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01 - 28.1 Psychoanalysis and Psychoanalytic Psycho

28.1 Psychoanalysis and Psychoanalytic Psychotherapy

Psychotherapies 28.1 Psychoanalysis and Psychoanalytic Psychotherapy As broadly practiced today, psychoanalytic treatment encompasses a wide range of uncovering strategies used in varied degrees and blends. Despite the inevitable blurring of boundaries in actual application, the original modality of classic psychoanalysis and major modes of psychoanalytic psychotherapy (expressive and supportive) are delineated separately here (Table 28.1-1). Analytical practice in all its complexity resides on a continuum. Individual technique is always a matter of emphasis, as the therapist titrates the treatment according to the needs and capacities of the patient at every moment. Table 28.1-1 Scope of Psychoanalytic Practice: A Clinical Continuum

Psychoanalysis is virtually synonymous with the renowned name of its founding father, Sigmund Freud (Freud and his theories are discussed in Section 4.1). It is also referred to as “classic” or “orthodox” psychoanalysis to distinguish it from more recent variations known as psychoanalytic psychotherapy (discussed below). Psychoanalysis is based on the theory of sexual repression and traces the unfulfilled infantile libidinal wishes in the individual’s unconscious memories. It remains unsurpassed as a method to discover the meaning and motivation of behavior, especially the unconscious elements that inform thoughts and feelings.

PSYCHOANALYSIS Psychoanalytic Process The psychoanalytic process involves bringing to the surface repressed memories and feelings by means of a scrupulous unraveling of hidden meanings of verbalized material and of the unwitting ways in which the patient wards off underlying conflicts through defensive forgetting and repetition of the past. The overall process of analysis is one in which unconscious neurotic conflicts are recovered from memory and verbally expressed, reexperienced in the transference, reconstructed by the analyst, and, ultimately, resolved through understanding. Freud referred to these processes as recollection, repetition, and working through, which make up the totality of remembering, reliving, and gaining insight. Recollection entails the

extension of memory back to early childhood events, a time in the distant past when the core of neurosis was formed. The actual reconstruction of these events comes through reminiscence, associations, and autobiographical linking of developmental events. Repetition involves more than mere mental recall; it is an emotional replay of former interactions with significant individuals in the patient's life. The replay occurs within the special context of the analyst as projected parent, a fantasized object from the patient's past with whom the latter unwittingly reproduces forgotten, unresolved feelings and experiences from childhood. Finally, working through is both an affective and cognitive integration of previously repressed memories that have been brought into consciousness and through which the patient is gradually set free (cured of neurosis). The analytical course can be subdivided into three major stages (Table 28.1-2). Table 28.1-2 Stages of Psychoanalysis

Indications and Contraindications In general, all of the so-called psychoneuroses are suitable for psychoanalysis. These include anxiety disorders, obsessional thinking, compulsive behavior, conversion disorder, sexual dysfunction, depressive states, and many other nonpsychotic conditions, such as personality disorders. Significant suffering must be present so that patients are motivated to make the sacrifices of time and financial resources required for psychoanalysis. Patients who enter analysis must have a genuine wish to understand themselves, not a desperate hunger for symptomatic relief. They must be able to withstand frustration, anxiety, and other strong affects that emerge in analysis without fleeing or acting out their feelings in a self-destructive manner. They must also have a reasonable, mature superego that allows them to be honest with the analyst. Intelligence must be at least average, and above all, they must be psychologically minded in the sense that they can think abstractly and symbolically about the unconscious meanings of their behavior. Many contraindications for psychoanalysis are the flip side of the indications. The absence of suffering, poor impulse control, inability to tolerate frustration and anxiety, and low motivation to understand are all contraindications. The presence of extreme dishonesty or antisocial personality disorder contraindicates analytic treatment. Concrete thinking or the absence of psychological mindedness is another contraindication. Some patients who might ordinarily be psychologically minded are not suitable for analysis because they are in the midst of a major upheaval or life crisis, such as a job loss or a divorce. Serious physical illness can also interfere with a person's ability to invest in a long-term treatment process. Patients of low intelligence generally

do not understand the procedure or cooperate in the process. An age older than 40 years was once considered a contraindication, but today analysts recognize that patients are malleable and analyzable in their 60s or 70s. One final contraindication is a close relationship with the analyst. Analysts should avoid analyzing friends, relatives, or persons with whom they have other involvements. Patient Requisites The most important patient requisites for psychoanalysis are listed in Table 28.1-3. Table 28.1-3 Patient Prerequisites for Psychoanalysis Ms. M, a 29-year-old unmarried woman who worked in a low-level capacity for a magazine, presented for consultation with the chief complaints of considerable sadness and distress over her parent's reaction when they found that she had had a homosexual relationship. She also realized that she had been working far below her potential. She had never sought any treatment before. She was clearly intelligent, sensitive, self-reflective, and insightful. When the possibility of psychoanalysis was presented to her, she worried that meant she was "sicker." Ms. M, however, began reading Freud, realized that analysis was actually recommended for those who are higher functioning, and

became intrigued by the idea. She agreed to come 4 days a

week for 50-minute sessions. She was the oldest of three children and the only girl. Ms. M's father, a successful professional, was described as very demanding and intrusive, someone who never thought anything was good enough. He had always expected his children to do the "extra credit" assignments as part of their regular work. Ms. M, however, was very proud of her father's accomplishments. She spoke of her mother in conflicting terms as well: She was a homemaker, weak, and sometimes acquiescent to the powerful father but also a woman in her own right who was involved in community volunteer work and could be a powerful public speaker. Just prior to beginning her analysis, Ms. M had had her wallet stolen. In her first analytic session, she spoke of losing all of her identification cards, and to her it seemed as if she were starting analysis "with a completely new identity." Initially, she was somewhat hesitant to use the couch because she wanted to see her analyst's reactions, but she quickly appreciated that she could associate more easily without seeing the analyst. As her analysis proceeded, through dreams and free associations, Ms. M became quite focused on the analyst. She became extremely curious about the analyst's life. What emerged from her associations to seeing the analyst's appointment book on the desk was that she felt "slotted in." Whenever Ms. M saw other patients, she felt the office was "like an assembly line." Further associations led to her feeling slotted in by her parents as they ran from one activity to another. Her resistance manifested itself in Ms. M's often coming as much or more than 15 minutes late to her sessions. Her associations led to her admitting that she did not want her analyst to think that she was "too eager." Ms. M was able to see that she needed to devalue her analyst and her importance to Ms. M as a defense against an overwhelming positive and even erotic transference toward her. For example, Ms. M wanted to improve her appearance so that the therapist, who she called a "role model," would find her more attractive. Her negative transference, however, was never far from the surface, and she denigrated the analyst by wondering if the analyst were a "clotheshorse" who was financing her wardrobe with the patient's payments. Her conflicts about her sexual orientation were a central preoccupation in the course of her analysis, particularly because her father was so homophobic. Early on, Ms. M felt awkward and uncomfortable when she went to a lesbian bar, and when asked if she qualified for the "lesbian discount," she said she did not. At one point, she began seeing several men, including a male psychologist. The analyst made the transference interpretation, which Ms. M accepted, that a date with this man seemed as if it were a date with the analyst and sleeping with him would be equivalent to sleeping with the analyst. Ms. M was also able to see that her transient choice of dating a male therapist was a defensive compromise. Although her homosexual object choice was multidetermined, Ms. M came to appreciate, through her work in analysis, that at least a part of her conflicts about homosexuality stemmed from her relationship toward her father. It was a means of securing his attention as well as

infuriating him. Over the course of 4 years, Ms. M began to do considerably better at work and was promoted to a job commensurate with her potential. She was also able to deal better with both her parents, and particularly her father, regarding her sexual orientation. She became much more comfortable with her "new identity" and became involved in a relationship with a professional woman. At the end of therapy, Ms. M and this woman were committed to each other and were thinking of adopting a child. (Courtesy of T. Byram Karasu, M.D., and S. R. Karasu, M.D.) Goals Stated in developmental terms, psychoanalysis aims at the gradual removal of amnesias rooted in early childhood based on the assumption that when all gaps in memory have been filled, the

morbid condition will cease because the patient no longer needs to repeat or remain fixated to the past. The patient should be better able to relinquish former regressive patterns and to develop new, more adaptive ones, particularly as he or she learns the reasons for his or her behavior. A related goal of psychoanalysis is for the patient to achieve some measure of self-understanding or insight. Psychoanalytic goals are often considered formidable (e.g., a total personality change), involving the radical reorganization of old developmental patterns based on earlier affects and the entrenched defenses built up against them. Goals may also be elusive, framed as they are in theoretical intrapsychic terms (e.g., greater ego strength) or conceptually ambiguous ones (resolution of the transference neurosis). Criteria for successful psychoanalysis may be largely intangible and subjective and they are best regarded as conceptual endpoints of treatment that must be translated into more realistic and practical terms. In practice, the goals of psychoanalysis for any patient naturally vary, as do the many manifestations of neuroses. The form that the neurosis takes—unsatisfactory sexual or object relationships, inability to enjoy life, underachievement, and fear of work or academic success, or excessive anxiety, guilt, or depressive ideation—determines the focus of attention and the general direction of treatment, as well as the specific goals. Such goals may change at any time during the course of analysis, especially as many years of treatment may be involved. Major Approach and Techniques Structurally, psychoanalysis usually refers to individual (dyadic) treatment that is frequent (four or five times per week) and long term (several years). All three features take their precedent from Freud himself. The dyadic arrangement is a direct function of the Freudian theory of neurosis as an intrapsychic phenomenon, which takes place within the person as instinctual impulses continually seek discharge. Because dynamic conflicts must be internally resolved if structural personality reorganization is to take place, the individual's memory and

perceptions of the repressed past are pivotal. Freud initially saw patients 6 days a week for 1 hour each day, a routine now reduced to four or five sessions per week of the classic 50-minute hour, which leaves time for the analyst to take notes and organize relevant thoughts before the next patient. Long intervals between sessions are avoided so that the momentum gained in uncovering conflictual material is not lost and confronted defenses do not have time to restrengthen. Freud's belief that successful psychoanalysis always takes a long time because profound changes in the mind occur slowly still holds. The process can be likened to the fluid sense of time that is characteristic of our unconscious processes. Moreover, because psychoanalysis involves a detailed recapitulation of present and past events, any compromise in time presents the risk of losing pace with the patient's mental life. Psychoanalytic Setting. As with other forms of psychotherapy, psychoanalysis takes place in a professional setting, apart from the realities of everyday life, in which the patient is offered a temporary sanctuary in which to ease psychic pain and reveal intimate thoughts to an accepting expert. The psychoanalytic environment is designed to promote relaxation and regression. The setting is usually spartan and sensorially neutral, and external stimuli are minimized. USE OF THE COUCH. The couch has several clinical advantages that are both real and symbolic: (1) the reclining position is relaxing because it is associated with sleep and so eases the patient's conscious control of thoughts; (2) it minimizes the intrusive influence of the analyst, thus curbing unnecessary cues; (3) it permits the analyst to make observations of the patient without interruption; and (4) it holds symbolic value for both parties, a tangible reminder of the Freudian legacy that gives credibility to the analyst's professional identity, allegiance, and expertise. The reclining position of the patient with analyst nearby can also generate threat and discomfort, however, as it recalls anxieties derived from the earlier parent-child configuration that

it physically resembles. It may also have personal meanings—for some, a portent of dangerous impulses or of submission to an authority figure; for others, a relief from confrontation by the analyst (e.g., fear of use of the couch and overeagerness to lie down may reflect resistance and, thus, need to be analyzed). Although the use of the couch is requisite to analytical technique, it is not applied automatically; it is introduced gradually and can be suspended whenever additional regression is unnecessary or counter-therapeutic. **FUNDAMENTAL RULE.** The fundamental rule of free association requires patients to tell the analyst everything that comes into their heads—however disagreeable, unimportant, or nonsensical—and to let themselves go as they would in a conversation that leads from “cabbages to kings.” It differs decidedly from ordinary conversation—instead of connecting personal remarks with a rational thread, the patient is asked to reveal those very thoughts and events that are objectionable precisely because of being averse to doing so. This directive represents an ideal because free association does not arise freely but is

guided and inhibited by a variety of conscious and unconscious forces. The analyst must not only encourage free association through the physical setting and a nonjudgmental attitude toward the patient’s verbalizations, but also examine those very instances when the flow of associations is diminished or comes to a halt—they are as important analytically as the content of the associations. The analyst should also be alert to how individual patients use or misuse the fundamental rule. Aside from its primary purpose of eliciting recall of deeply hidden early memories, the fundamental rule reflects the analytical priority placed on verbalization, which translates the patient’s thoughts into words so they are not channeled physically or behaviorally. As a direct concomitant of the fundamental rule, which prohibits action in favor of verbal expression, patients are expected to postpone making major alterations in their lives, such as marrying or changing careers, until they discuss and analyze them within the context of treatment. **PRINCIPLE OF EVENLY SUSPENDED ATTENTION.** As a reciprocal corollary to the rule that patients communicate everything that occurs to them without criticism or selection, the principle of evenly suspended attention requires the analyst to suspend judgment and to give impartial attention to every detail equally. The method consists simply of making no effort to concentrate on anything specific, while maintaining a neutral, quiet attentiveness to all that is said. **ANALYST AS MIRROR.** A second principle is the recommendation that the analyst be impenetrable to the patient and, as a mirror, reflect only what is shown. Analysts are advised to be neutral blank screens and not to bring their own personalities into treatment. This means that they are not to bring their own values or attitudes into the discussion or to share personal reactions or mutual conflicts with their patients, although they may sometimes be tempted to do so. The bringing in of reality and external influences can interrupt or bias the patient’s unconscious projections. Neutrality also allows the analyst to accept without censure all forbidden or objectionable responses. **RULE OF ABSTINENCE.** The fundamental rule of abstinence does not mean corporal or sexual abstinence, but refers to the frustration of emotional needs and wishes that the patient may have toward the analyst or part of the transference. It allows the patient’s longings to persist and serve as driving forces for analytical work and motivation to change. Freud advised that the analyst carry through the analytical treatment in a state of renunciation. The analyst must deny the patient who is longing for love the satisfaction he or she craves. **Limitations.** At present, the predominant treatment constraints are often economic, relating to the high cost in time and money, both for patients and in the training of future practitioners. In addition, because clinical requirements emphasize such requisites as psychological mindedness, verbal and cognitive ability, and stable life situation, psychoanalysis may be unduly restricted to a diagnostically, socioeconomically, or

intellectually advantaged patient population. Other intrinsic issues pertain to the use and misuse of its stringent rules, whereby overemphasis on technique may interfere with an authentic human encounter between analyst and patient, and to the major long-term risk of interminability, in which protracted treatment may become a substitute for life. Reification of the classic analytical tradition may interfere with a more open and flexible application of its tenets to meet changing needs. It may also obstruct a comprehensive view of patient care that includes a greater appreciation of other treatment modalities in conjunction with, or as an alternative to, psychoanalysis. Ms. A, a 25-year-old articulate and introspective medical student, began analysis complaining of mild, chronic anxiety, dysphoria, and a sense of inadequacy, despite above-average intelligence and performance. She also expressed difficulty in longterm relationships with her male peers. Ms. A began the initial phase of analysis with enthusiastic self-disclosure, frequent reports of dreams and fantasies, and overidealization of the analyst; she tried to please him by being a compliant, good patient, just as she had been a good daughter to her father (a professor of medicine) by going to medical school. Over the next several months, Ms. A gradually developed a strong attachment to the analyst and settled into a phase of excessive preoccupation with him. Simultaneously, however, she began dating an older psychiatrist and proceeded to complain about the analyst's coldness and unresponsiveness, even considering dropping out of analysis because he did not meet her demands. In the course of analysis, through dreams and associations, Ms. A recalled early memories of her ongoing competition with her mother for her father's attention and realized that, failing to obtain his exclusive love, she had tried to become like him. She was also able to see how her increasing interest in becoming a psychiatrist (rather than following her original plan to be a pediatrician), as well as her recent choice of a man to date, were recapitulations of the past vis-à-vis the analyst. As this repeated pattern was recognized, the patient began to relinquish her intense erotic and dependent tie to the analyst, viewing him more realistically and beginning to appreciate the ways in which his quiet presence reminded her of her mother. She also became less disturbed by the similarities she shared with her mother and was able to disengage from her father more comfortably. By the fifth year of analysis, she was happily married to a classmate, was pregnant, and was a pediatric chief resident. Her anxiety was now attenuated and situation specific (that is, she was concerned about motherhood and the termination of analysis). (Courtesy of T. Byram Karasu, M.D.)

