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Examining the Effect of Therapeutic Communication on Phobias and Emotional Disorders: A Case Study

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Abstract
This study highlights that the therapeutic communication can combat stress related to human emotions and behavioral disorders and in particular how communication becomes the tool for healing and modifying [1]our psychology and behavior respectively. Not just our emotions but communication may heal many phobias and mild psychological disorders. It explores different practices of therapeutic communication by the communication experts across the globe and proposes a framework for monitoring the emotional &behavioral build out of the patients, also how communicating with such patients can generate passive to dynamic personality in their daily behavior. The study also provides the communication experts that how the communication becomes an assessment tool to monitor and track progress in the uptake of effective use of communication. There are different results to "therapeutic communication" as all patients differs in their characters, background, social status, culture, etc.

Keywords: therapeutic communication, psychological disorders, phobias, patient, verbal communication

1. INTRODUCTION

Communication is a regular feature and skill through which one transmits messages to the recipient. [1,2] This is an interactive process of exchanging thoughts, emotions and information which inevitably occur whenever there is an interaction between two or more persons. The verbal and nonverbal messages comforts and. Helps to reduce emotional anguish. Communication has many attributes and its therapeutic role is one amongst those. The therapeutic intervention is an art through whichthe clinical practitioners use various means of communication as a medium to heal psychological disorders.[3]

The therapeutic interventions not only help gaining emotional boost up but also gives social support.[4] 'The concept of "therapeutic communication" refers to the process by which the communication expert consciously motivates a patient for better understanding through verbal andnon-verbalcommunication'. Therapeutic and communication are two very complex words and each of them have different meanings. But together the term depicts a different meaning when considered as a compound noun. Derived from Greek term therapeutikos, which means to treat medically, Therapeutic communication, involves clinical technique that motivates the patient to accept and reject thoughts and ideas.[5]Human psychology is quite wide and most difficult subject for the experts even. It is complicated and is directly linked with the relationships we possess with the natural environment, thus the abnormal human psychologyis quite common.[6,7] As the human emotions are of wide range and critical, the field of psychology has distinguished and identified the psychological disorders separately. The Psychotic and neurotic types are the two primary classification of disorders observed in the clinical psychology. [8] Where the psychotic disorders need pharmacological treatment along with the medical counselling, the neurotic and mild psychological disorders can be treated only with therapeutic communications.[9]

2.BACKGROUND OF THE STUDY

The current study is a part of doctoral research of the researcher. Therapeutic communication is as important as pharmacological treatment healing ailments and especially psychological disorders. Therapeutic communication is most important topic to discuss in the recent scenario where our psyches are more prone to absorb neurotic problems. The cognitive approaches to understanding in treating emotional disorder becomes crucial. [10,11] So this study is also interesting to appreciate the cognitive understanding of thoughts whenever required.

2.1Research Objectives:

The communication has a healing property while in a structured form. Thus, this research is intended:

- To study the therapeutic communication as a healing way in treating phobias.
- To find the emotional and behavioral change of the client when treated with therapeutic interventions

2.2Hypothesis:

The hypothesis of this research states that 'The therapeutic communication can heal phobias and emotional disorders".

3. RESEARCH METHODOLOGY:

To conduct this study, qualitative approach has been opted where a particular case has been selected, observed and analyzed. Thomas W. Lee, Terence R. Mitchell and Chris J. Sablynski (1999) "Case study research enhances understanding through theory development that can occur within an in-depth investigation of one case situation or across in-depth investigations of multiple cases".[12] In this research, the case study method is applied on secondary data which is collected from RML hospital, New Delhi. Prior permissions from the authoritative sources and the medical norms (concealing of the identity of the patient) were followed while conducting the research. Due to the medical research guidelines the name of the patients and their registration numbers are not disclosed.

4. CASE STUDY

4.1 Brief Case History

The client is a 37-year-old married male with a diploma from ITI, a sound technician by profession, middle socio-economic status, and urban background. There is nil contributory past, family and treatment history. The client was pre-morbidly well adjusted. The client presented with symptoms of insidious onset, chronic course characterized by excessive fear of encountering blood or injury accompanied byanxious apprehension of the same, autonomic arousal and panic like reactions on encountering the feared stimuli. He also experienced intrusive images of the same following viewing of the feared stimuli accompanied by active avoidance of the same. The informant was the client himself. The information was adequate and reliable.

