers also goes on to suggest that therapy is not an "artistic accident", but a "genuine process" (p.437). Rogers implies that the improvement and refinement of this process "challenge the imagination and give constructive and realistic hope for the future" (p. 437). Although there is always room for improvement, I think Carl Rogers would be proud to see what the field has become over the years.

As it seems, the role of psychotherapy in mental illness has evolved over the years, with many important realizations being made over the decades. After reviewing

various literatures, I feel that I have come up with some more specific opinions regarding the research questions of this paper. First, does anyone really "need" psychotherapy or can we say that an individual will only "benefit" from services? I would like to presume the role that most individuals with a serious mental illness can benefit from psychotherapy, but it does seem possible when looking at needs both psychologically and physiologically that there may be some individuals that in fact, do "need" psychotherapy, as without this service they may end up losing their lives, when they could in fact be saved. This brings us to my next research question: is "recovery" really an option for those suffering from severe and chronic mental illness, and what exactly defines "recovery"? For many decades, recovery was viewed as a cure, but now the field has taken on a new perspective on what defines "recovery". In my own experience working for Birch Tree Communities Inc., a short-term residential treatment facility for those suffering from severe mental illness, we utilize a recovery philosophy. We strive to place the individual at the center of the treatment and recovery process, to form an equal partnership that will enable them to realize their worth and dignity, participate in developing and directing their recovery process, recognize and build upon their strengths and abilities, develop self-awareness, make their own choices, and to live, socialize, and work successfully in the community. I believe that our program as well as many others offer hope to those with serious mental illnesses, even those suffering from co-occurring disorders, such as substance abuse. This leads me into my next research question: can those suffering from co-occurring mental illness and substance abuse disorders benefit from psychotherapy? My answer is <u>definitely</u>. As I have learned in the classroom, by reviewing various literatures, and through direct observation/interaction, this is most definitely possible, and even probable. Most individuals that suffer from a mental disorder seek out ways to self-medicate, often leading to substance abuse. I have personally worked with individuals with co-occurring disorders and found in my experience that these individuals might possibly benefit from psychotherapy even more than those without. The reason I feel this way is because a person who suffers from a serious mental illness is very likely to be self-damaging, and if these self-damaging behaviors such as substance abuse can be eradicated, the individual is more likely to go on to lead a higher-quality life. Sometimes, this higher-quality life is made possible by the use of prescription medications. My next research question examined psychotherapy vs. psychopharmacology in treating mental illness. Some studies, such as the abovementioned one (Hein et al., 2009), have shown that the combination of both treatments is more successful than psychotherapy alone in the treatment of certain types of mental illness, such as depression. I feel that a combination of both treatments is usually more effective in those suffering from psychotic disorders. For instance, if a person with a psychotic disorder does not take their psychotropic medication, they are not as likely to benefit from psychotherapy, and vice versa.

One of the main things I wanted to examine in this paper was counter transference issues and client perspectives, thus the research questions regarding these. I have always been curious as to how to keep particular emotions from being awakened and/or re-experienced when identifying with the feelings of a client. After reviewing various literatures on this topic, I was presented with varying viewpoints. However, the viewpoint to which I best related is the viewpoint that counter transference can either be a wall or a window, either creating a barrier between client and clinician internal

experiences, or opening up the therapist's own experiences to deepen the connection to the client's own reality (Horowitz, 2002). Lastly, I was curious to examine some of the client's perspectives regarding psychotherapy. I was not surprised that the abovementioned study (Coursey et al., 1995) found that most clients with serious mental illness thought that individual psychotherapy had positive effects. I was also not surprised that only a small percentage of those suffering from schizophrenia preferred deeper, longer sessions. Working with individuals with schizophrenia can be very challenging, and I know from experience that even getting them to open up to talk can be extremely difficult.