PSYCHOANALYTIC PSYCHOTHERAPY

Psychoanalytic psychotherapy, which is based on fundamental dynamic formulations and techniques that derive from psychoanalysis, is designed to broaden its scope. Psychoanalytic psychotherapy, in its narrowest sense, is the use of insight-oriented

methods only. As generically applied today to an ever-larger clinical spectrum, it incorporates a blend of uncovering and suppressive measures. The strategies of psychoanalytic psychotherapy currently range from expressive (insight-oriented, uncovering, evocative, or interpretive) techniques to supportive (relationship-oriented, suggestive, suppressive, or repressive) techniques. Although those two types of methods are sometimes regarded as antithetical, their precise definitions and the distinctions between them are by no means absolute. The duration of psychoanalytic psychotherapy is generally shorter and more variable than in psychoanalysis. Treatment may be brief, even with an initially agreed-upon or fixed time limit, or may extend to a less definite number of months or years. Brief treatment is chiefly used for selected problems or highly focused conflict, whereas longer treatment may be applied for more chronic conditions or for intermittent episodes that require ongoing attention to deal with pervasive conflict or recurrent decompensation. Unlike psychoanalysis, psychoanalytic psychotherapy rarely uses the couch;

instead, patient and therapist sit face to face. This posture helps to prevent regression because it encourages the patient to look on the therapist as a real person from whom to receive direct cues, even though transference and fantasy will continue. The couch is considered unnecessary because the free-association method is rarely used, except when the therapist wishes to gain access to fantasy material or dreams to enlighten a particular issue. Expressive Psychotherapy Indications and Contraindications. Diagnostically, psychoanalytic psychotherapy in its expressive mode is suited to a range of psychopathology with mild to moderate ego weakening, including neurotic conflicts, symptom complexes, reactive conditions, and the whole realm of nonpsychotic character disorders, including those disorders of the self that are among the more transient and less profound on the severity-of-illness spectrum, such as narcissistic behavior disorders and narcissistic personality disorders. It is also one of the treatments recommended for patients with borderline personality disorders, although special variations may be required to deal with the associated turbulent personality characteristics, primitive defense mechanisms, tendencies toward regressive episodes, and irrational attachments to the analyst. Ms. B, an intelligent and verbal 34-year-old divorced woman, presented with complaints of being unappreciated at work. Always angry and irritable, she considered quitting her job and even leaving the city. Her social life was also being negatively affected; her boyfriend had threatened to leave her because of her extremely hostile, clinging behavior (the same reason her ex-husband had given when he left her 9 years earlier after only 16 months of marriage). Her past included promiscuity and experimentation with various drugs, and, currently, she indulged in heavy drinking on weekends and occasionally smoked

marijuana. She had held many jobs and had lived in various cities. The eldest of three children of a middle-class family, she came from an unhappy and unstable home: her brother had been in and out of psychiatric hospitals; her sister had left home at the age of 16 after becoming pregnant and being forced to marry; and her overly controlling parents had subjected their children to psychological (and occasionally physical) abuse, alternating between heated arguments and passionate reconciliations. Initially, Ms. B attempted to contain her rage in treatment, but it frequently surfaced and alternated with child-like helplessness; she interrogated the psychiatrist regarding his credentials, ridiculed psychodynamic concepts, constantly challenged statements, and would demand practical advice but then denigrate or fail to follow the guidance given. The psychiatrist remained unprovoked by her aggression and explored with her the need to engage him negatively. Her response was to question and test his continued concern. When her boyfriend left her, she attempted suicide (she cut her wrists superficially), was briefly hospitalized, and, on discharge, was placed on selective serotonin reuptake inhibitors (SSRIs) for 6 months for her minor, but protracted, depression. The psychiatrist maintained their regular frequency of sessions despite her greater demands. Although she was puzzled by the steadiness of his interest, she gradually felt safe enough to express her vulnerabilities. As they explored her lack of full commitment to work, friends, and therapy, she began to understand the meaning of her anger in terms of the early abusive relationship with her parents and her tendency to bring it into contemporary relationships. With the psychiatrist's encouragement, she also began to seek work and make small strides in relationship-oriented efforts. By the end of her second year of treatment, she had decided to remain in the city, to stay at her place of employment, and to continue therapy. She needed to experience and practice her somewhat fragile new self, which included greater intimacy in relationships, additional mastery of work skills, and a more cohesive sense of self. (Courtesy of T. Byram Karasu, M.D.) The persons best suited for the expressive psychotherapy approach have

fairly well integrated egos and the capacity to both sustain and detach from a bond of dependency and trust. They are, to some degree, psychologically minded and self-motivated, and they are generally able, at least temporarily, to tolerate doses of frustration without decompensating. They must also have the ability to manage the rearousal of painful feelings outside the therapy hour without additional contact. Patients must have some capacity for introspection and impulse control, and they should be able to recognize the cognitive distinction between fantasy and reality. Goals. The overall goals of expressive psychotherapy are to increase the patient's self-awareness and to improve object relations through exploration of current interpersonal events and perceptions. In contrast to psychoanalysis, major structural

changes in ego function and defenses are modified in light of patient limitations. The aim is to achieve a more limited and, thus, select and focused understanding of one's problems. Rather than uncovering deeply hidden and past motives and tracing them back to their origins in infancy, the major thrust is to deal with preconscious or conscious derivatives of conflicts as they became manifest in present interactions. Although insight is sought, it is less extensive; instead of delving to a genetic level, greater emphasis is on clarifying recent dynamic patterns and maladaptive behaviors in the present. Major Approach and Techniques. The major modus operandi involves establishment of a therapeutic alliance and early recognition and interpretation of negative transference. Only limited or controlled regression is encouraged, and positive transference manifestations are generally left unexplored, unless they are impeding therapeutic progress; even here, the emphasis is on shedding light on current dynamic patterns and defenses. Limitations. A general limitation of expressive psychotherapy, as of psychoanalysis, is the problem of emotional integration of cognitive awareness. The major danger for patients who are at the more disorganized end of the diagnostic spectrum, however, may have less to do with the overintellectualization that is sometimes seen in neurotic patients than with the threat of decompensation from, or acting out of, deep or frequent interpretations that the patient is unable to integrate properly. Some therapists fail to accept the limitations of a modified insight-oriented approach and so apply it inappropriately to modulate the techniques and goals of psychoanalysis. Overemphasis on dreams and fantasies, zealous efforts to use the couch, indiscriminate deep interpretations, and continual focus on the analysis of transference may have less to do with the patient's needs than with those of a therapist who is unwilling or unable to be flexible. Ms. S was an attractive 30-year-old unmarried woman working as a secretary when she presented for consultation. Her chief complaints at the time were feeling "only anger and tension" and an inability to apply herself to studying voice, "which is one of the most important things to me." In obtaining a history, the therapist noted that Ms. S had never completed anything: She had dropped out of college; never pursued a music degree; and switched from job to job, and even city to city. What initially seemed like a woman with diverse interests (e.g., jobs as a research assistant, freelance copyeditor, part-time radio announcer; manager of data entry for a software company; and, most recently, secretary) really reflected a woman with a chaotic lifestyle and serious difficulties committing to anyone or anything. Although obviously intelligent, Ms. S presented with unrealistic expectations regarding her consultation. For example, after the first

consultative session, Ms. S said she felt good afterward but felt there were "no revelations yet." Because of Ms. S's inability to commit and her somewhat disorganized life, the therapist recommended a course of psychotherapy, beginning twice a week, rather than something more intense like psychoanalysis. The therapist also realized over the course of the consultation that Ms.

S would have difficulty with free association without getting disorganized. The therapist also thought that Ms. S might regress unproductively on the couch without visual contact with the therapist. Ms. S was the second oldest of four children—two brothers and a younger sister, with whom she was most competitive and who clearly seemed the mother's favorite. She described her mother as a successful professor who was demanding and critical, as if she had a "raised eyebrow" in disapproval. For example, much to her mother's chagrin, Ms. S had once wanted a sandwich "with everything on it." Ms. S was also disappointed when she was given one piece of luggage rather than a complete set for a Christmas gift. She was able to accept the therapist's interpretation that she felt "part of a set" by being one of four siblings. Ms. S initially idealized her father, who was active in the family church, but eventually saw him as disappointing and rejecting. Ms. S's ideal therapist would be "flexible," by which she meant a therapist who might do hypnosis one session, psychotherapy the next, and, maybe, analysis another session. In fact, within the first week of beginning therapy, Ms. S had simultaneously consulted a hypnotherapist, which she mentioned in passing only weeks later, for her neck pain and tension. Although she did not pursue hypnosis, she did maintain a chiropractor for most of her therapy, also something she mentioned many months after beginning therapy. She did speak of wanting to be "on best behavior" and "follow the rules." Her tremendous sense of entitlement, however, was evident: She had an expectation of getting "cut-rate prices" on everything from haircuts and car repairs to doctors' visits. Her initial fee was a much-reduced one, which she paid late and begrudgingly. Although she was seen only twice a week, Ms. S developed intense feelings for her therapist. Mostly she experienced rage when she saw evidence of the therapist's other patients, such as footprints on the waiting room floor after a snowstorm or a coat hanger turned around. She expressed the wish to keep some of her things, like bobby pins and hairspray, in the therapist's bathroom. She vacillated between feelings she wanted to move in and feelings that the therapist did not exist. For example, before she took a plane flight, she wondered who would tell her therapist if something happened to her. She had never given the therapist's name to anyone, nor did she have her name in her weekly appointment book. The therapist interpreted that she had a simultaneous wish to devalue her and not to share her with anyone else. Associations to a dream with an image of a string of baroque pearls led to thoughts that these pearls—irregular and imperfect—defective and even lopsided, represented how she viewed herself. Over the course of the next few years, Ms. S was able to commit to coming regularly to therapy, although the course was somewhat tumultuous, with many threats of

quitting and much withholding of information. At one point, she even tried to provoke the therapist by seeking a consultation with another therapist in order to "tattle" on her, just as she had tattled on her siblings. Her therapist remained unprovoked and continued to provide a safe environment for Ms. S to explore her ambivalence to the therapist and the therapeutic situation. The therapist was also able to contain Ms. S's tendency to regress, particularly with separations, by providing her with the therapist's telephone number. She had actually entered therapy with an unconscious wish to become a worldfamous singer who would win her mother's approval and praise. Her narcissism and sense of entitlement made it difficult for her to give up on that fantasy despite repeated evidence that she did not have sufficient talent. She was finally able to settle on a compromise: She began to work diligently and closely as a research assistant to her mother, who was writing a book, and as Ms. S became more focused and organized over time, she even thought she might write a book about the church. (Courtesy of T. Byram Karasu, M.D., and S. R. Karasu, M.D.)

Supportive Psychotherapy Supportive psychotherapy aims at the creation of a therapeutic

relationship as a temporary buttress or bridge for the deficient patient. It has roots in virtually every therapy that recognizes the ameliorative effects of emotional support and a stable, caring atmosphere in the management of patients. As a nonspecific attitude toward mental illness, it predates scientific psychiatry, with foundations in 18th-century moral treatment, whereby for the first time patients were treated with understanding and kindness in a humane, interpersonal environment free from mechanical restraints. Supportive psychotherapy has been the chief form used in the general practice of medicine and rehabilitation, frequently to augment extratherapeutic measures, such as prescriptions of medication to suppress symptoms, rest to remove the patient from excessive stimulation, or hospitalization to provide a structured therapeutic environment, protection, and control of the patient. It can be applied as primary or ancillary treatment. The global perspective of supportive psychotherapy (often part of a combined treatment approach) places major etiological emphasis on external rather than intrapsychic events, particularly on stressful environmental and interpersonal influences on a severely damaged self. Indications and Contraindications. Supportive psychotherapy is generally indicated for those patients for whom classic psychoanalysis or insight-oriented psychoanalytic psychotherapy is typically contraindicated—those who have poor ego strength and whose potential for decompensation is high. Amenable patients fall into the following major areas: (1) individuals in acute crisis or a temporary state of disorganization and inability to cope (including those who might otherwise be well functioning) whose intolerable life circumstances have produced extreme anxiety or

sudden turmoil (e.g., individuals going through grief reactions, illness, divorce, job loss, or who were victims of crime, abuse, natural disaster, or accident); (2) patients with chronic severe pathology with fragile or deficient ego functioning (e.g., those with latent psychosis, impulse disorder, or severe character disturbance); (3) patients whose cognitive deficits and physical symptoms make them particularly vulnerable and, thus, unsuitable for an insight-oriented approach (e.g., certain psychosomatic or medically ill persons); and (4) individuals who are psychologically unmotivated, although not necessarily characterologically resistant to a depth approach (e.g., patients who come to treatment in response to family or agency pressure and are interested only in immediate relief or those who need assistance in very specific problem areas of social adjustment as a possible prelude to more exploratory work). Mr. C, a 50-year-old married man with two sons, the owner of a small construction company, was referred by his internist after recovery from bypass surgery because of frequent, unfounded physical complaints. He was taking minor tranquilizers in increasing doses, not complying with his daily regimen, avoiding sexual contact with his wife, and had dropped out of group therapy for postsurgical patients after one session. He came to his first appointment 20 minutes late, after having “forgotten” two previous appointments. He was extremely anxious, often lost in his train of thought, and was semidelusional about his wife and sons, suggesting that they might want to have him locked up. He briefly told his life history, which included his coming from a strict and hard-working but caring middle-class family and the death of his mother when he was only 11 years old. He had joined his father’s business (taking over after his father’s death 2 years earlier), with both of his sons as associates. Describing himself as successful in work and marriage, he claimed that “the only test I ever failed was the stress test.” Mr. C explained his lack of compliance with diet restrictions as a lack of will and his constant contact with the internist as his having real physical problems not yet diagnosed; he rejected the idea of addiction to tranquilizers, insisting that he could quit any time. He had no fantasy life, remembered no dreams, made it clear that he had entered treatment on his internist’s instruction only, and started each session by stating that he had nothing to talk about. After

suggesting that Mr. C was coming to sessions just to pass the “sanity test” and that there was no reason to have him locked up, the psychiatrist encouraged the patient to join him in figuring out the real reasons for his anxiety. Initial sessions were devoted to discussing the patient’s medical condition and providing factual information about heart and bypass surgery. The therapist likened the patient’s condition to that of an older house getting new plumbing, trying to allay his unrealistic fears of impending death. As Mr. C’s anxiety declined, he became less defensive and more psychologically accessible. As the therapist began to explore his difficulty in accepting help, Mr. C was able to talk about his inability to admit

problems (i.e., weaknesses). The therapist’s explicit recognition of the patient’s strength in admitting his weaknesses encouraged the patient to reveal more about himself—how he had welcomed his father’s death and his belief that perhaps his illness was punishment. The psychiatrist also encouraged him to speak about his unrealistic guilt and, at the same time, helped him recognize his suspicion of his sons as the reflection of his own wishes concerning his father and his lack of commitment to his medical regimen as a wish to die so as to expiate guilt. After steady urging by the therapist, Mr. C returned to work. He agreed to meet monthly with the psychiatrist and to taper off his use of tranquilizers. He even agreed that he might see the psychiatrist for “deep analysis” in the future because his wife now jokingly complained of his obsessive dieting, his uncompromising exercise regimens, and his regularly scheduled sexual activities. (Courtesy of T. Byram Karasu, M.D.) Because support forms a tacit part of every therapeutic modality, it is rarely contraindicated as such. The typical attitude regards better-functioning patients as unsuitable not because they will be harmed by a supportive approach, but because they will not be sufficiently benefited by it. In aiming to maximize the patient’s potential for further growth and change, supportive therapy tends to be regarded as relatively restricted and superficial and, thus, is not recommended as the treatment of choice if the patient is available for, and capable of, a more in-depth approach. Goals. The general aim of supportive treatment is the amelioration or relief of symptoms through behavioral or environmental restructuring within the existing psychic framework. This often means helping the patient to adapt better to problems and to live more comfortably with his or her psychopathology. To restore the disorganized, fragile, or decompensated patient to a state of relative equilibrium, the major goal is to suppress or control symptomatology and to stabilize the patient in a protective and reassuring benign atmosphere that militates against overwhelming external and internal pressures. The ultimate goal is to maximize the integrative or adaptive capacities so that the patient increases the ability to cope, while decreasing vulnerability by reinforcing assets and strengthening defenses. Major Approach and Techniques. Supportive therapy uses several methods, either singly or in combination, including warm, friendly, strong leadership; partial gratification of dependency needs; support in the ultimate development of legitimate independence; help in developing pleasurable activities (e.g., hobbies); adequate rest and diversion; removal of excessive strain, when possible; hospitalization, when indicated; medication to alleviate symptoms; and guidance and advice in dealing with current issues. This therapy uses techniques to help patients feel secure, accepted, protected, encouraged, safe, and not anxious. Limitations. To the extent that much supportive therapy is spent on practical, everyday realities and on dealing with the external environment of the patient, it may

be viewed as more mundane and superficial than depth approaches. Because those patients are seen intermittently and less frequently, the interpersonal commitment may not be as compelling on the part of either the patient or the therapist. Greater severity of illness (and possible

psychoses) also makes such treatment potentially more erratic, demanding, and frustrating. The need for the therapist to deal with other family members, caretakers, or agencies (auxiliary treatment, hospitalization) can become an additional complication, because the therapist comes to serve as an ombudsman to negotiate with the outside world of the patient and with other professional peers. Finally, the supportive therapist must be able to accept personal limitations and the patient's limited psychological resources and to tolerate the often unrewarded efforts until small gains are made. Mr. W was a 42-year-old widowed businessman who was referred by his internist because of the sudden death of his wife, who had had an intracranial hemorrhage, about 2 months earlier. Mr. W had two children, a boy and a girl, ages 10 and 8 years, respectively. Mr. W had never been to a psychiatrist before, and when he arrived he admitted he was not certain what a psychiatrist could do for him. He just had to get over his wife's death. He was not sure how talking about anything could really help. He had been married for 15 years. He admitted to having difficulty sleeping, particularly awakening in the middle of the night with considerable anxiety about the future. One of his relatives had given him some of her own Klonopin for his anxiety, which helped tremendously, but he feared getting dependent on it. He was also drinking more than he thought he should. He was most concerned about raising his children alone and felt somewhat overwhelmed by the responsibility. He was beginning to appreciate just how wonderful a mother his wife had been and now saw how critical he had been of her for spending so much time with the children. "It really does take a lot of effort," he said. Mr. W did admit to feelings of guilt. For one thing, he admitted to some sense that he could now start over. He had been somewhat restless in the marriage recently before his wife's death and had actually been unfaithful for a brief period early in the marriage. He also felt some guilt that had he been awake the night of his wife's hemorrhage, maybe he could have saved his wife. In reality, there was nothing he could have done. Mr. W agreed to come for a few sessions to talk about his wife. At this point, only 2 months after her death, he seemed to have an uncomplicated mourning reaction. Although he talked easily in session, he was clearly worried that he might like "being here too much." The therapist chose not to interpret his dependency conflicts. Mr. W seemed to have good coping skills and used humor as a high-functioning defense. For example, in giving a eulogy for his wife (who had been a very popular member of their congregation), he looked around at the enormous crowd of people at the church service and said he had never seen so many people attending church before, adding,

"Sorry, Reverend." After about four sessions, Mr. W said he that felt better and no longer saw the need for further sessions. He was sleeping better and had stopped drinking excessively. The therapist suggested that he might want to continue to talk more about his guilt and his life as he went forward without his wife. The therapist was also reassuring that there seemed to be nothing else Mr. W could have done to save his wife. He also encouraged the patient to begin dating when he felt ready, something that Mr. W's inlaws were clearly not encouraging. For now, however, Mr. W was not interested in any further therapy. He was appreciative of the therapist and felt that talking about his wife's death had been helpful. The therapist accepted his wish to discontinue their sessions but encouraged Mr. W to keep in touch to let him know how he was doing. (Courtesy of T. Byram Karasu, M.D., and S. R. Karasu, M.D.)