4.2 Persenting Complaints

- Feeling nauseas, giddy and experiencing a loss of consciousness at the sight of blood or any injury.
- Being unable to go out alone for the fear that he may encounter blood/ injury.
- The above-mentioned complaints being present for 20 years.

Onset: Insidious Course: Progressive

The client reported that when he was about 10 years of age on seeing for the first time his brother's burnt skin being peeled off by the villagers, he experienced nausea, giddiness and nearly fainted at the sight. The client did not encounter any similar event until the age of 17, when he peered into his cousin's mouth after a tooth extraction. On viewing the sane he experienced nausea, giddiness and a

general uneasiness. He had difficulty even standing up seeing the blood-soaked cotton. The client noticed that in any situation where he encountered the sight of blood, an injured person or an amputee he would experience autonomic arousal in the form of palpitations, churning of the stomach and dizziness. He would engage in avoidance
by way of actively avoiding places where he may encounter such sights such as hospitals and clinics.
About two years ago the client went to visit a colleague's daughter in the hospital. On seeing her on IV fluids the client lost consciousness. Ever since, the client has anxious apprehension regarding the possibility of seeing blood or injury. He has given up riding his motorcycle for thefear that he may see an amputee/ injured person or an accident and may faint on the road. He also avoids going out for thesame reason. He also experiences recurrent intrusive images of the accident/ injured person following the viewing the same. This added to his distress. His avoidant behaviors have led to significant difficulties in his socio- occupational functioning; his job requires him to constantly commute and due to his anxious apprehension is unable to do this. His relationship with his family members is also being adversely affected as his anxiety about fainting keeps him from visiting ill or hospitalizedrelatives.

Negative History

- No history of any other specific phobias.
- No history of Generalized Anxiety Disorder.
- No history of obsessive-compulsive disorder.
- No history of pervasive sad or elated mood.
- No history of substance abuse or dependence.

There is nil contributory past history, treatment history, and family history. Pre morbidly well-adjusted except for his fear of blood.

4.3 Mental Status Examination

The client's appearance, behavior and psychomotor activity were within normal range. Volume, tone, tempo and reaction time for speech was within normal range. Stream, form and possession of thought were normal. Content revealed preoccupation with the possibility of seeing blood or injury. An excessive fear of the same was present with concern of the adverse effect of the same on both, his work and interpersonal relationships. No depressive features were present. Mood, both, subjectively and objectively was anxious. No perceptual abnormalities were reported. Cognitive functions were adequate and insight was present.

4.4 Diagnosis

Specific phobia- Blood Injury type and Mild- Moderate impairment.

4.5 Behavioural Analysis

Behavioral assessment was done to understand the nature of the client's problem and to infer possible antecedent and maintaining factors for the same.

4.6 Initial Analysis of the Problem Situation

The client had behavioral excesses in the form of anticipatory anxiety most of the time, worrying about the possibility of seeing blood/ injury or an amputee and a sense of helplessness regarding the same. Behavioral excesses also manifested by way of autonomic arousal characterized by palpitations, nausea, uneasiness and dizziness. Avoiding hospitals, clinics, riding and going out unescorted for fear of fainting are primary deficit behavior. Behavioral assets include his education, interest in work, motivation in overcoming his problem, reading, watching documentaries and movies. He also enjoyed being with people. Cognition and behavior following the antecedent event were: On seeing blood/ injured person/ amputee the client would experience a dull pain at the base of his neck. It would be accompanied by giddiness, nausea and the fear of fainting. The antecedent cognitions included

imagining the pain the person would be experiencing, intrusive images of previously seen images of accidents/ injury/ blood, which would increase his anxiety. The anxious apprehension of encountering the phobic stimuli and hyper vigilance for the same would impact adversely on the work the client wasengage in at that time.