However challenging as it might be, after working with chronically mentally ill individuals for a couple of weeks, I absolutely fell in love with them. I quickly found out that no matter how much one has studied mental illness, experience and dedication are essential to developing bonds that will build clients' trust and confidence. I suspect that this is true across the spectrum of working with all populations who would benefit from psychotherapy. I am extremely passionate about the fields of mental illness and psychotherapy, and plan to spend the rest of my life contributing to the profession. I plan to do this as a clinical mental health counselor one day, which I personally feel is the best option. Although there are several different types of clinicians out there who believe in the benefits of psychotherapy in mental illness, I believe that licensed counselors have much to offer clients. It is at times challenging being a counseling student who is specifically focused on working with those with severe mental illnesses, because often times social workers, psychologists, and psychiatrists are preferred as therapists and directors of mental illness treatment facilities. One of my goals as a counseling student and future professional in the field is to help bridge the gap between counselors and other therapeutic professionals. I would like to one day show that clinical mental health counselors have their place in the role of providing therapy for those with severe mental illness. I strongly believe in the benefits of psychotherapy, recovery principles, and the inspiration of hope for the future of treating mental illness.

References

Arean, P., & Alexopoulos, G. (2007). Psychosocial interventions for mental illness in late-life. *International Journal of Geriatric Psychiatry, 22*(2), 99-100.

Beeble, M., & Salem, D. (2009). Understanding the phases of recovery from serious mental illness: The roles of referent and expert power in a mutual-help setting. *Journal of Community Psychology, 37*(2), 249-267.

Coursey, R., Keller, A., & Farrell, E. (1995). Individual psychotherapy and persons with serious mental illness: The client's perspective. *Schizophrenia Bulletin, 21*(2), 283-301.

Cuijpers, P., van Straten, A., Warmerdam, L., & Andersson, G., (2009). Psychotherapy versus the combination of psychotherapy and pharmacotherapy in the treatment of depression: A meta-analysis. *Depression and Anxiety, 26*(3), 279-288.

Dinger, U., Strack, M., Sachsse, T., & Schauenburg, H. (2009). Therapists' attachment, patients' interpersonal problems and alliance development over time in inpatient psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 46*(3), 277-

290.
Hien, D., Cohen, L., & Campbell, A. (2009). Methodological innovation to increase the utility and efficiency of psychotherapy research for patients with co-occurring mental health and substance use disorders. *Professional Psychology: Research and Practice, 40*(5), 502-509.
Horowitz, R. (2002). Psychotherapy and schizophrenia: The mirror of counter transference. *Clinical Social Work Journal, 30*(3), 235-244.
Marcus, D., Kashy, D., & Baldwin, S. (2009). Studying psychotherapy using the one-with-many design: *The therapeutic alliance as an exemplar. Journal of Counseling Psychology, 56*(4), 537-548.
Pesale, F., & Hilsenroth, M. (2009). Patient and therapist perspectives on session depth in relation to technique during psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 46*(3), 390-396.
Rogers, C. (1942). *Counseling and psychotherapy*. Cambridge, MA: The Riverside Press.
Rogers, C. (1961). *On becoming a person*. Cambridge, MA: The Riverside Press.
Winokur, D. (1973). Does anybody really need psychotherapy? Consequences for retaining a mental illness model. *Psychotherapy: Theory, Research, & Practice, 10*(1), 41-43.

Biographical Sketch

Kristen Wade is a native of Murfreesboro, Arkansas. She attended Henderson State University for her undergraduate studies in psychology. After working in the mental health field, she decided to return to Henderson as a graduate student in the Clinical Mental Health Counseling program. Kristen is passionate about the field of counseling and would like to pursue a lifelong career in the field, perhaps opening a private counseling practice one day.

A Baseball Necrological Progress Report

Fred Worth, Ph.D.
Professor of Mathematics and Computer Science

Abstract - As part of my baseball related research, I visit and document burial sites of major league baseball players. This paper gives a progress report on my hunting.

About five years ago, shortly after I had joined the Society for American Baseball Research (SABR), I found out that Travis Jackson, Hall of Fame shortstop of the New York Giants, was buried in Waldo, Arkansas. Wanting a break for the day, my wife and I drove down to Waldo and visited the grave. Little did I know that excursion would be the start of a substantial research project.