CORRECTIVE EMOTIONAL EXPERIENCE. The relationship between therapist and patient gives a therapist an opportunity to display behavior different from the destructive or unproductive behavior of a patient's parent. At times, such experiences seem to neutralize or reverse some effects of the parents' mistakes. If the patient had overly authoritarian parents, the therapist's friendly, flexible, nonjudgmental, nonauthoritarian—but at times firm and limit setting—attitude gives the patient an opportunity to

adjust to, be led by, and identify with a new parent figure. Franz Alexander described this process as a corrective emotional experience. It draws on elements of both psychoanalysis and psychoanalytic psychotherapy.

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02 - 28.2 Brief Psychodynamic Psychotherapy

28.2 Brief Psychodynamic Psychotherapy

Siegel E. Psychoanalysis as a traditional form of knowledge: An inquiry into the methods of psychoanalysis. *Int J Appl Psychoanal Stud.* 2006;2(2):146-163. Strenger C. *The Designed Self: Psychoanalysis and Contemporary Identities.* Hillsdale, NJ: Analytic Press; 2005. Tummala-Narra P. Psychoanalytic applications in a diverse society. *Psychoanal Psychol.* 2013;30(3):471-487. Unit P. Mentalization-based treatment for psychosis: Linking an attachment-based model to the psychotherapy for impaired mental state understanding in people with psychotic disorders. *Isr J Psychiatry Relat Sci.* 2014;51(1). Varvin S. Which patients should avoid psychoanalysis, and which professionals should avoid psychoanalytic training? A critical evaluation. *Scand Psychoanal Rev.* 2003;26:109-122.

28.2 Brief Psychodynamic Psychotherapy The growth of psychotherapy in general and of dynamic psychotherapies derived from the psychoanalytic framework in particular represents a landmark achievement in the history of psychiatry. Brief psychodynamic psychotherapy has gained widespread popularity, partly because of the great pressure on health care professionals to contain treatment costs. It is also easier to evaluate treatment efficacy by comparing groups of persons who have had short-term therapy for mental illness with control groups than it is to measure the results of long-term psychotherapy. Thus, short-term therapies have been the subject of much research, especially on outcome measures, which have found them to be effective. Other short-term methods include interpersonal therapy (discussed in Section 28.10) and cognitive-behavioral therapy (discussed in Section 28.7). Brief psychodynamic psychotherapy is a time-limited treatment (10 to 12 sessions) that is based on psychoanalysis and psychodynamic theory. It is used to help persons with depression, anxiety, and posttraumatic stress disorder, among others. There are several methods, each having its own treatment technique and specific criteria for selecting patients; however, they are more similar than different. In 1946, Franz Alexander and Thomas French identified the basic characteristics of brief psychodynamic psychotherapy. They described a therapeutic experience designed to put patients at ease, to manipulate the transference, and to use trial interpretations flexibly. Alexander and

French conceived psychotherapy as a corrective emotional experience capable of repairing traumatic events of the past and convincing patients that new ways of thinking, feeling, and behaving are possible. At about the same time, Eric Lindemann established a consultation service at Massachusetts General Hospital in Boston for persons experiencing a crisis. He developed new treatment methods to deal with these situations and eventually applied these techniques to persons who were not in crisis, but who were experiencing various kinds of emotional distress. Since then, the field has been influenced by many workers such as David Malan in England, Peter Sifneos in the United States, and Habib Davanloo in Canada.

TYPES Brief Focal Psychotherapy (Tavistock-Malan) Brief focal psychotherapy was originally developed in the 1950s by the Balint team at the Tavistock Clinic in London. Malan, a member of the team, reported the results of the therapy. Malan's selection criteria for treatment included eliminating absolute

contraindications, rejecting patients for whom certain dangers seemed inevitable, clearly assessing patients' psychopathology, and determining patients' capacities to consider problems in emotional terms, face disturbing material, respond to interpretations, and endure the stress of the treatment. Malan found that high motivation invariably correlated with a successful outcome.

Contraindications to treatment were serious suicide attempts, substance dependence, chronic alcohol abuse, incapacitating chronic obsessional symptoms, incapacitating chronic phobic symptoms, and gross destructive or self-destructive acting out.

Requirements and Techniques. In Malan's routine, therapists should identify the transference early and interpret it and the negative transference. They should then link the transferences to patients' relationships with their parents. Both patients and therapists should be willing to become deeply involved and to bear the ensuing tension. Therapists should formulate a circumscribed focus and set a termination date in advance, and patients should work through grief and anger about termination. An experienced therapist should allow about 20 sessions as an average length for the therapy; a trainee should allow about 30 sessions. Malan himself did not exceed 40 interviews with his patients.

Time-Limited Psychotherapy (Boston University-Mann) A psychotherapeutic model of exactly 12 interviews focusing on a specified central issue was developed at Boston University by James Mann and his colleagues in the early 1970s. In contrast with Malan's emphasis on clear-cut selection and rejection criteria, Mann has not been as explicit about the appropriate candidates for time-limited psychotherapy. Mann considered the major emphases of his theory to be determining a patient's central conflict reasonably correctly and exploring young persons' maturational crises with many psychological and somatic complaints. Mann's exceptions, similar to his rejection criteria, include persons with major depressive disorder that interferes with the treatment agreement, those with acute psychotic states, and desperate patients who need, but cannot tolerate, object relations.

Requirements and Techniques. Mann's technical requirements included strict limitation to 12 sessions, positive transference predominating early, specification and strict adherence to a central issue involving transference, positive identification, making separation a maturational event for patients, absolute prospect of termination to avoid development of dependence, clarification of present and past experiences and resistances, active therapists who support and encourage patients, and education of patients through direct information, reeducation, and manipulation. The conflicts likely to be encountered included independence versus dependence, activity versus passivity, unresolved or delayed grief, and adequate versus inadequate self-esteem.

Short-Term Dynamic Psychotherapy (McGill University-Davanloo)

As conducted by Davanloo at McGill University, short-term dynamic psychotherapy encompasses nearly all varieties of brief psychotherapy and crisis intervention. Patients treated in Davanloo's series are classified as those whose psychological conflicts are predominantly oedipal, those whose conflicts are not oedipal, and those whose conflicts have more than one focus. Davanloo also devised a specific psychotherapeutic technique for patients with severe, long-standing neurotic problems, specifically those with incapacitating obsessive-compulsive disorders and phobias. Davanloo's selection criteria emphasize evaluating those ego functions of primary importance to psychotherapeutic work: the establishment of a psychotherapeutic focus; the psychodynamic formulation of the patient's psychological problems; the ability to interact emotionally with evaluators; a history of give-and-take relationships with a significant person in the patient's life; the patient's ability to experience and tolerate anxiety, guilt, and depression; the patient's motivations for change, psychological mindedness, and an ability to respond to interpretation and to link evaluators with persons in the present and past. Both Malan and Davanloo emphasized a patient's responses to interpretation as an important selection and prognostic criterion. Requirements and Techniques. The highlights of Davanloo's psychotherapeutic approach are flexibility (therapists should adapt the technique to the patient's needs), control, the patient's regressive tendencies, active intervention to avoid having the patient develop overdependence on a therapist, and the patient's intellectual insight and emotional experiences in the transference. These emotional experiences become corrective as a result of the interpretation. Ana, a divorced 60-year-old woman, sought psychiatric help following a severe depressive episode lasting several months. This episode, which was one of many in her life, was especially severe in terms of loss of energy, interest, and motivation, as well as in terms of the intensity of her sadness and her wish to die. Only her profound religious convictions protected her from acting on these wishes. Ana had lost a lot of weight, had trouble sleeping, experienced many nightmares, and had difficulty with concentration. She was plagued by pervasive feelings of hatred for her mother, who was very old, ill, and dependent on Ana, who was unable to forgive her for abandoning her in an orphanage when she was 5 or 6 years of age. After an extensive assessment, the dynamic formulation of Ana's problem was represented as follows:

1. Life problems: Recurrent depressive episodes plagued by feelings of guilt and selfreproach; problems with men involving choosing partners who are commonly cold, distant, or otherwise unavailable; involuntary and painful emotional distance from her children, friends, and other close relationships; and unproductive and unrewarding work life, despite considerable intellectual gifts.
2. Dynamics: Ambivalent relationship with her mother, whom she blames for most of the tragedies of her life; guilt and need for punishment in relation to her unrelenting

hatred for her mother; and pathological grief reaction for the loss of an idealized and more optimal relationship with her mother, the one she remembers she had prior to her orphanage placement. From this focus there flows a melancholic conviction of the inevitable failure of human relationships. 3. Pathogenic foci: Grief and inability to mourn the loss of her mother after she was placed in the orphanage, with attendant rage and guilt; pathological grief for the loss of her father, who, because of severe alcoholism, abandoned the family first, a move that caused the mother to place her children in an orphanage in order to be able to work and ultimately recover their care. Unconsciously, she blamed her mother for the family catastrophe, thus "protecting" an idealized view of her father, to whom she was profoundly attached. For Ana, the initial phase of treatment

focused on the clarification and the experience of her destructive impulses toward her mother, which, as they were worked through, made possible the appearance of a modicum of empathy with her mother's painful life situation around the time she placed Ana and her sisters in the orphanage. Next, the therapy focused on Ana's father. Deep feelings of idealization, disappointment, anger, and grief were experienced with increasing clarity and intensity, frequently via displaced feelings in the transference and after overcoming considerable resistance. The last phase of treatment permitted the development of realistic feelings of empathy and appreciation for her mother, now without anger or emotional distancing, and the reawakening within Ana of feelings of joy and hope, as well as professional ambition. (Courtesy of M. Trujillo, M.D.) Short-Term Anxiety-Provoking Psychotherapy (Harvard University- Sifneos) Sifneos developed short-term anxiety-provoking psychotherapy at the Massachusetts General Hospital in Boston during the 1950s. He used the following criteria for selection: a circumscribed chief complaint (implying a patient's ability to select one of a variety of problems to be given top priority and the patient's desire to resolve the problem in treatment), one meaningful or give-and-take relationship during early childhood, the ability to interact flexibly with an evaluator and to express feelings appropriately, above-average psychological sophistication (implying not only aboveaverage intelligence but also an ability to respond to interpretations), a specific psychodynamic formulation (usually a set of psychological conflicts underlying a patient's difficulties and centering on an oedipal focus), a contract between therapist and patient to work on the specified focus and the formulation of minimal expectations of outcome, and good to excellent motivation for change, not just for symptom relief. Chris, a 31-year-old single man, sought help for a moderate depressive episode precipitated by the loss of his relationship with his girlfriend, Joanna. She had broken

off the relationship after approximately 1 year, tired of Chris's erratic work ethic and emotional instability and discouraged by his fear of commitment to the future of their relationship. This cycle of infatuation, increasing fear of commitment, and relationship loss had become a pattern in Chris's interpersonal life. His work life was plagued with similar problems. Jobs were frequently lost because of serious conflict and threatening confrontations with his superiors. As conflicts arose at both work and home, Chris typically suffered increasing anxiety and episodic panic attacks. After the loss of each relationship, Chris usually confronted moderate depressive feelings, at times accompanied by suicidal ideation. After an assessment, the dynamic hologram for Chris was represented as follows:

1. Life problems: Recurrent episodes of anxiety and depression; work problems; unstable interpersonal relationships; conflict with authority figures; antagonism toward, and emotional distance from, his father, brother, and male friends; and fears of heterosexual intimacy and of commitment.
2. Dynamic forces: Ongoing hostility and envy toward males, authority figures, and successful people, and compulsive and possessive seeking of female love objects with a serious inability to consider, fulfill, or tolerate their independent needs.
3. Genetic pathogenic foci: Unconscious loss of maternal objects precipitated by birth of a brother when Chris was age 2 years; uncontrolled grief for that loss with a compulsive drive to experience child-like possession of love objects; and compulsive hostility toward others perceived as rivals. The therapist's active inquiry yielded additional confirmation of the persistence of repressed sexual feelings toward his mother and the presence of hostile feelings toward all rivals for his mother's affection. A memory suffused with very

visceral feelings emerged in this phase as a result of the therapist's active inquiry. In this memory, Chris saw himself in his mother's arms in a dark room. He remembered vividly the intense pleasure of the contact with the warm skin of his mother, the texture of her clothes, and the smell of her perfume. While narrating this memory to the therapist, Chris was so absorbed in the experience that he blushed intensely. He also described the painful termination of this moment of pleasure by his father's sudden and disruptive opening of the door and the flood of light that disturbed his pleasurable absorption. This sequence gave way to the experience of grief at the loss of the intense and exclusive bond with his mother after his brother's birth and to a reexperiencing of a sense of anger, impotence, and loneliness. These feelings were all too familiar in his present life when his romantic attachments would be threatened or lost. The affective link between this childhood experience and his intimacy problems in the present became very obvious to Chris, and the acceptance of this link enhanced his capacity to work through this essential component of his pathology. A parallel conflict appeared in the transference as the patient resented the "intrusion" of the inquiring therapist into the zealously guarded privacy of this primal fantasy of material possession. (Courtesy of M. Trujillo, M.D.)

Requirements and Techniques. Treatment can be divided into four major phases: patient-therapist encounter, early therapy, height of treatment, and evidence of change and termination. Therapists use the following techniques during the four phases. **PATIENT-THERAPIST ENCOUNTER.** A therapist establishes a working alliance by using the patient's quick rapport with, and positive feelings for, the therapist that appear in this phase. Judicious use of open-ended and forced-choice questions enables the therapist to outline and concentrate on a therapeutic focus. The therapist specifies the minimal expectations of outcome to be achieved by the therapy. **EARLY THERAPY.** In transference, feelings for the therapist are clarified as soon as they appear, a technique that leads to the establishment of a true therapeutic alliance. **HEIGHT OF THE TREATMENT.** Height of treatment emphasizes active concentration on the oedipal conflicts that have been chosen as the therapeutic focus; repeated use of anxietyprovoking questions and confrontations; avoidance of pregenital characterological issues, which the patient uses defensively to avoid dealing with the therapist's anxietyprovoking techniques; avoidance at all costs of a transference neurosis; repetitive demonstration of the patient's neurotic ways or maladaptive patterns of behavior; concentration on the anxiety-laden material, even before the defense mechanisms have been clarified; repeated demonstrations of parent-transference links by the use of properly timed interpretations based on material given by the patient; establishment of a corrective emotional experience; encouragement and support of the patient, who becomes anxious while struggling to understand the conflicts; new learning and problem-solving patterns; and repeated presentations and recapitulations of the patient's psychodynamics until the defense mechanisms used in dealing with oedipal conflicts are understood. **EVIDENCE OF CHANGE AND TERMINATION OF PSYCHOTHERAPY.** The final phase of therapy emphasizes the tangible demonstration of change in the patient's behavior outside therapy, evidence that adaptive patterns of behavior are being used, and initiation of talk about terminating the treatment. **OVERVIEW AND RESULTS** The shared techniques of all the brief psychotherapies described above outdistance their differences. They share the therapeutic alliance or dynamic interaction between therapist and patient, the use of transference, the active interpretation of a therapeutic focus or central issue, the repetitive links between parental and transference issues, and the early termination of therapy. The outcomes of these brief treatments have been investigated extensively. Contrary to prevailing ideas that the therapeutic factors in

psychotherapy are nonspecific, controlled studies and other assessment methods (e.g., interviews with unbiased evaluators, patients' self-evaluations) point to the importance of the specific techniques used. The capacity for genuine recovery in certain patients is far greater than was thought. A certain type of patient receiving brief psychotherapy can benefit greatly from a practical working through of his or her nuclear conflict in the transference. Such patients can be recognized in advance through a process of dynamic interaction, because they are responsive, motivated, and able to face disturbing feelings and because a circumscribed focus can be formulated for them. The more radical the technique in terms of transference, depth of interpretation, and the link to childhood, the more radical the therapeutic effects will be. For some disturbed patients, a carefully chosen partial focus can be therapeutically effective.

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03 - 28.3 Group

Psychotherapy, Combined Individual

28.3 Group Psychotherapy, Combined Individual and Group Psychotherapy, and Psychodrama

28.3 Group Psychotherapy, Combined Individual and Group Psychotherapy, and Psychodrama

Group psychotherapy is a modality that employs a professionally trained leader who selects, composes, organizes, and leads a collection of members to work together toward the maximal attainment of the goals for each individual in the group and for the group itself. Certain properties present in groups, such as mutual support, can be harnessed in the service of providing relief from psychological suffering and supply peer support to counter isolation experienced by many who seek psychiatric help. Similarly, homogeneously composed small groups are ideal settings for the dissemination of accurate information about a condition shared by group members. Medical illness, substance abuse, and chronic and persistent severe psychiatric conditions, including schizophrenia and major affective disorders, are cases in point. A widely accepted psychiatric treatment modality, group psychotherapy uses therapeutic forces within the group, constructive interactions among members, and interventions of a trained leader to change the maladaptive behaviors, thoughts, and feelings of emotionally distressed individuals. In an era of increasingly stringent financial constraints, decreasing emphasis on individual psychotherapies, and expanding use of psychopharmacological approaches, more patients have been treated with group psychotherapy than with any other form of verbal therapy. Group therapy is applicable to inpatient and outpatient settings, institutional work, partial hospitalization units, halfway houses, community settings, and private practice. Group psychotherapy is also widely used by those who are not mental health

professionals in the adjuvant treatment of physical disorders. The principles of group psychotherapy have also been applied with success in the fields of business and education in the form of training, sensitivity, and role-playing. Group psychotherapy is a treatment in which carefully selected persons who are emotionally ill meet in a group guided by a trained therapist and help one another effect personality change. By using a variety of technical maneuvers and theoretical constructs, the leader directs group members' interactions to bring about changes.