4.7 Motivational Analysis
The client's avoidance of all situations where he may possibly encounter the feared stimuli had served in reducing anxiety and thereby to maintain his avoidance behaviors. Teaching the client alternative skills through exposure, involving the family members along with the use of differential reinforcement from them could be used to strengthen desired behaviors.

4.8 Developmental Analysis
Developmental analysis revealed that the client as a child, when about 10 years of age, had witnessed his brother's burnt skin being removed by the villagers as was heir custom. This had been his first experience of encountering blood/ injury. He recalled feeling nauseous and uneasy on having witnessed it. The client however, had not viewed this early aversive experience as having contributed to his current problem.

4.9 Sociological Changes
The client hails from a middle socio-economic stratum, urban background. The family and relatives expressed surprise at the client's problem and had encouraged him to seek help for the same.

4.10 Behavioural Changes
Pre-morbidly the client was well functioning. However, after his experiencing nausea, giddiness and dizziness on seeing blood in his cousin's mouth following a tooth extraction and subsequently fainting on seeing a person on IV fluid the client became very anxious that he would faint on encountering blood/ injury. This led to significant avoidance behavior by way of not traveling alone, avoiding hospitals and clinics which has adversely affected his socio- occupational functioning.

4.11 Analysis Of Self Control
The client's wife and friends try to reassure him when he feels distressed. The wife is especially anxious regarding the consequences of his problem on both, work and social relations. There is no one who directly reinforces his problem behavior; family members and friends urge him to seek treatment.

4.12 Analysis Of Socio- Cultural- Physical Environment
The client's current behavior of avoiding traveling unescorted, not riding his motorcycle and also of not visiting ill relatives or those hospitalized as hampering his role demands adversely. The family members considered psychological procedures as appropriate in helping the client with his problems.

4.13 Cognitive Behavioural Formulation
Acquisition of the problem may be explained by way of single trial learning of a classical conditioning type to a traumatic event of seeing his brother's burns being treated by bursting the water collection under the skin in his childhood, during which time he experienced uneasiness and nausea. The client however was not exposed to similar situations until adult life. The mediating factors include anxiety, catastrophic cognitions regarding how much pain the injured person would be experiencing, and also that he may lose consciousness. These were accompanied by physiological arousal in the form of palpitations, experiencing a dull pain at the base of his neck, giddiness and dizziness. It was also accompanied by repeated intrusive thoughts/ images of scenes previously witnessed along with anticipatory anxiety. These reactions came to occur in all situations involving viewing of blood/ injury including viewing the same in print or media; to real and anticipated situations through the process of generalization. Negative reinforcement by way of avoidance leading to anxiety reduction served asthe maintaining factor.

4.14 Early Experiences And Use Of Avoidance

Exposure to traumatic (Classical conditioning)
event of seeing his
brother's burns
treated.
↓
Severe physiological
reaction by way of
nausea, giddiness
and dizziness.
↓
Subsequent similar
response to the sight
of blood in cousin's
mouth and other
situations after a long
interval with no
exposure before this.
↓
Catastrophic cognitions
regarding pain.
↓
Generalization of the
physiological reaction
and cognitions to similar
situations accompanied by
anticipatory anxiety of
encountering the feared
stimuli.
↕
Avoidance.
↓
Anxiety reduction and
maintenance of
avoidance behavior.

4.15 Rationale For Therapy

The client was significantly distressed as his fear of seeing blood/ injury and avoidance behaviors had led to difficulties in both work and social functioning. Physiological arousal was also present; all of which would improve with therapy. The cognitive error by way of catastrophizing would also improve with cognitive work.

4.16 Plan Of Treatment

The plan was to see the client on an out- patient basis (OP) for cognitive behavioral intervention. Sessions were conducted daily. In the initial phase, intake, assessment and relaxation training was done. Subsequently systematic desensitization and graded exposure were employed. Sessions were spaced to four times a week. The duration of each session ranged from one hour to one hour fifteen minutes.

4.17 Therapeutic Techniques And Rationale

- **Psycho Education-** This technique was employed to help the client better conceptualize his problem within the psychological framework; as a problem that was curable. It also served as a platform for the client to clarify his doubts regarding the nature of his problems.