CLASSIFICATION Group therapy at present has many approaches. Some clinicians work within a psychoanalytic frame of reference. Others use therapy techniques, such as transactional group therapy, which was devised by Eric Berne and emphasizes the here-and-now interactions among group members; behavioral group therapy, which relies on conditioning techniques based on learning theory; Gestalt group therapy, which was created from the theories of Frederick Perls, enables patients to abreact and express themselves fully; and client-centered group psychotherapy, which was developed by Carl Rogers and is based on the nonjudgmental expression of feelings among group members. Table 28.3-1 outlines the major group psychotherapy approaches.

Table 28.3-1 Comparison of Types of Group Psychotherapy

PATIENT SELECTION To determine a patient's suitability for group psychotherapy, a therapist needs a great deal of information, which is gathered in a screening interview. The psychiatrist should take a psychiatric history and perform a mental status examination to obtain certain dynamic, behavioral, and diagnostic information. Table 28.3-2 outlines the general criteria for the selection of patients for group therapy.

Table 28.3-2 Therapist's Role in Group Therapy

Authority Anxiety Those patients whose primary problem is their relationship to authority and who are extremely anxious in the presence of authority figures may do well in group therapy because they are more comfortable in a group and more likely to do better in a group than in a dyadic (one-to-one) setting. Patients with a great deal of authority anxiety may be blocked, anxious, resistant, and unwilling to verbalize thoughts and feelings in an individual setting, generally for fear of the therapist's censure or disapproval. Thus, they may welcome the suggestion of group psychotherapy to avoid the scrutiny of the dyadic situation. Conversely, if a patient reacts negatively to the suggestion of group psychotherapy or openly resists the idea, the therapist should consider the possibility that the patient has high peer anxiety.

Peer Anxiety Patients with conditions such as borderline and schizoid personality disorders who have destructive relationships with their peer groups or who have been extremely isolated from peer group contact generally react negatively or anxiously when placed in a group setting. When such patients can work through their anxiety, however, group therapy can be beneficial.

Robert entered therapy seeking to understand why he was unable to maintain close or lasting relationships. A handsome and successful businessman, he had made a painful and courageous transition away from self-centered, dysfunctional parents early in his life. Although he made good initial impressions in his jobs, he was always puzzled and disappointed when his superiors gradually lost interest in him and his colleagues avoided him. In one-on-one therapy, he was charming and entertaining, but was easily injured by perceived narcissistic slights and would become angry and attacking. Group psychotherapy was suggested when his transference feelings remained intense and therapy was at a seeming impasse. Initially, Robert charmed the group and strove to be the center of attention. Visibly annoyed whenever he felt the group leader was paying more attention to other members, Robert was especially critical and hostile toward older people in the group and displayed little empathy for others. After repeated and forceful confrontations from

the group about his

antagonistic behavior, he gradually realized that he was repeating childhood patterns in his family of desperately seeking the attention of unloving parents and then entering violent rages when they lost interest. (Courtesy of Normund Wong, M.D.)

Diagnosis The diagnosis of patients' disorders is important in determining the best therapeutic approach and in evaluating patients' motivations for treatment, capacities for change, and personality structure strengths and weaknesses. Few contraindications exist to group therapy. Antisocial patients generally do poorly in a heterogeneous group setting because they cannot adhere to group standards; but if the group is composed of other antisocial patients, they may respond better to peers than to perceived authority figures. Depressed patients profit from group therapy after they have established a trusting relationship with the therapist. Patients who are actively suicidal or severely depressed should not be treated solely in a group setting. Patients who are manic are disruptive but, once under pharmacological control, do well in the group setting. Patients who are delusional and who may incorporate the group into their delusional system should be excluded, as should patients who pose a physical threat to other members because of uncontrollable aggressive outbursts.

PREPARATION Patients prepared by a therapist for a group experience tend to continue in treatment longer and report less initial anxiety than those who are not prepared. The preparation consists of having a therapist explain the procedure in as much detail as possible and answer the patient's questions before the first session.

STRUCTURAL ORGANIZATION Table 28.3-2 summarizes some of the critical tasks that a group therapist must face when organizing a group. Size Group therapy has been successful with as few as 3 members and as many as 15, but most therapists consider 8 to 10 members the optimal size. Interaction may be insufficient with fewer members unless they are especially verbal, and with more than 10 members, the interaction may be too great for the members or the therapist to follow. Frequency and Length of Sessions Most group psychotherapists conduct group sessions once a week. Maintaining continuity in sessions is important. When there are alternate sessions, the group meets

twice a week, once with and once without the therapist. Group sessions generally last anywhere from 1 to 2 hours, but the time limit should be constant. Marathon groups were most popular in the 1970s but are much less common today. In time-extended therapy (marathon group therapy), the group meets continuously for 12 to 72 hours. Enforced interactional proximity and, during the longest time-extended sessions, sleep deprivation break down certain ego defenses, release affective processes, and theoretically promote open communication. Time-extended sessions, however, can be dangerous for patients with weak ego structures, such as persons with schizophrenia or borderline personality disorder.

Homogeneous versus Heterogeneous Groups Most therapists believe that groups should be as heterogeneous as possible to ensure maximal interaction. Members with different diagnostic categories and varied behavioral patterns; from all races, social levels, and educational backgrounds; and of varying ages and both sexes should be brought together. Patients between the ages of 20 and 65 years can be included effectively in the same group. Age differences help in developing parent-child and brother-sister models, and patients have the opportunity to relive and rectify interpersonal difficulties that may have appeared insurmountable. Both children and adolescents are best treated in groups comprising mostly persons in their own age groups. Some adolescent patients are capable of assimilating the material of an adult group, regardless of content, but they should not be deprived of a constructive peer experience that they might otherwise not have.

Open versus Closed Groups Closed groups

have a set number and composition of patients. If members leave, no new members are accepted. In open groups, membership is more fluid, and new members are taken on whenever old members leave. MECHANISMS Group Formation Each patient approaches group therapy differently and, in this sense, groups are microcosms. Patients use typical adaptive abilities, defense mechanisms, and ways of relating, and when these tactics are ultimately reflected back to them by the group, they learn to be introspective about their personality functioning. A process inherent in group formation requires that patients suspend their previous ways of coping. In entering the group, they allow their executive ego functions—reality testing, adaptation to and mastery of the environment, and perception—to be assumed, to some degree, by the collective assessment provided by the total membership, including the leader. Therapeutic Factors

Table 28.3-3 outlines 20 significant therapeutic factors that account for change in group psychotherapy. Table 28.3-3 Twenty Therapeutic Factors in Group Psychotherapy ROLE OF THE THERAPIST Although opinions differ about how active or passive a group therapist should be, the consensus is that the therapist's role is primarily facilitative. Ideally, the group members themselves are the primary source of cure and change. The climate produced by the therapist's personality is a potent agent of change. The therapist is more than an expert

applying techniques; he or she exerts a personal influence that taps such variables as empathy, warmth, and respect. INPATIENT GROUP PSYCHOTHERAPY Group therapy is an important part of hospitalized patients' therapeutic experiences. Groups can be organized in many ways on a ward. In a community meeting, an entire inpatient unit meets with all the staff members (e.g., psychiatrists, psychologists, and nurses). In team meetings, 15 to 20 patients and staff members meet; a regular or small group comprising eight to ten patients may meet with one or two therapists, as in traditional group therapy. Although the goals of each group vary, they all have common purposes: to increase patients' awareness of themselves through their interactions with the other group members, who provide feedback about their behavior; to provide patients with improved interpersonal and social skills; to help the members adapt to an inpatient setting; and to improve communication between patients and staff. In addition, one type of group meeting is attended only by inpatient hospital staff and is meant to improve communication among the staff members and to provide mutual support and encouragement in their day-to-day work with patients. Community meetings and team meetings are more helpful for dealing with patient treatment problems than they are for providing insight-oriented therapy, which is the province of the small-group therapy meeting. Group Composition Two key factors of inpatient groups common to all short-term therapies are the heterogeneity of the members and the rapid turnover of patients. Outside the hospital, therapists have large caseloads from which to select patients for group therapy. On the ward, therapists have a limited number of patients to choose from and are further restricted to those patients who are both willing to participate and suitable for a small-group experience. In certain settings, group participation may be mandatory (e.g., in substance abuse and alcohol dependence units), but mandatory attendance does not usually apply in a general psychiatry unit. In fact, most group experiences are more productive when the patients themselves choose to enter them. More sessions are preferable to fewer. During patients' hospital stays, groups may meet daily to allow interactional continuity and the carryover of themes from one session to the next. A new member of a group can be brought up to date quickly, either by the therapist in an orientation meeting or by one of the members. A newly admitted patient has often learned many details about the small-group program from another patient before actually

attending the first session. The less frequently the group sessions are held, the greater the need for a therapist to structure the group and be active in it. Inpatient versus Outpatient Groups
Although the therapeutic factors that account for change in small inpatient groups are

similar to those in the outpatient settings, there are qualitative differences. For example, the relatively high turnover of patients in inpatient groups complicates the process of cohesion. But the fact that all the group members are together in the hospital aids cohesion, as do the therapists' efforts to foster the process. Sharing of information, universalization, and catharsis are the main therapeutic factors at work in inpatient groups. Although insight more likely occurs in outpatient groups because of their longterm nature, some patients can obtain a new understanding of their psychological makeup within the confines of a single group session. A unique quality of inpatient groups is the patients' extragroup contacts, which are extensive because they live together on the same ward. Verbalizing their thoughts and feelings about such contacts in the therapy sessions encourages interpersonal learning. In addition, conflicts between patients or between patients and staff members can be anticipated and resolved. Twelve former psychiatric inpatients who attended the monthly medication clinic would meet for 1 hour before their individual appointments with the psychiatrist to review their current social situation and medications. All had been treated by the same ward doctor and had known one another while on the inpatient service. The psychiatrist who performed the medication reviews also served as the group leader. Periodically, he was assisted by a staff member who was also familiar with the patients. Coffee was available, and the patients often brought pastries from home. The patients socialized with one another during the hour and frequently exchanged helpful ideas and tips about job opportunities. Those without cars shared rides with other members. The group was open ended and well attended. Most of the patients were single and had a long history of psychotic illness. For most, this meeting was their only opportunity to socialize and be among peers. Frequently, on learning that a member had been rehospitalized, many in the group would visit their colleague on the ward. (Courtesy of Normund Wong, M.D.)

SELF-HELP GROUPS Self-help groups comprise persons who are trying to cope with a specific problem or life crisis and are usually organized with a particular task in mind. Such groups do not attempt to explore individual psychodynamics in great depth or to change personality functioning significantly, but self-help groups have improved the emotional health and well-being of many persons. A distinguishing characteristic of the self-help groups is their homogeneity. The members have the same disorders and share their experiences—good and bad, successful and unsuccessful—with one another. By so doing, they educate one another, provide mutual support, and alleviate the sense of alienation usually felt by persons drawn to this kind of group. Self-help groups emphasize cohesion, which is exceptionally strong in these groups. Because the group members have similar problems and symptoms, they develop a strong

emotional bond. Each group may have its unique characteristics, to which the members can attribute magical qualities of healing. Examples of self-help groups are Alcoholics Anonymous (AA), Gamblers Anonymous (GA), and Overeaters Anonymous (OA). The self-help group movement is presently in ascendancy. These groups meet their members' needs by providing acceptance, mutual support, and help in overcoming maladaptive patterns of behavior or states of feeling that traditional mental health and medical professionals have not generally dealt with successfully. Self-help groups and therapy groups have begun to converge. Self-help groups have enabled their members to give up patterns of unwanted behavior; therapy groups have helped their members understand why and how they got to be the way they were or are. **COMBINED INDIVIDUAL AND**

GROUP PSYCHOTHERAPY In combined individual and group psychotherapy, patients see a therapist individually and also take part in group sessions. The therapist for the group and individual sessions is usually the same person. Groups can vary in size from 3 to 15 members, but the most helpful size is 8 to 10. Patients must attend all group sessions. Attendance at individual sessions is also important, and failure to attend either group or individual sessions should be examined as part of the therapeutic process. Combined therapy is a particular treatment modality, not a system by which individual therapy is augmented by an occasional group session or a group therapy in which a participant meets alone with a therapist from time to time. Rather, it is an ongoing plan in which meaningful integration of the group experience with the individual sessions yields reciprocal feedback to help form an integrated therapeutic experience. Although the one-to-one doctor-patient relationship makes a deep examination of the transference reaction possible for some patients, it may not provide other patients with the corrective emotional experiences necessary for therapeutic change. The group gives patients a variety of persons with whom they can have transference reactions. In the microcosm of the group, patients can relive and work through familial and other important influences. Techniques Differing techniques based on varying theoretical frameworks have been used in the combined therapy format. Some clinicians increase the frequency of individual sessions to encourage the emergence of the transference neurosis. In the behavioral model, individual sessions are scheduled regularly, but they tend to be less frequent than in other approaches. Whether patients use a couch or a chair during individual sessions depends on a therapist's orientation. Techniques such as alternate meetings or "aftersessions" without the therapist present may be used. A combined therapy approach called structured interactional group psychotherapy has a different group member as the focus of each weekly group session who is discussed in depth by the other members.

Results Most workers in the field believe that combined therapy has the advantages of both dyadic and group settings, without sacrificing the qualities of either. Generally, the dropout rate in combined therapy is lower than that in group therapy alone. In many cases, combined therapy appears to bring problems to the surface and to resolve them more quickly than might be possible with either method alone.

PSYCHODRAMA Psychodrama is a method of group psychotherapy originated by the Viennese-born psychiatrist Jacob Moreno in which personality makeup, interpersonal relationships, conflicts, and emotional problems are explored by means of special dramatic methods. Therapeutic dramatization of emotional problems includes the protagonist or patient, the person who acts out problems with the help of auxiliary egos, persons who enact varying aspects of the patient, and the director, psychodramatist, or therapist, the person who guides those in the drama toward the acquisition of insight.

Roles Director. The director is the leader or therapist and so must be an active participant. He or she has a catalytic function by encouraging the members of the group to be spontaneous. The director must also be available to meet the group's needs without superimposing his or her values. Of all the group psychotherapies, psychodrama requires the most participation from the therapist.

Protagonist. The protagonist is the patient in conflict. The patient chooses the situation to portray in the dramatic scene, or the therapist chooses it if the patient so desires.

Auxiliary Ego. An auxiliary ego is another group member who represents something or someone in the protagonist's experience. The auxiliary egos help account for the great range of therapeutic effects available in psychodrama.

Group. The members of the psychodrama and the audience make up the group. Some are participants, and others are observers, but all benefit from the experience to the extent that they can identify with the ongoing events. The concept of spontaneity in psychodrama refers to the ability of each

member of the group, especially the protagonist, to experience the thoughts and feelings of the moment and to communicate emotion as authentically as possible. Techniques The psychodrama can focus on any special area of functioning (a dream, a family, or a

community situation), a symbolic role, an unconscious attitude, or an imagined future situation. Such symptoms as delusions and hallucinations can also be acted out in the group. Techniques to advance the therapeutic process and to increase productivity and creativity include the soliloquy (a recital of overt and hidden thoughts and feelings), role reversal (the exchange of the patient's role for the role of a significant person), the double (an auxiliary ego acting as the patient), the multiple double (several egos acting as the patient did on varying occasions), and the mirror technique (an ego imitating the patient and speaking for him or her). Other techniques include the use of hypnosis and psychoactive drugs to modify the acting behavior in various ways. ETHICAL AND LEGAL ISSUES Confidentiality Except where disclosure is required by law, the group therapist legally and ethically gives information about the group members to others only after obtaining appropriate patient consent. The therapist is obligated to take appropriate steps to be responsible to society, as well as to patients, when patients pose a danger to themselves or to others. The guidelines for ethics of the American Group Psychotherapy Association state that therapists must obtain specific permission to confer with the referring therapist or with the individual therapist when the patient is in conjoint therapy. Although the group members, as well as the therapist, should protect the identity of the members and maintain confidentiality, the group members are not legally bound to do so. During the preparation of patients for group psychotherapy, therapists should routinely instruct the prospective members to keep all material discussed in the group confidential. Theoretically, in a legal case, one member of a group can be asked to testify against another, but such a situation has not yet occurred. A therapist must exercise clinical judgment and caution in placing a patient in a group if he or she thinks that the burdens of maintaining secrets will be too great for some potential members or if a prospective group patient harbors a secret of such magnitude or notoriety that membership in a group would not be wise. Violence and Aggression Although reports of violence and aggression are rare, the potential exists that a group member may physically attack another patient or a therapist. The attack may occur within the group or outside the group. The likelihood of such an event can be diminished through the careful selection of group members. Patients with a demonstrated history of assaultive behavior and psychotic patients who pose a potential for violence should not be placed in a group. In institutional settings, in which group therapy is commonly practiced, sufficient safeguards must be in place to discourage any physical danger to others—for example, guards or attendants can act as observers. Sexual Behavior

For therapists, sexual intercourse with a patient or a former patient is unethical; in many states, such behavior is considered a criminal act. The issue is complicated in group psychotherapy, however, because members may engage in sexual activities with one another. The issues of pregnancy, rape, and the transmission of acquired immunodeficiency syndrome (AIDS) by group members are open questions. If a patient is injured as a result of sexual activity by group members, the therapist could be held accountable for not preventing such behavior. The therapist should advise prospective group members that each patient is responsible for reporting any sexual contact between members. The therapist cannot anticipate every group sexual encounter or prevent sexual relationships from developing, but he or she is obligated to provide patients with guidelines of acceptable behavior. The therapist should identify sexual, vulnerable, or exploitive

patients in the selection and preparation of patients for the group. Sociopathic patients who sexually exploit others should be informed that such behavior is explicitly not acceptable in the group and that such behavior should be verbalized rather than acted out. The group must be conducted in such a way that the therapist does not encourage or tacitly allow sexual activity. Patients with AIDS are encouraged to reveal that they harbor the virus. To protect members if sexual relationships occur, some therapists do not accept patients with AIDS into a group unless they agree to reveal their condition. In those situations, the therapist discusses the issue of AIDS with the patient and the group into which the patient is to be placed.

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04 - 28.4 Family Therapy and Couples Therapy

28.4 Family Therapy and Couples Therapy

Zoger S, Suedland J, Holgers K. Benefits from group psychotherapy in treatment of severe refractory tinnitus. *J Psychosom Res.* 2003;55:134. 28.4 Family Therapy and Couples Therapy

FAMILY THERAPY The family is the foundation on which most societies are built. The study of families in different cultures has been a subject of fascination and scientific interest from viewpoints as diverse as sociology, group dynamics, anthropology, ethnicity, race, evolutionary biology, and, of course, the mental health field. The confluence of information gleaned from family studies has set the backdrop against which the contemporary practice of family therapy has evolved. Family therapy can be defined as any psychotherapeutic endeavor that explicitly focuses on altering the interactions between or among family members and seeks to improve the functioning of the family as a unit, or its subsystems, and the functioning of individual members of the family. Both family therapy and couple therapy aim at some change in relational functioning. In most cases, they also aim at some other change, typically in the functioning of specific individuals in the family. Family therapy meant to heal a rift between parents and their adult children is an example of the use of family therapy centered on relationship goals. Family therapy aimed at increasing the family's coping with schizophrenia and at reducing the family's expressed emotion is an example of family therapy aimed at individual goals (in this case, the functioning of the person with schizophrenia), as well as family goals. In the early years of family therapy, change in the family system was seen as being sufficient to produce individual change. More recent treatments aimed at change in individuals, as well as in the family system, tend to supplement the interventions that focus on interpersonal relationships with specific strategies that focus on individual behavior. **Indications** The presence of a relational difficulty is a clear indication for family and couple therapy. Couples and family therapies are the only treatments that have been shown to be efficacious for such problems as marital maladjustment, and other methods, such as individual therapy, have been shown to often have deleterious effects in these situations. Couples and family therapy has also been demonstrated to have a clear and important role in the treatment of numerous specific psychiatric disorders, often as a component within a multimethod treatment. Of course, as with any therapy, the indications for family and couple therapy are broad and vary from case to case. Family therapy is a therapeutic collage of ideas regarding the underpinnings of family and individual stability and change, psychopathology, and problems in living, as well as relational

ethics. Family therapy might better be called systemically sensitive therapy and, in this sense, reflects a basic

worldview as much as a clinical treatment methodology. For therapists thus inclined, then, all clinical problems involve salient interactional components; thus, some kind of family (or other functionally significant other's) involvement in therapy is always called for, even in treatment that emphasizes individual problems. An impressive array now exists of common clinical disorders and problems, including child, adolescent, and adult disorders, for which research has demonstrated family or couple treatment methods to be effective. In a few instances, couple and family interventions are probably even the treatment of choice, and for several disorders, the research argues for family intervention to be an essential part of treatment. Techniques Initial Consultation. Family therapy is familiar enough to the general public for families with a high level of conflict to request it specifically. When the initial complaint is about an individual family member, however, pretreatment work may be needed. Underlying resistance to a family approach typically includes fears by parents that they will be blamed for their child's difficulties, that the entire family will be pronounced sick, that a spouse will object, and that open discussion of one child's misbehavior will have a negative influence on siblings. Refusal by an adolescent or young adult patient to participate in family therapy is frequently a disguised collusion with the fears of one or both parents. Interview Technique. The special quality of a family interview springs from two important facts. A family comes to treatment with its history and dynamics firmly in place. To a family therapist, the established nature of the group, more than the symptoms, constitutes the clinical problem. Family members usually live together and, at some level, depend on one another for their physical and emotional well-being. Whatever transpires in the therapy session is known to all. Central principles of technique also derive from these facts. For example, the therapist must carefully channel the catharsis of anger by one family member toward another. The person who is the object of the anger will react to the attack, and the anger may escalate into violence and fracture relationships, with one or more member withdrawing from therapy. For another example, free association is inappropriate in family therapy because it can encourage one person to dominate a session. Thus, therapists must always control and direct the family interview. Table 28.4-1 summarizes the principles in which the history of the family is examined in an effort to understand how that history informs the current familial interactions. Table 28.4-1 Rationale for Family-Life Chronology

Frequency and Length of Treatment. Unless an emergency arises, sessions are usually held no more than once a week. Each session, however, may require as much as 2 hours. Long sessions can include an intermission to give the therapist time to organize the material and plan a response. A flexible schedule is necessary when geography or personal circumstances make it physically difficult for the family to get together. The length of treatment depends both on the nature of the problem and on the therapeutic model. Therapists who use problem-solving models exclusively may accomplish their goals in a few sessions, whereas therapists using growth-oriented models may work with a family for years and may schedule sessions at long intervals. Table 28.4-2 summarizes one model for treatment termination. Table 28.4-2 Criteria for Treatment Termination

Models of Intervention Many models of family therapy exist, none of which is superior to the others. The particular model used depends on the training received, the context in which therapy occurs, and the personality of the therapist. Psychodynamic-Experiential Models. Psychodynamic-

experiential models emphasize individual maturation in the context of the family system and are free from unconscious patterns of anxiety and projection rooted in the past. Therapists seek to establish an intimate bond with each family member, and sessions alternate between the therapist's exchanges with the members and the members' exchanges with one another. Clarity of communication and honestly admitted feelings are given high priority. Toward this end, family members may be encouraged to change their seats, to touch each other, and to make direct eye contact. Their use of metaphor, body language, and parapraxes helps reveal the unconscious pattern of family relationships. The therapist may also use family sculpting, in which family members physically arrange one another in tableaux depicting their personal view of relationships, past or present. The therapist both interprets the living sculpture and modifies it in a way to suggest new relationships. In addition, the therapist's subjective responses to the family are given great importance. At appropriate moments, the therapist expresses these responses to the family to form yet another feedback loop of self-observation and change.

Bowen Model. Murray Bowen called his model family systems, but in the family therapy field it rightfully carries the name of its originator. The hallmark of the Bowen model is persons' differentiation from their family of origin, their ability to be their true selves in the face of familial or other pressures that threaten the loss of love or social position. Problem families are assessed on two levels: the degree of their enmeshment versus the degree of their ability to differentiate and the analysis of emotional triangles in the problem for which they seek help. An emotional triangle is defined as a three-party system (and many of these can exist

within a family) arranged so that the closeness of two members expressed as either love or repetitive conflict tends to exclude a third. When the excluded third person attempts to join with one of the other two or when one of the involved parties shifts in the direction of the excluded one, emotional cross-currents are activated. The therapist's role is, first, to stabilize or shift the "hot" triangle—the one producing the presenting symptoms—and, second, to work with the most psychologically available family members, individually if necessary, to achieve sufficient personal differentiation so that the hot triangle does not recur. To preserve his or her neutrality in the family's triangles, the therapist minimizes emotional contact with family members. Bowen also originated the genogram, a theoretical tool that is a historical survey of the family, going back several generations.

Structural Model. In a structural model, families are viewed as single, interrelated systems assessed in terms of significant alliances and splits among family members, hierarchy of power (parents in charge of children), clarity and firmness of boundaries between the generations, and family tolerance for one another. The structural model uses concurrent individual and family therapy.

General Systems Model. Based on general systems theory, a general systems model holds that families are systems and that every action in a family produces a reaction in one or more of its members. Families have external boundaries and internal rules. Every member is presumed to play a role (e.g., spokesperson, persecutor, victim, rescuer, symptom bearer, nurturer), which is relatively stable, but which member fills each role may change. Some families try to scapegoat one member by blaming him or her for the family's problems (the identified patient). If the identified patient improves, another family member may become the scapegoat. The general systems model overlaps with some of the other models presented, particularly the Bowen and structural models.

Modifications of Techniques Family Group Therapy. Family group therapy combines several families into a single group. Families share mutual problems and compare their interactions with those of the other families in the group. Treatment of schizophrenia has been effective in multiple family groups. Parents of disturbed children may also meet together

to share their situations. **Social Network Therapy.** In social network therapy, the social community or network of a disturbed patient meets in group sessions with the patient. The network includes those with whom the patient comes into contact in daily life, not only the immediate family but also relatives, friends, tradespersons, teachers, and coworkers. **Paradoxical Therapy.** With the paradoxical therapy approach, which evolved from the work of Gregory Bateson, a therapist suggests that the patient intentionally

engage in the unwanted behavior (called the paradoxical injunction) and, for example, avoid a phobic object or perform a compulsive ritual. Although paradoxical therapy and the use of paradoxical injunctions seem to be counterintuitive, the therapy can create new insights for some patients. It is used in individual therapy as well as in family therapy. **Reframing.** Reframing, also known as positive connotation, is a relabeling of all negatively expressed feelings or behavior as positive. When the therapist attempts to get family members to view behavior from a new frame of reference, "This child is impossible" becomes "This child is desperately trying to distract and protect you from what he or she perceives as an unhappy marriage." Reframing is an important process that allows family members to view themselves in new ways that can produce change. **Goals** Family therapy has several goals: to resolve or reduce pathogenic conflict and anxiety within the matrix of interpersonal relationships; to enhance the perception and fulfillment by family members of one another's emotional needs; to promote appropriate role relationships between the sexes and generations; to strengthen the capacity of individual members and the family as a whole to cope with destructive forces inside and outside the surrounding environment; and to influence family identity and values so that members are oriented toward health and growth. The therapy ultimately aims to integrate families into the large systems of society, extended family, and community groups and social systems, such as schools, medical facilities, and social, recreational, and welfare agencies. **COUPLES (MARITAL) THERAPY** Couples or marital therapy is a form of psychotherapy designed to psychologically modify the interaction of two persons who are in conflict with each other over one parameter or a variety of parameters—social, emotional, sexual, or economic. In couples therapy, a trained person establishes a therapeutic contract with a patient couple and, through definite types of communication, attempts to alleviate the disturbance, to reverse or change maladaptive patterns of behavior, and to encourage personality growth and development. Marriage counseling may be considered more limited in scope than marriage therapy: Only a particular familial conflict is discussed, and the counseling is primarily task oriented, geared to solving a specific problem, such as child rearing. Marriage therapy, by contrast, emphasizes restructuring a couple's interaction and sometimes explores the psychodynamics of each partner. Both therapy and counseling stress helping marital partners cope effectively with their problems. Most important is the definition of appropriate and realistic goals, which may involve extensive reconstruction of the union or problem-solving approaches or a combination of both.

Types of Therapies Individual Therapy. In individual therapy, the partners may consult different therapists, who do not necessarily communicate with each other and indeed may not even know each other. The goal of treatment is to strengthen each partner's adaptive capacities. At times, only one of the partners is in treatment; and, in such cases, it is often helpful for the person who is not in treatment to visit the therapist. The visiting partner may give the therapist data about the patient that may otherwise be overlooked; overt or covert anxiety in the visiting partner as a result of change in the patient can be identified and dealt with; irrational beliefs about treatment events

can be corrected; and conscious or unconscious attempts by the partner to sabotage the patient's treatment can be examined. Individual Couples Therapy. In individual couples therapy, each partner is in therapy, which is either concurrent, with the same therapist, or collaborative, with each partner seeing a different therapist. Conjoint Therapy. In conjoint therapy, the most common treatment method in couples therapy, either one or two therapists treat the partners in joint sessions. Cotherapy with therapists of both sexes prevents a particular patient from feeling ganged up on when confronted by two members of the opposite sex. Four-Way Session. In a four-way session, each partner is seen by a different therapist, with regular joint sessions in which all four persons participate. A variation of the four-way session is the roundtable interview, developed by William Masters and Virginia Johnson for the rapid treatment of sexually dysfunctional couples. Two patients and two opposite-sex therapists meet regularly. Group Psychotherapy. Group therapy for couples allows a variety of group dynamics to affect the participants. Groups usually consist of three to four couples and one or two therapists. The couples identify with one another and recognize that others have similar problems; each gains support and empathy from fellow group members of the same or opposite sex. They explore sexual attitudes and have an opportunity to gain new information from their peer groups, and each receives specific feedback about his or her behavior, either negative or positive, which may have more meaning and be better assimilated coming from a neutral, nonspouse member, for example, than from the spouse or the therapist. During the middle phase of a couples group comprising four couples, the theme of whether to have children arose. One couple had just come from a visit to the gynecologist, who informed them that they were running out of time because of the wife's age. The woman in the couple did not want to have children, but her husband

did. His complaint about the marriage was that his wife never was demonstrative in showing her loving feelings for him. He felt her to be detached, distant, and sexually inhibited. The prevailing sentiment among the other couples who had children was that children only added additional stress to an already stressed relationship. One other couple, however, voiced their different view by describing how their children had enriched their lives. As the talk about going forward and getting pregnant progressed, the group leader noted the nonverbal communication between the ambivalent couple. Whenever the tone of the group leaned toward having children, the wife would reach out and grasp the hand of her husband in a tender way. This invariably had the effect of stopping him from pursuing the topic for fear of the withdrawal of the affection he hungered for. All this occurred without words. Once identified, this repetitive nonverbal pattern was available for examination in the group, and the supportive elements provided by other members and the leader encouraged a frank, direct, and open conversation between the partners, who eventually chose to go forward and attempt to have a child. (Courtesy of H. I. Spitz, M.D., and S. Spitz, ACSW.) Combined Therapy. Combined therapy refers to all or any of the preceding techniques used concurrently or in combination. Thus, a particular patient-couple may begin treatment with one or both partners in individual psychotherapy, continue in conjoint therapy with the partner, and terminate therapy after a course of treatment in a married couples' group. The rationale for combined therapy is that no single approach to marital problems has been shown to be superior to another. A familiarity with a variety of approaches thus allows therapists a flexibility that provides maximal benefit for couples in distress. Indications Whatever the specific therapeutic technique, initiation of couples therapy is indicated when individual therapy has failed to resolve the relationship difficulties, when the onset of distress in one or both partners is clearly a relational problem, and when couples therapy is requested by a couple in conflict. Problems in

communication between partners are a prime indication for couples therapy. In such instances, one spouse may be intimidated by the other, may become anxious when attempting to tell the other about thoughts or feelings, or may project unconscious expectations onto the other. The therapy is geared toward enabling each partner to see the other realistically. Conflicts in one or several areas, such as the partners' sexual life, are also indications for treatment. Similarly, difficulty in establishing satisfactory social, economic, parental, or emotional roles implies that a couple needs help. Clinicians should evaluate all aspects of the marital relationship before attempting to treat only one problem, which could be a symptom of a pervasive marital disorder.

Contraindications Contraindications for couples therapy include patients with severe forms of psychosis, particularly patients with paranoid elements and those in whom the marriage's homeostatic mechanism is a protection against psychosis, marriages in which one or both partners really want to divorce, and marriages in which one spouse refuses to participate because of anxiety or fear.

Goals Nathan Ackerman defined the aims of couples therapy as follows: The goals of therapy for partner relational problems are to alleviate emotional distress and disability and to promote the levels of well-being of both partners together and of each as an individual. Ideally, therapists move toward these goals by strengthening the shared resources for problem solving, by encouraging the substitution of adequate controls and defenses for pathogenic ones, by enhancing both the immunity against the disintegrative effects of emotional upset and the complementarity of the relationship, and by promoting the growth of the relationship and of each partner. Part of a therapist's task is to persuade each partner in the relationship to take responsibility in understanding the psychodynamic makeup of personality. Each person's accountability for the effects of behavior on his or her own life, the life of the partner, and the lives of others in the environment is emphasized, and the result is often a deep understanding of the problems that created the marital discord. Couples therapy does not ensure the maintenance of any marriage or relationship. Indeed, in certain instances, it may show the partners that they are in a nonviable union that should be dissolved. In these cases, couples may continue to meet with therapists to work through the difficulties of separating and obtaining a divorce, a process that has been called divorce therapy.

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05 - 28.5 Dialectical Behavior Therapy

28.5 Dialectical Behavior Therapy

Snyder DK, Whisman MA, eds. *Treating Difficult Couples*. New York: Guilford; 2003. Spitz HI, Spitz S. Family and couple therapy. In: Sadock BJ, Sadock VA, Ruiz P, eds. *Kaplan & Sadock's Comprehensive Textbook of Psychiatry*. 9th ed. Vol. 2. Philadelphia: Lippincott Williams & Wilkins; 2009:2845. Walker MD. When clients want your help to "pray away the gay": Implications for couple and family therapists. *J Fam Fam Ther*. 2013;25(2):112-134.