- **Systematic Desensitisation-** This technique was employed as the client had significant avoidance behaviors which interfered with his functioning. After the client had been trained in progressive muscular relaxation (JPMR), he was asked to construct a hierarchy of anxiety-eliciting situations, ranging from the least anxiety evoking to the most anxiety evoking. He was also asked to generate a scene which he found pleasant and relaxing. Initially in Virto exposure to anxiety evoking situations was paired with relaxation. When the client experienced some degree of mastery in handling the situation in vivo activity for situations in the hierarchy was done.

- **Cognitive Restructuring-** This was employed to make the client aware of his cognitive distortions/ errors; particularly catastrophizing. The downward arrow technique was employed.

4.18 Process Of Therapy

A total number of 39 sessions were held. The sessions were held as mentioned earlier. Therapy was initiated with emphasis on establishing a collaborative relationship with the client. He had sought out help himself; was highly motivated and co-operative for therapy. He was psychologically minded and was found to accept the hypothesis that had been put forth to him. A complete behavioral assessment was done incorporating an exploration of his childhood and early childhood experiences in order to understand their role in the evolution of the problem and the current consequences of the same on functioning wasalso delved into. The client received psycho education. The cognitive behavioral conceptualization regarding the origin and maintenance of the problem was discussed as well as the plan and process of therapy. During the next phase of therapy, the client was educated about the rationale for relaxation training. He was informed about the procedure of JPMR. In his first session the client was anxious as to whether he would be able to follow the instructions of the relaxation procedure. In the following sessions however, he was able to relax and reported a lowering of his anxiety levels. Following this the therapist continued to review relaxation practice in the sessions and also introduced the systematic desensitization procedure by pairing the least anxiety provoking items with relaxation. The procedure was in Virto. Gradually as the client was able to move up the hierarchy and reported no distress for the items of higher units of distress, in vivo exposure for the items below them was done. Thus, the client was first asked to imagine cotton soaked with blood, an injured person, and blood storage bags, scenes of accidents in the print media and only when he reported that the anxiety was manageable and had moved on to greater anxiety evoking events was an actual exposure done. With being able to stay in the scene, not faint and not engage in security behaviors the client gained greater confidence in being able to conquer his fears.

The downward arrow technique was employed to help the client identify his cognitive error of catastrophizing and restructuring was attempted. The client was able to identify when he was engaging in catastrophizing and would try to generate alternate and more realistic appraisals of the situation.

The systematic desensitization combined with graded exposure and cognitive restructuring had helped the client significantly and he was able to realize the goals of therapy in that he could view blood, visit hospitals and even watch a blood donation without fainting or feeling faint. He also resumed riding his motorcycle without an escort which was one of the highest items on his hierarchy.

5. CLINICAL OBSERVATIONS AND FINDINGS:

Major findings of the study shows that; the client was motivated for therapy. He was compliant and adhered to the treatment plan, and would repeatedly revise his anxiety eliciting hierarchy with enthusiasm and practice relaxation regularly. The goals of therapy could be achieved largely because

of the motivation and cooperation of the client and his determination to overcome his problem. The cooperative approach and willingness to induced the therapy helped the patient resolving his problem.[13] He had taken leave from work for a month and a half for treatment and was very regular for the same. The availability of time combined with the client's determination facilitated the planning of an elaborate and extensive hierarchy of subjective units of distress, and systematic desensitization to the same without which perhaps the extent of improvement seen would not have been possible. The discussions with the supervisor proved beneficial and helped the therapist to increase reflections in the sessions and bring in needed changes in the collaborative work with the client.

6. CONCLUSION:

Therapeutic communication is not only a predominant way of treating psychological disorders but also bring many changes in the understanding of the clients and shape their emotional and behavioral pattern.[14]

There are many ways for psychotherapeutic interventions, the current study is based on verbal communication in a structured manner.[15] This research concludes that the communication has a healing effect when used in a structured form. Thus, the therapeutic communication can change and shape the psychological phobias and emotional disorders.

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