28.5 Dialectical Behavior Therapy Dialectical behavior therapy (DBT) is the psychosocial treatment that has received the most empirical support for patients with borderline personality disorder. Put simply, the overarching goal of DBT is to help create a life worth living for patients who often suffer tremendously from chronic and pervasive problems across many areas of their lives. DBT is a type of psychotherapy that was originally developed for chronically selfinjurious patients with borderline personality disorder and parasuicidal behavior. In recent years, its use has extended to other forms of mental illness. The method is eclectic, drawing on concepts derived from supportive, cognitive, and behavioral therapies. Some elements can be traced to Franz Alexander's view of therapy as a corrective emotional experience and other elements from certain Eastern philosophical schools (e.g., Zen). Patients are seen weekly, with the goal of improving interpersonal skills and decreasing self-destructive behavior using techniques involving advice, metaphor, storytelling, and confrontation, among others. Patients with borderline personality disorder especially are helped to deal with the ambivalent feelings that are characteristic of the disorder. Marsha Linehan, Ph.D., developed the treatment method, based on her theory that such patients cannot identify emotional experiences and cannot tolerate frustration or rejection. As with other behavioral approaches, DBT assumes all behavior (including thoughts and feelings) is learned and that patients with borderline personality disorder behave in ways that reinforce or even reward their behavior, regardless of how maladaptive it is.

FUNCTIONS OF DBT As described by its originator, there are five essential "functions" in treatment: (1) to enhance and expand the patient's repertoire of skillful behavioral patterns; (2) to improve patient motivation to change by reducing reinforcement of maladaptive behavior, including dysfunctional cognition and emotion; (3) to ensure that new behavioral patterns generalize from the therapeutic to the natural environment; (4) to structure the environment so that effective behaviors, rather than dysfunctional behaviors, are reinforced; and (5) to enhance the motivation and capabilities of the therapist so that effective treatment is rendered. Figure 28.5-

1 illustrates how DBT breaks the cycle of problem behavior being used to avoid emotional distress.

FIGURE 28.5-1 How dialectical behavior therapy (DBT) works. The four modes of treatment in DBT are as follows: (1) group skills training, (2) individual therapy, (3) phone consultations, and (4) consultation team. These are described below. Other ancillary treatments used are pharmacotherapy and hospitalization, when needed. Group Skills Training In group format, patients learn specific behavioral, emotional, cognitive, and interpersonal skills. Unlike traditional group therapy, observations about others in the group are discouraged. Rather, a didactic approach, using specific exercises taken from a skills training manual, is used, many of which are geared toward control emotional dysregulation and impulsive behavior. Individual Therapy Sessions in DBT are held weekly, generally for 50 to 60 minutes, in which skills learned during group training are reviewed and life events from the previous week are examined. Particular attention is paid to episodes of pathological behavioral patterns that could have been corrected if learned skills had been put into effect. Patients are

encouraged to record their thoughts, feelings, and behaviors on diary cards, which are analyzed in the session. Telephone Consultation Therapists are available for phone consultation 24 hours per day. Patients are encouraged to call when they feel themselves heading toward some crisis that might lead to injurious behavior to themselves or others. Calls are intended to be brief and usually last about 10 minutes. Consultation Team Therapists meet in weekly meetings to review their work with their patients. By doing so, they provide support for one another and maintain motivation in their work. The meetings enable them to compare techniques used and to validate those that are most effective (Table 28.5-1). Table 28.5-1 Consultation Team Agreements in Dialectical Behavior Therapy RESULTS Several studies evaluating the effect of DBT for patients with borderline personality disorder found that such therapy was positive. Patients had a low dropout rate from treatment; the incidence of parasuicidal behaviors declined; self-report of angry affect decreased; and social adjustment and work performance improved. The method is now being applied to other disorders, including substance abuse, eating disorders, schizophrenia, and posttraumatic stress disorder. REFERENCES Bedics JD, Korlund KE, Sayrs JH, McFarr LM. The observation of essential clinical strategies during an individual session of dialectical behavior therapy. *Psychotherapy*. 2013;50(3):454-457. Brown MZ, Comtois KA, Linehan MM. Reasons for suicide attempts and nonsuicidal self-injury in women with borderline personality disorder. *J Abnorm Psychol*. 2002;111:198. Hadjiosif M. From strategy to process: Validation in dialectical behaviour therapy. *Counsel Psychol Rev*. 2013;28(1):72-80.

06 - 28.6 Biofeedback

28.6 Biofeedback

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28.6 Biofeedback Biofeedback involves the recording and display of small changes in the physiological levels of the feedback parameter. The display can be visual, such as a big meter or a bar of lights, or auditory. Patients are instructed to change the levels of the parameter, using the feedback from the display as a guide. Biofeedback is based on the idea that the autonomic nervous system can come under voluntary control through operant conditioning. Biofeedback can be used by itself or in combination with relaxation. For example, patients with urinary incontinence use biofeedback alone to regain control over the pelvic musculature. Biofeedback is also used in the rehabilitation of neurological disorders. The benefits of biofeedback may be augmented by the relaxation that patients are trained to facilitate.

THEORY Neal Miller demonstrated the medical potential of biofeedback by showing that the normally involuntary autonomic nervous system can be operantly conditioned by use of appropriate feedback. By means of instruments, patients acquire information about the status of involuntary biological functions, such as skin temperature and electrical conductivity, muscle tension, blood pressure, heart rate, and brain wave activity. Patients then learn to regulate one or more of these biological states that affect symptoms. For example, a person can learn to raise the temperature of his or her hands to reduce the frequency of migraines, palpitations, or angina pectoris. Presumably, patients lower the sympathetic activation and voluntarily self-regulate arterial smooth muscle vasoconstrictive tendencies.

METHODS Instrumentation The feedback instrument used depends on the patient and the specific problem. The most effective instruments are the electromyogram (EMG), which measures the electrical

potentials of muscle fibers; the electroencephalogram (EEG), which measures alpha waves that occur in relaxed states; the galvanic skin response (GSR) gauge, which shows decreased skin conductivity during a relaxed state; and the thermistor, which measures skin temperature (which drops during tension because of peripheral vasoconstriction). Patients are attached to one of the instruments that measures a physiological function and translates the measurement into an

audible or visual signal that patients use to gauge their responses. For example, in the treatment of bruxism, an EMG is attached to the masseter muscle. The EMG emits a high tone when the muscle is contracted and a low tone when at rest. Patients can learn to alter the tone to indicate relaxation. Patients receive feedback about the masseter muscle, the tone reinforces the learning, and the condition ameliorates—all of these events interacting synergistically. Many less-specific clinical applications (e.g., treating insomnia, dysmenorrhea, and speech problems; improving athletic performance; treating volitional disorders; achieving altered states of consciousness; managing stress; and supplementing psychotherapy for treating anxiety associated with somatic symptom and related disorders) use a model in which frontalis muscle EMG biofeedback is combined with thermal biofeedback and verbal instructions in progressive relaxation. Table 28.6-1 outlines some important clinical applications of biofeedback and shows that a wide variety of biofeedback modalities have been used to treat numerous conditions. Table 28.6-1 Biofeedback Applications

Relaxation Therapy Muscle relaxation is used as a component of treatment programs (e.g., systematic desensitization) or as treatment in its own right (relaxation therapy). Relaxation is characterized by (1) immobility of the body, (2) control over the focus of attention, (3) low muscle tone, and (4) cultivation of a specific frame of mind, described as contemplative, nonjudgmental, detached, or mindful. Progressive relaxation was developed by Edmund Jacobson in 1929. Jacobson observed that when an individual lies “relaxed,” in the ordinary sense, the following clinical signs reveal the presence of residual tension: respiration is slightly irregular in time or force; the pulse rate, although often normal, is in some instances moderately increased as compared with later tests; voluntary or local reflex activities are revealed in such slight marks as wrinkling of the forehead, frowning, movements of the eyeballs frequent or rapid winking, restless shifting of the head, a limb, or even a finger; and finally, the mind continues to be active, and once started, worry or oppressive emotion will persist. It is amazing that a faint degree of tension can be responsible for all of this. Learning relaxation, therefore, involves cultivating a muscle sense. To develop the

muscle sense further, patients are taught to isolate and contract specific muscles or muscle groups, one at a time. For example, patients flex the forearm while the therapist holds it back to observe tenseness in the biceps muscle. (Jacobson used the word “tenseness” rather than “tension” to emphasize the patient’s role in tensing the muscles.) Once this sensation is reported, Jacobson would say, “This is your doing! What we wish is the reverse of this—simply not doing.” Patients are repeatedly reminded that relaxation involves no effort. In fact “making an effort is being tense and therefore is not to relax.” As the session progresses, patients are instructed to let go further and further, even past the point when the body part seems perfectly relaxed. Patients would work in this fashion with different muscle groups, often over more than 50 sessions. For example, an entire session might be devoted to relaxing the biceps muscle. Another feature of Jacobson’s method was that instructions were given tersely so they would not interfere with a patient’s focus on muscle sensations; suggestions commonly used today (e.g., “Your arm is becoming limp”) were avoided. Patients were also frequently left alone, while the therapist attended to other patients. In psychiatry, relaxation therapy is mainly used as a component of multifaceted broad-spectrum programs. Its use in desensitization was mentioned previously. Relaxing breathing exercises are often helpful for patients with panic disorder, especially when considered to be related to hyperventilation. In the treatment of patients with anxiety disorders, relaxation can serve as an occasion-setting stimulus (i.e., as a context of safety in which other

specific intervention can be confidently tried). Later Adaptation of Progressive Muscular Relaxation Joseph Wolpe chose progressive relaxation as a response incompatible with anxiety when designing his systematic desensitization treatment (discussed below). For this purpose, Jacobson's original method was too lengthy to be practical. Wolpe abbreviated the program to 20 minutes during the first six sessions (devoting the remainder of these sessions to other things, such as behavioral analysis). In a later modification of progressive relaxation, patients completed work with all the principal muscle groups in one session. The specific muscle groups and instructions for this type of progressive relaxation are listed in Table 28.6-2. Once patients have mastered this procedure (typically after three sessions), these groups are combined into larger groups. Finally, patients practice relaxation by recall (i.e., without tensing the muscles). Table 28.6-2 Outline of Initial Progressive Relaxation Session, All Muscle Groups

Autogenic Training Autogenic training is a method of self-suggestion that originated in Germany. It involves the patients directing their attention to specific bodily areas and hearing themselves think certain phrases reflecting a relaxed state. In the original German version, patients progressed through six themes over many sessions. The six areas are listed in Table 28.6.3 along with representative autogenic phrases. Autogenic relaxation is an American modification of autogenic training, in which all six areas are covered in one session. Table 28.6-3 Sample Autogenic Phrases Applied Tension Applied tension is a technique that is the opposite of relaxation; applied tension can be used to counteract the fainting response. The treatment extends over four sessions. In the first session, patients learn to tense the muscles of the arms, legs, and torso for 10 to 15 seconds (as if they were bodybuilders). The tension is maintained long enough for a sensation of warmth to develop in the face. The patients then release the tension, but do not progress to a state of relaxation. The maneuver is repeated five times at half-minute intervals. This method can be augmented with feedback of the patient's blood pressure during the muscle contraction; increased blood pressure suggests that appropriate muscle tension was achieved. The patients continue to practice the technique five times

a day. An adverse effect of treatment that sometimes develops is headache. In this case, the intensity of the muscle contraction and the frequency of treatment are reduced. Patients with blood and injury phobia show a unique, biphasic response when exposed to a phobic stimulus. The first phase is associated with increased heart rate and blood pressure. In the second phase, however, blood pressure suddenly falls and the patient faints. To treat the problem, patients are shown a series of slides that are provocative (e.g., mutilated bodies). They are coached in identifying early warning signs of fainting, such as queasiness, cold sweats, or dizziness, and in applying the learned muscle tension response quickly, contingent on these warning signs. Patients can also perform applied tension while donating blood or watching a surgical operation. The technique of isometric tension raises blood pressure, which prevents fainting. Applied Relaxation Applied relaxation involves eliciting a relaxation response in the stressful situation itself. The previous discussion showed that this is not advisable right away because of the possible ironic effects of relaxation. Therefore, patients should first practice relaxation in nonstressful circumstances. The method developed by Lars-Göran Öst and coworkers in Sweden has been proven efficacious for panic disorder and generalized anxiety disorder. Establishing the relaxation response in the patient's natural environment consists of seven phases of one to two sessions each: progressive relaxation, release-only relaxation, cue-controlled relaxation, differential relaxation, rapid relaxation, application training, and maintenance. Details are provided in Table 28.6-4. Table 28.6-4 Steps in

Applied Relaxation

RESULTS Biofeedback, progressive relaxation, and applied tension have been shown to be effective treatment methods for a broad range of disorders. They form one basis of behavioral medicine in which the patient changes (or learns how to change) behavior that contributes to illness. They form a basis on which many complementary and alternative medical procedures are effective (e.g., yoga and Reiki) in which relaxation is an important component. Relaxation also informs more mainstream treatments, such as hypnosis.

07 - 28.7 Cognitive Therapy

28.7 Cognitive Therapy

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28.7 Cognitive Therapy A central feature of the cognitive theory of emotional disorders is its emphasis on the psychological significance of people's beliefs about themselves, their personal world (including the people in their lives), and their future—the "cognitive triad." When people experience excessive, maladaptive emotional distress, it is linked to their problematic, stereotypic, biased interpretations pertinent to this cognitive triad of self, world, and future. For example, clinically depressed patients may be prone to believe that they are incapable and helpless and to view others as being judgmental and critical and the future as being bleak and unrewarding. Similarly, patients with anxiety disorders may be apt to see themselves as highly vulnerable, others as more capable, and the future as likely to be characterized by personal disasters.

Although the patient's viewpoints are flawed and dysfunctional, they nonetheless tend to be perpetuated by cognitive processes that maintain them. Cognitive therapy is a short-term, structured therapy that uses active collaboration between patient and therapist to achieve its therapeutic goals, which are oriented toward current problems and their resolution. Cognitive therapy is used with depression, panic disorder, obsessive-compulsive disorder, personality disorders, and somatoform disorders. Therapy is usually conducted on an individual basis, although group methods are sometimes helpful. A therapist may also prescribe drugs in conjunction with therapy. The treatment of depression can serve as a paradigm of the cognitive approach. Cognitive therapy assumes that perception and experiencing, in general, are active processes that involve both inspective and introspective data. The patient's cognitions represent a synthesis of internal and external stimuli. The way persons appraise a situation is generally evident in their cognitions (thoughts and visual images). Those cognitions constitute their stream of consciousness or phenomenal field, which reflects their configuration of themselves, their world, their past, and their future. Alterations in the content of their underlying cognitive structures affect their affective state and behavioral pattern. Through psychological therapy, patients can become aware of their cognitive distortions. Correction of faulty dysfunctional constructs can lead to clinical improvement.

COGNITIVE THEORY OF DEPRESSION According to the cognitive theory of depression, cognitive dysfunctions are the core of depression, and affective and physical changes and other associated features of depression are consequences of cognitive dysfunctions. For example, apathy and low energy result from a person's expectation of failure in all areas. Similarly, paralysis of will stems from a person's pessimism and feelings of hopelessness. From a cognitive perspective, depression can be explained by the cognitive triad, which explains that negative thoughts are about the self, the world, and the future. The goal of therapy is to alleviate depression and to prevent its recurrence by helping patients to identify and test negative cognitions, to develop alternative and more flexible schemas, and to rehearse both new cognitive and behavioral responses. Changing the way a person thinks can alleviate the psychiatric disorder.

STRATEGIES AND TECHNIQUES Therapy is relatively short and lasts about 25 weeks. If a patient does not improve in this time, the diagnosis should be reevaluated. Maintenance therapy can be carried out over years. As with other psychotherapies, therapists' attributes are important to successful therapy. Therapists must exude warmth, understand the life experience of each patient, and be genuine and honest with themselves and with their patients. They must be able to relate skillfully and interactively with their patients. Cognitive therapists set the agenda at the beginning of each session, assign homework to be performed between sessions, and teach new skills. Therapist and patient collaborate

actively (Table 28.7-1). The three components of cognitive therapy are didactic aspects, cognitive techniques, and behavioral techniques. Table 28.7-1 Cognitive Psychotherapy Didactic Aspects The therapy's didactic aspects include explaining to patients the cognitive triad, schemas, and faulty logic. Therapists must tell patients that they will formulate hypotheses together and test them over the course of the treatment. Cognitive therapy requires a full explanation of the relation between depression and thinking, affect, and behavior, as well as the rationale for all aspects of treatment. This explanation contrasts with psychoanalytically oriented therapies, which require little explanation.

Cognitive Techniques The therapy's cognitive approach includes four processes: eliciting automatic thoughts, testing automatic thoughts, identifying maladaptive underlying assumptions, and testing the validity of maladaptive assumptions.

Eliciting Automatic Thoughts. Automatic thoughts, also called cognitive distortions, are cognitions that intervene between external events and a person's emotional reaction to the event. For example, the belief that

“people will laugh at me when they see how badly I bowl” is an automatic thought that occurs to someone who has been asked to go bowling and responds negatively. Another example is the thought “She doesn’t like me” when someone passes in the hall without saying “Hello.” Every psychopathological disorder has its own specific cognitive profile of distorted thought, which, if known, provides a framework for specific cognitive interventions (Table 28.72).

Table 28.7-2 Cognitive Profile of Psychiatric Disorders Testing Automatic Thoughts. Acting as a teacher, a therapist helps a patient test the validity of automatic thoughts. The goal is to encourage the patient to reject inaccurate or exaggerated automatic thoughts after careful examination. Patients often blame themselves when things that are outside their control go awry. The therapist reviews the entire situation with the patient and helps reassign the blame or cause of the unpleasant events. Generating alternative explanations for events is another way of undermining inaccurate and distorted automatic thoughts. Identifying Maladaptive Assumptions. As the patient and therapist continue to identify automatic thoughts, patterns usually become apparent. The patterns represent rules or maladaptive general assumptions that guide a patient’s life. Samples of such rules are “In order to be happy, I must be perfect” and “If anyone doesn’t like me, I’m not lovable.” Such rules inevitably lead to disappointments and failure and, ultimately, to depression (Fig. 28.7-1). Testing the Validity of Maladaptive Assumptions. Testing the accuracy of maladaptive assumptions is similar to testing the validity of automatic thoughts. In a particularly effective test, therapists ask patients to defend the validity of their assumptions. For example, patients may state that they should always work up to their potential, and a therapist may ask “Why is that so important to you?” Table 28.7-3 gives examples of some interventions designed to elicit, identify, test, and correct the cognitive distortions that lead to depressive and other painful affects. Table 28.7-3 Cognitive Errors Derived from Assumptions

A woman presented for therapy with anger control problems. She had sent a slew of hostile voicemail and e-mail messages to a colleague, had alienated her neighbors with her complaints about noise, and had been asked to leave her bowling league after two physical altercations with members of other teams. A careful review of the patient’s thoughts and beliefs surrounding these situations revealed a common denominator of a sense of mistrust and entitlement. In each situation, she believed that the persons who were the objects of her anger had gone out of their way to mistreat her. Furthermore, she had an exaggerated sense of self-importance represented by beliefs such as, “Nobody has the right to treat me that way,” “I shouldn’t have to deal with these people and their stupidity,” and “I have to show them they can’t ever push me around.” To this patient, her anger was justified, as she was trying to defend herself from the misbehavior of others. However, to the outside observer, the patient was a “loose cannon” who took offense at the drop of a hat and whose behavior was outrageous and indefensible. In therapy, the patient at first was not open to viewing her anger problem in the manner just described. However, as she learned to recognize the activation of her schemas of mistrust and entitlement, she became more willing to consider ways in which she could modify her viewpoints and behaviors. This positive change was facilitated by the therapist’s empathic responses to the patient’s more credible stories of mistreatment she had received from her family, whose abusive behavior gave her the message that she should never trust anyone and that she should never put up with being mistreated again. (Courtesy of C. F. Newman, Ph.D., and A. T. Beck, M.D.)

FIGURE 28.1 Sample automatic thought record. Behavioral Techniques Behavioral and cognitive techniques go hand in hand; behavioral techniques test and change maladaptive and inaccurate cognitions. The overall purposes of such techniques are to help patients understand the inaccuracy of their cognitive assumptions and learn new strategies and ways of dealing with issues. Among the behavioral techniques in cognitive therapy are scheduling activities, mastery and pleasure, graded task assignments, cognitive rehearsal, self-reliance training, role playing, and diversion techniques. One of the first things done in therapy is to schedule activities on an hourly basis. Patients keep records of the activities and review them with the therapist. In addition to scheduling activities, patients are asked to rate the amount of mastery and pleasure their activities bring them. Patients are often surprised to learn that they have much more mastery of activities and enjoy them more than they had thought. To simplify the situation and allow miniaccomplishments, therapists often break tasks into subtasks, as in graded task assignments, to show patients that they can succeed. In cognitive rehearsal, patients imagine and rehearse the various steps in meeting and mastering a challenge. Patients (especially inpatients) are encouraged to become self-reliant by doing such

simple things as making their own beds, doing their own shopping, and preparing their own meals. This process is called self-reliance training. Role playing is a particularly powerful and useful technique to elicit automatic thoughts and to learn new behaviors. Diversion techniques are useful in helping patients get through difficult times and include physical activity, social contact, work, play, and visual imagery. Imagery or thought stoppage can treat impulsive or obsessive behavior. For instance, patients imagine a stop sign with a police officer nearby or another image that evokes inhibition at the same time that they recognize an impulse or obsession that is alien to the ego. Similarly, obesity can be treated by having patients visualize themselves as thin, athletic, trim, and well muscled, and then training them to evoke this image whenever they have an urge to eat. Hypnosis or autogenic training can enhance such imagery. In a technique called guided imagery, therapists encourage patients to have fantasies that can be interpreted as wish fulfillments or attempts to master disturbing affects or impulses.

EFFICACY Cognitive therapy can be used alone in the treatment of mild to moderate depressive disorders or in conjunction with antidepressant medication for major depressive disorder. Studies have clearly shown that cognitive therapy is effective and in some cases is superior or equal to medication alone. It is one of the most useful psychotherapeutic interventions currently available for depressive disorders, and it shows promise in the treatment of other disorders. Cognitive therapy has also been studied as a way of increasing compliance with lithium (Eskalith) prescription by patients with bipolar I disorder and as an adjunct in treating withdrawal from heroin. Table 28.7-4 outlines Beck's criteria for determining when cognitive therapy is indicated.

Table 28.7-4 Indications for Cognitive Therapy

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08 - 28.8 Behavior Therapy

28.8 Behavior Therapy

Mulder R, Chanen AM. Effectiveness of cognitive analytic therapy for personality disorders. *Br J Psychiatry*. 2013;202(2):89-90. Newman CF, Beck AT. Cognitive therapy. In: Sadock BJ, Sadock VA, Ruiz P, eds. *Kaplan & Sadock's Comprehensive Textbook of Psychiatry*. 9th ed. Vol. 2. Philadelphia: Lippincott Williams & Wilkins; 2009:2857. Rector NA, Seeman MV, Segal ZV. Cognitive therapy for schizophrenia: A preliminary randomized controlled trial. *Schiz Res*. 2003;63:1-11. Reinecke MA, Clark DA. *Cognitive Therapy Across the Lifespan: Evidence and Practice*. Cambridge, UK: Cambridge University Press; 2003. Sturmey P. On some recent claims for the efficacy of cognitive therapy for people with intellectual disabilities. *J Appl Res Intellect Disabil*. 2006; 19:109-117.

28.8 Behavior Therapy The term behavior in behavior therapy refers to a person's observable actions and responses. Behavior therapy involves changing the behavior of patients to reduce dysfunction and to improve quality of life. Behavior therapy includes a methodology, referred to as behavior analysis, for the strategic selection of behaviors to change, and a technology to bring about behavior change, such as modifying antecedents or consequences or giving instructions. Behavior therapy has not only influenced mental health care, but, under the rubric of behavioral medicine, it has also made inroads into other medical specialties. Behavior therapy represents clinical applications of the principles developed in learning theory. Behavioral psychology, or behaviorism, arose in the early 20th century in reaction to the method of introspection that dominated psychology at the time. John B. Watson, the father of behaviorism, had initially studied animal psychology. This background made it a small conceptual leap to argue that psychology should concern itself only with publicly observable phenomena (i.e., overt behavior). According to behavioristic thinking, because mental content is not publicly observable, it cannot be subjected to rigorous scientific inquiry. Consequently, behaviorists developed a focus on overt behaviors and their environmental influences. Today, different behavioral schools continue to share a focus on verifiable behavior. Behavioral views differ from cognitive views in holding that physical, rather than mental, events control behavior. According to behaviorism, mental phenomena or speculations about them are of little or no scientific interest.

HISTORY As early as the 1920s, scattered reports about the application of learning principles to the treatment of behavioral disorders began to appear, but they had little effect on the mainstream of psychiatry and clinical psychology. Not until the 1960s did behavior therapy emerge as a systematic and comprehensive approach to psychiatric (behavioral) disorders; at that time, it arose independently on three continents. Joseph Wolpe and his colleagues in Johannesburg, South Africa, used Pavlovian techniques to produce and

eliminate experimental neuroses in cats. From this research, Wolpe developed systematic desensitization, the prototype of many current behavioral procedures for the treatment of maladaptive anxiety produced by identifiable stimuli in the environment. At about the same time, a

group at the Institute of Psychiatry of the University of London, particularly Hans Jurgen Eysenck and M. B. Shapiro, stressed the importance of an empirical, experimental approach to understanding and treating individual patients, using controlled, single-case experimental paradigms and modern learning theory. The third origin of behavior therapy was work inspired by the research of Harvard psychologist B. F. Skinner. Skinner's students began to apply his operant-conditioning technology, developed in animal-conditioning laboratories, to human beings in clinical settings.

SYSTEMATIC DESENSITIZATION Developed by Wolpe, systematic desensitization is based on the behavioral principle of counterconditioning, whereby a person overcomes maladaptive anxiety elicited by a situation or an object by approaching the feared situation gradually, in a psychophysiological state that inhibits anxiety. In systematic desensitization, patients attain a state of complete relaxation and are then exposed to the stimulus that elicits the anxiety response. The negative reaction of anxiety is inhibited by the relaxed state, a process called reciprocal inhibition. Rather than using actual situations or objects that elicit fear, patients and therapists prepare a graded list or hierarchy of anxiety-provoking scenes associated with a patient's fears. The learned relaxation state and the anxiety-provoking scenes are systematically paired in treatment. Thus, systematic desensitization consists of three steps: relaxation training, hierarchy construction, and desensitization of the stimulus.

Relaxation Training Relaxation produces physiological effects opposite to those of anxiety: slow heart rate, increased peripheral blood flow, and neuromuscular stability. A variety of relaxation methods have been developed. Some, such as yoga and Zen, have been known for centuries. Most methods use so-called progressive relaxation, developed by the psychiatrist Edmund Jacobson. Patients relax major muscle groups in a fixed order, beginning with the small muscle groups of the feet and working cephalad or vice versa. Some clinicians use hypnosis to facilitate relaxation or use tape-recorded exercise to allow patients to practice relaxation on their own. Mental imagery is a relaxation method in which patients are instructed to imagine themselves in a place associated with pleasant, relaxed memories. Such images allow patients to enter a relaxed state or experience (as Herbert Benson termed it) the relaxation response. The physiological changes that take place during relaxation are the opposite of those induced by the adrenergic stress responses that are part of many emotions. Muscle tension, respiration rate, heart rate, blood pressure, and skin conductance decrease. Finger temperature and blood flow to the finger usually increase. Relaxation increases

respiratory heart rate variability, an index of parasympathetic tone.

Hierarchy Construction When constructing a hierarchy, clinicians determine all the conditions that elicit anxiety, and then patients create a hierarchy list of 10 to 12 scenes in order of increasing anxiety. For example, an acrophobic hierarchy may begin with a patient's imagining standing near a window on the second floor and end with being on the roof of a 20-story building, leaning on a guard rail and looking straight down. Table 28.8-1 provides an example of a hierarchy construction for fear of water and heights.

Table 28.8-1 Hierarchy Construction (Least Anxious to Most Anxious): Fear of Water and Heights

Desensitization of the Stimulus In the final step, called desensitization, patients proceed systematically through the list from the least to the most anxiety-provoking scene while in a deeply relaxed state. The rate at which patients progress through the list is determined by their responses to the

stimuli. When patients can vividly imagine the most anxiety-provoking scene of the hierarchy with equanimity, they experience little anxiety in the corresponding real-life situation.

Adjunctive Use of Drugs. Clinicians have used various drugs to hasten relaxation, but drugs should be used cautiously

and only by clinicians trained and experienced in potential adverse effects. Either the ultrarapidly acting barbiturate sodium methohexital (Brevital) or diazepam (Valium) is given intravenously in subanesthetic doses. If the procedural details are followed carefully, almost all patients find the procedure pleasant, with few unpleasant side effects. The advantages of pharmacological desensitization are that preliminary training in relaxation can be shortened, almost all patients can relax adequately, and the treatment itself seems to proceed more rapidly than without the drugs.

Indications. Systematic desensitization works best in cases of a clearly identifiable anxiety-provoking stimulus. Phobias, obsessions, compulsions, and certain sexual disorders have been treated successfully with this technique.

THERAPEUTIC-GRADED EXPOSURE Therapeutic-graded exposure is similar to systematic desensitization, except that relaxation training is not involved and treatment is usually carried out in a real-life context. This means that the individual must be brought in contact with (i.e., be exposed to) the warning stimulus to learn firsthand that no dangerous consequences will ensue. Exposure is graded according to a hierarchy. Patients afraid of cats, for example, might progress from looking at a picture of a cat to holding one.

FLOODING Flooding (sometimes called implosion) is similar to graded exposure in that it involves exposing the patient to the feared object in vivo; however, there is no hierarchy. Flooding is based on the premise that escaping from an anxiety-provoking experience reinforces the anxiety through conditioning. Thus, clinicians can extinguish the anxiety and prevent the conditioned avoidance behavior by not allowing patients to escape the situation. Clinicians encourage patients to confront feared situations directly, without a gradual buildup, as in systematic desensitization or graded exposure. No relaxation exercises are used, as in systematic desensitization. Patients experience fear, which gradually subsides after a time. The success of the procedure depends on having patients remain in the fear-generating situation until they are calm and feel a sense of mastery. Prematurely withdrawing from the situation or prematurely terminating the fantasized scene is equivalent to an escape, which then reinforces both the conditioned anxiety and the avoidance behavior and produces the opposite of the desired effect. In a variant, called imaginal flooding, the feared object or situation is confronted only in the imagination, not in real life. Many patients refuse flooding because of the psychological

discomfort involved. It is also contraindicated when intense anxiety would be hazardous to a patient (e.g., those with heart disease or fragile psychological adaptation). The technique works best with specific phobias. An example of in vivo flooding is presented in the case study. The patient was a 33-year-old woman with social fears of eating in public. In particular, she was afraid of being observed by others when chewing and swallowing, particularly at dinner parties. A contrived situation was arranged in which the patient came to the session with a prepared meal and drink. She entered a conference room in which five persons in professional attire were already seated along a table. The patient was instructed to eat her meal in front of these individuals. Between bites, she was instructed to look at them often, and they had been instructed to avoid staring contests. She was not to distract herself from her anxiety symptoms. She was to eat her meal slowly, paying attention to the behavior of the observers and to her anxiety symptoms (e.g., dry mouth or difficulty swallowing). No conversation between the patient and observers was permitted. The observers would look at her and observe her chewing and swallowing behaviors, at times writing comments in a notebook. Occasionally, observers would communicate by whispering to each other, exchanging written notes, or giving knowing glances and smiles. The only other communication occurred between the patient and therapist, and this was limited to the patient providing her subjective units of distress rating. The session lasted 90 minutes. Note: this situation

may seem quite traumatizing. Because the exposure session is long and continues until ratings decline, the patient becomes desensitized. (Courtesy of Rolf G. Jacob, M.D., and William H. Pelham, M.D.)

PARTICIPANT MODELING In participant modeling, patients learn a new behavior by imitation, primarily by observation, without having to perform the behavior until they feel ready. Just as irrational fears can be acquired by learning, they can be unlearned by observing a fearless model confront the feared object. The technique has been useful with phobic children who are placed with other children of their own age and sex who approach the feared object or situation. With adults, a therapist may describe the feared activity in a calm manner that a patient can identify. Or, the therapist may act out the process of mastering the feared activity with a patient. Sometimes a hierarchy of activities is established, with the least anxiety-provoking activity being dealt with first. The participant-modeling technique has been used successfully with agoraphobia by having a therapist accompany a patient into the feared situation. In a variant of the procedure, called behavior rehearsal, real-life problems are acted out under a therapist's observation or direction.

The following is a self-report by a patient with a contamination phobia, who is afraid to touch objects for fear of being infected or contaminated. She describes her reactions. [The therapist] started touching everything very slowly. I was told to follow behind and touch everything she touched. It was like we were spreading the contamination. She touched doorknobs, light switches, walls, pictures, and woodwork. She opened drawers in each bedroom and touched the contents. She opened closets and touched clothes hanging on the rods. She touched the towels and sheets in the linen closet. She went through the children's rooms, touching dolls, stuffed animals, models, Star Wars figures, Transformers, and books. [The therapist] kept talking to me quietly and calmly all the time we went along. I had been anxious when we started, but as we continued, my anxiety level decreased. At one point, when I had begun to think the worst was over, she pointed to the attic door and said we were going inside. I said, "No, that's where the mice were." She told me I didn't want to have a place in my home that was off limits. I agreed but became very anxious. It was very hard for me to go inside. I began touching the boxes too, but I was very upset. Then, she put her hands down on the floor and wanted me to do the same. I said, "I can't. I just can't." [The therapist] said, "Yes you can." [The therapist] spent several hours with me that day. Before she left, she made a list of things for me to do by myself. Twice a day I was to go through the house touching everything the way she had done with me. I was to invite a friend of mine who had a pet to come and visit and also friends of my children who had pets. (Courtesy of Rolf G. Jacobs, M.D., and William H. Pelham, M.D.)

EXPOSURE TO STIMULI PRESENTED IN VIRTUAL REALITY Advances in computer technology have made it possible to present environmental cues in virtual reality for exposure treatment. Beneficial effects have been reported with virtual reality exposure of patients with height phobia, fear of flying, spider phobia, and claustrophobia. Much experimental work is being done in the field. One model uses an avatar of the patient walking through a crowded supermarket filled with other avatars (including one of the therapists) as a way of conquering agoraphobia.

ASSERTIVENESS TRAINING Assertiveness is defined as assertive behavior that enables a person to act in his or her own best interest, to stand up for herself or himself without undue anxiety, to express honest feelings comfortably, and to exercise personal rights without denying the rights of others. Two types of situations frequently call for assertive behaviors: (1) setting limits on pushy friends or relatives and (2) commercial situations, such as countering a sales pitch or being persistent when returning defective merchandise. Early assertiveness training

programs tended to define specific behaviors as assertive or nonassertive. For example, individuals were encouraged to assert themselves if somebody got in front of them in a supermarket checkout line. Increasing attention is now given to context, that is, what would be assertive behavior in this situation depends on circumstances. SOCIAL SKILLS TRAINING The negative symptoms in patients with schizophrenia constitute behavioral deficits that go beyond difficulties with assertiveness. These patients have inadequate expressive behaviors and inappropriate stimulus control of their social behaviors (i.e., they do not pick up social cues). Similarly, patients with depression often experience a lack of social reinforcement because of a lack of social skills, and social skills training has been found to be efficacious for depression. Patients with social phobia similarly often have not acquired adolescents' social skills. In fact, their social defensive behaviors (e.g., avoiding eye contact, making brief statements, and minimizing self-disclosure) increase the probability of the rejection that they fear. Social skills training programs for patients with schizophrenia cover skills in the following areas: conversation, conflict management, assertiveness, community living, friendship and dating, work and vocation, and medication management. Each of these skills has several components. For example, assertiveness skills include making requests, refusing requests, making complaints, responding to complaints, expressing unpleasant feelings, asking for information, making apologies, expressing fear, and refusing alcohol and street drugs. Each component involves specific steps. For example, conflict management includes skills in negotiating, compromising, tactful disagreeing, responding to untrue accusations, and leaving overly stressful situations. A situation in which conflict management skills might be used is when the patient and a friend decide to go to a movie and their choice of movie differs. Negotiating and compromising, for example, involves the following steps:

1. Explain one's viewpoint briefly.
2. Listen to the other person's viewpoint.
3. Repeat the other person's viewpoint.
4. Suggest a compromise. At his initial appointment, Phillip described very serious symptoms of obsessive-compulsive disorder (OCD). He was 23 years old and living at home because he was no longer able to work or go to school. His days were consumed with behaviors related to checking, repeating, and hoarding. Phillip was unable to throw away anything—he saved junk mail, used tissues and napkins, old papers and magazines, and any kind of receipt for fear that he might lose something important. Phillip spent many hours checking his trash, his car, and his home to be sure that he had not thrown away anything important. He also checked everything he wrote (e.g., checks,

school exams and papers, letters and e-mails) to be sure that he had not made a mistake, and he read and reread books, magazines, and articles to be sure he understood the written material adequately. Phillip worried constantly that he had done something wrong and would disappoint his parents. He was also depressed because he was unable to function well in life, and he had tremendous social anxiety that had plagued him for many years, making it difficult to make and keep friends. By the end of Phillip's second session, his therapist was beginning to get a good idea of the general nature and severity of his symptoms and some of the maintaining factors. However, to plan the treatment in more detail and to get a better idea of how the symptoms occurred during his daily life, she asked Phillip to keep daily records over the next week using a form that she had prepared for him. The form had a place for recording the amount of time he spent doing rituals each morning, afternoon, and evening, as well as another place to record more details about at

least one episode of rituals each day (e.g., what was happening before, during, and after the rituals; see Table 28.8-2). Table 28.8-2 Daily Monitoring of Rituals Phillip's therapist determined that his difficulties with obsessions, rituals, depression, and social fears reflected a core fear of negative evaluation. Phillip was overly concerned with making mistakes, being imperfect, and disappointing others. Even as a child, Phillip was concerned about not doing well enough, and he had difficulty making friends for fear that others would not like him. His parents, who were highly anxious, provided much adulation when Phillip did things well (e.g., learned to ride a bike, got good grades in school), and they spent much time instructing him about how to improve his performance when an activity or grade was not perfect. As Phillip took on more responsibility at school and with part-time work, he became more concerned about doing things right. He learned that going back and

checking his work relieved his anxiety. He also learned that saving his papers for future checking reassured him that he would be able to fix any unrecognized mistakes at a later time. His parents helped him to reduce his anxiety when he was uncertain about his work by reassuring him that he was doing okay. As Phillip progressed from elementary school to junior high school to high school, his workload and anxiety gradually increased, but he was able to manage things with some moderate checking and saving. When he began attending college, however, the workload increased extensively, and he found himself doing even more checking and hoarding to reduce his fears about making mistakes. Phillip began to feel that these behaviors were getting out of control, but he could not stop them. He had to check and recheck to be sure that he was not making mistakes. The cycle of anxiety S ritual S reduced anxiety was so powerfully reinforcing that he could not stop. He needed help to break this cycle and to address his persistent fear of negative evaluation. Phillip's therapist decided to begin treatment with a course of exposure and response prevention (ERP) to get his obsessions and rituals under control and begin to address his core fear of making mistakes and being evaluated negatively. Given that Phillip's depression had grown from the disability associated with his OCD, the therapist expected that a successful course of ERP might also help to reduce his depressive symptoms. ERP for Phillip began with a home visit, where the therapist helped him to complete common daily activities with adherence to his RP plan, which included the following: No more checking: After eating, leave the table immediately without inspecting your plate and the surrounding areas (including under the table and chair) for lost items. Leave the restroom immediately after using it, without checking the toilet, trash, and sink for lost items. When leaving the car, no more checking of seats, floors, and windows. Write everything (papers, checks, etc.) only once; no checking to be sure that letters and words are correct. No more repeating: No more rereading books. No staring repeatedly at items to ensure that nothing is lost. No more saving. Throw tissues away immediately after using. Discard trash and junk mail immediately. Do not look into the trash can for lost items. Phillip's parents also were asked to stop reassuring him and to discontinue doing rituals for him. This was a very difficult session for Phillip and his family, but they understood the logic of ERP, and they were willing to try anything. For the next 3 weeks, Phillip and his therapist met three times a week to conduct in vivo exposure sessions that helped him to face his core fears. For many of these sessions, Phillip was asked to bring hoarded items from home and to discard all unnecessary items during the therapy session. At first, this created tremendous anxiety, but over time, Phillip was able to throw things away with less fear of losing something important. He also developed the ability to conduct self-directed exposure at home. Other exposure sessions involved writing letters and mailing them without checking, reading passages from magazines and books only once, and sorting through junk mail to make quick

decisions about what to save or discard. As Phillip was able

to take on more responsibility for home-based exposure, session frequency decreased to two times per week, and then to once per week. After 3 months of treatment, Phillip's scores on the YBOCS (Yale-Brown Obsessive-Compulsive Scale) and BDI (Beck Depression Inventory) had decreased to 20 and 19, respectively, demonstrating significant improvement in obsessive-compulsive symptoms and depression. His SPAI (Social Phobia and Anxiety Inventory) score, however, remained relatively unchanged, suggesting that he was still experiencing significant social anxiety. Next, while Phillip worked on maintaining the gains he had made following ERP, he and his therapist conducted some role plays to evaluate his social skills. It was apparent that Phillip had extreme difficulty with initiating and maintaining conversations. His eye contact also was quite poor in social interactions. Thus, the therapist devised a plan for teaching and practicing new skills, which also involved additional exposure to Phillip's core fears as he was asked to resume contact with old friends and identify activities where he could meet new people. He practiced new behaviors first in session with his therapist and then developed a hierarchy of feared social situations in which he could practice his new behaviors. These practice exercises also involved a form of exposure as Phillip was asked to make social contact, which produced fears of negative evaluation. After another 3 months of treatment focused on social skills training (and associated exposure), Phillip's scores on the YBOCS and BDI had decreased further (YBOCS = 15; BDI = 13), and his SPAI score had decreased to 100. Phillip had gone back to school to take one class, he was spending small amounts of time with old friends, and he was volunteering a few hours each week at his church. (Courtesy of M. A. Stanley, Ph.D., and D. C. Beidel, Ph.D.)

AVERSION THERAPY When a noxious stimulus (punishment) is presented immediately after a specific behavioral response, theoretically, the response is eventually inhibited and extinguished. Many types of noxious stimuli are used: electric shocks, substances that induce vomiting, corporal punishment, and social disapproval. The negative stimulus is paired with the behavior, which is thereby suppressed. The unwanted behavior may disappear after a series of such sequences. Aversion therapy has been used for alcohol abuse, paraphilias, and other behaviors with impulsive or compulsive qualities, but this therapy is controversial for many reasons. For example, punishment does not always lead to the expected decreased response and can sometimes be positively reinforcing. Aversion therapy has been used with good effect in some cultures in the treatment of opioid addicts (Fig. 28.8-1).

FIGURE 28.8-1 Treatment of addicts at Tham Krabok Monastery in Thailand results in a 70 percent success rate, according to its records. The 10-day free treatment begins with a vow to Buddha never to use narcotics again. Then, patients are given an herbal medicine that makes them vomit immediately. (From White PT, Raymer S. The poppy—for good and evil. National Geographic. 1985;167:187, with permission.)

EYE MOVEMENT DESENSITIZATION AND REPROCESSING Saccadic eye movements are rapid oscillations of the eyes that occur when a person tracks an object that is moved back and forth across the line of vision. A few studies have demonstrated that inducing saccades while a person is imagining or thinking about an anxiety-producing event can yield a positive thought or image that results in decreased anxiety. Eye movement desensitization and reprocessing has been used in posttraumatic stress disorders and phobias.

POSITIVE REINFORCEMENT When a behavioral response is followed by a generally rewarding event, such as food, avoidance of pain, or praise, it tends to be strengthened and to occur more frequently than before the reward. This principle has been applied in a variety of situations. On inpatient hospital wards, patients with mental disorders receive a reward for performing a desired behavior, such as

tokens that they can use to purchase luxury items or certain privileges. The process, known as token economy, has successfully altered behavior. Table 28.8-3 gives a summary of some clinical applications of behavior

therapy. Table 28.8-3 Some Common Clinical Applications of Behavior Therapy Charles was a 70-year-old retired business executive. Throughout his life, his work consumed him. Although he married and had a family, his job was his primary focus. He went to the office early and came home late. He enjoyed what he did—it was stimulating and made him feel important and useful. But as he got older, his performance was not what it used to be, and he decided it was time to retire. However, his mood was pretty low when he no longer had a job. He did not have the energy to get more involved in his church or to develop other hobbies, so he sat around all day, without any social contacts. His wife and best friend encouraged him to go talk to someone. The therapist suggested that they try behavioral activation. Charles was somewhat skeptical, as it seemed too simple, but he needed to do something. The therapist spent some time with Charles talking about the kinds of activities that used to make him feel good and some of the things he used to enjoy. They then put together a list of things he might be able to do—even if he did not feel much like it—just to see what would happen. The list included looking for volunteer work where he could use his job skills, spending more time with his wife in some of the activities they once had enjoyed (e.g., watching movies, taking walks), and rejuvenating an old hobby from his college days—fishing. Charles initially agreed to do some easy activities—go to one movie a week, take one walk a week, and contact his church activity leader about possible volunteer activities. He was surprised to find that even these “baby steps” helped him feel better. He had the chance to talk with

other people and began to see that even in retirement, he could find useful and fun things to do. (Courtesy of M. A. Stanley, Ph.D., and D. C. Beidel, Ph.D.) RESULTS Behavior therapy has been used successfully for a variety of disorders (Table 28.8-3) and can be easily taught (Table 28.8-4). It requires less time than other therapies and is less expensive to administer. Although useful for circumscribed behavioral symptoms, the method cannot be used to treat global areas of dysfunction (e.g., neurotic conflicts, personality disorders). Controversy continues between behaviorists and psychoanalysts, which is epitomized by Eysenck’s statement: “Learning theory regards neurotic symptoms as simply learned habits; there is no neurosis underlying the symptoms, but merely the symptom itself. Get rid of the symptom and you have eliminated the neurosis.” Analytically oriented theorists have criticized behavior therapy by noting that simple symptom removal can lead to symptom substitution: When symptoms are not viewed as consequences of inner conflicts and the core cause of the symptoms is not addressed or altered, the result is the production of new symptoms. Whether this occurs remains open to question, however. Table 28.8-4 Social Skills Competence Checklist of Therapist-Trainer Behaviors

BEHAVIORAL MEDICINE Behavioral medicine uses the concepts and methods described above to treat a variety of physical diseases. Emphasis is placed on the role of stress and its influence on the body, particularly on the endocrine system. Attempts to relieve stress are made with the expectation that either the disease state will lessen or the patient’s ability to tolerate the disease state will strengthen. One study measured the effects of a behavioral medicine program on symptoms of acquired immunodeficiency syndrome (AIDS). The treatment group received training in biofeedback, guided imagery, and hypnosis. Results included significant decreases in fever,

fatigue, pain, headache, nausea, and insomnia and increased vigor and hardiness. Another study of immunological and psychological outcomes of a stress reduction program was conducted with patients with malignant melanoma. Results included significant increases in large granular lymphocytes (defined as CD57 with Leu-7) and natural killer (NK) cells (defined as CD16 with Leu-II and CD56 with NKHI), along with indications of increased NK cytotoxic activity. Also noted were significantly lower levels of psychological distress and higher levels of positive coping methods in comparison with patients who were not part of the group. Many other applications of behavior therapy are used in medical care. In general, most patients feel they benefit from such interventions, especially in their ability to cope with chronic illness.

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09 - 28.9 Hypnosis

28.9 Hypnosis

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28.9 Hypnosis The concept of hypnosis conjures up myriad perceptions among clinicians and the lay public. Even the term hypnosis can be misleading, coming as it does from the Greek root *hypnos* (meaning "sleep"). In reality, hypnosis is not sleep. It is more likely a complex process that requires alert focused and receptive attention. Hypnosis is a powerful means of directing innate capabilities of imagination, imagery, and attention. Many also believe the myth that the clinician projects the hypnotic trance onto the patient or has the power to influence the patient. In reality it is the patient who has the hypnotic gift, and the clinician's role is to assess the patient's capacity to capitalize on this asset and to help the patient discover and use it effectively. Patient motivation, personality style, and biological predisposition may contribute to the manifestation of this talent. During the hypnotic trance, focal attention and imagination are enhanced and simultaneously peripheral awareness is decreased. This trance may be induced by a hypnotist through formalized induction procedures, but it can also occur spontaneously. The capacity to be hypnotized and, relatedly, the occurrence of spontaneous trance states is a trait that varies among individuals but is relatively stable throughout a person's life cycle.

HISTORY

Descriptions of trance states, ecstatic states, and spontaneous dissociative states abound in the Eastern and Western religious, literary, and philosophical traditions. Anton Franz Anton Mesmer (1734-1815) first formally described hypnosis as a therapeutic modality in the 18th century and believed it to be the result of a magnetic energy or an invisible fluid that the therapist channels into the patient to correct imbalances, restoring health. James Braid (1795-1860), an English physician and surgeon, used eye fixation and closure to induce trance states. Later, Jean Martin Charcot (1825-1893) theorized the hypnotic state to be a neurophysiologic phenomenon that was a sign of mental illness. Contemporaneously, Hippolyte Bernheim (1840-1919) believed it to be a function of the normal brain. Early in his career, Sigmund Freud (1856-1939) used hypnosis as part of his psychoanalysis and noticed that patients in a trance could relive traumatic events, a process called *abreaction*. Later, Freud switched from hypnosis to free association because he wanted to minimize the transference that sometimes accompanies the trance

state. Importantly, the switch did not eliminate the occurrence of spontaneous trance during the analysis. World War I produced many shell-shocked soldiers and Ernst Simmel (1882-1947), a German psychoanalyst, developed a technique for accessing repressed material that he named

hypnoanalysis. During World War II, hypnosis played a prominent role in the treatment of pain, combat fatigue, and neurosis. Formal recognition of hypnosis as a therapeutic modality did not occur, however, until the 1950s. The British Medical Society recommended its teaching in medical schools in 1955 and the American Medical Association and American Psychiatric Association officially stated its safety and efficacy in 1958. DEFINITION Hypnosis is currently understood as a normal activity of a normal mind through which attention is more focused, critical judgment is partially suspended, and peripheral awareness is diminished. The trance state, being a function of the subject's mind, cannot be forcibly projected by an outside person. The hypnotist, however, may aid in the achievement of the state and use its uncritical, intense focus to facilitate the acceptance of new thoughts and feelings, thereby accelerating therapeutic change. For the subject, hypnosis is typified by a feeling of involuntariness and movements seem automatic. TRAIT OF HYPNOTIZABILITY A person's degree of hypnotizability is a trait that is relatively stable throughout the life cycle and is measurable. The process of hypnosis takes the hypnotizability trait and transforms it into the hypnotized state. Experiencing the hypnotic concentration state requires a convergence of three essential components: absorption, dissociation, and suggestibility. Absorption is an ability to reduce peripheral awareness that results in a greater focal attention. It can be metaphorically described as a psychological zoom lens that increases attention to the given thought or emotion to the increasing exclusion of all context, even including orientation to time and space. Dissociation is the separating out from consciousness elements of the patient's identity, perception, memory, or motor response as the hypnotic experience deepens. The result is that components of self-awareness, time, perception, and physical activity can occur without being known to the patient's consciousness and so may seem involuntary. Suggestibility is the tendency of the hypnotized patient to accept signals and information with a relative suspension of normal critical judgment; it is controversial whether critical judgment can be completely suspended. This trait will vary from an almost compulsive response to input in the highly hypnotizable to a sense of automaticity in the less hypnotizable individual. Table 28.9-1 lists the indicators of trance development. Table 28.9-1

Indicators of Trance Development QUANTIFICATION OF HYPNOTIZABILITY Quantifying a patient's degree of hypnotizability is useful in a clinical setting because it predicts the effectiveness of hypnosis as a therapeutic modality. Quantification also provides useful information about the way patients relate to themselves and the social environment. Highly hypnotizable patients have an increased incidence of spontaneous trance-like states and so may be unduly influenced by ideas and emotions that are not being appropriately self-critiqued. NEUROPHYSIOLOGICAL CORRELATES OF HYPNOSIS Neurological testing of individuals in the hypnotized state and those with a high degree of hypnotizability has led to some interesting findings, but no set of changes has been shown to be sensitive or specific for the trance state or hypnotizability trait. Electroencephalographic (EEG) studies have shown that hypnotized persons exhibit electrical patterns that are similar to those of fully awake and attentive persons and not like those found during sleep. Increased alpha activity and theta power in the left frontal region has been reported in highly hypnotizable patients as compared with those who are less hypnotizable; these differences exist in the trance and nontrance states.

Positron emission tomography (PET) studies that compare regional blood flow in the brain in both hypnotized and nonhypnotized subjects lend further evidence to the hypothesis that hypnosis exerts some of its effects at lower-level modalities of the brain. Hypnotic suggestions to add color

to a visual image result in increased blood flow to the lingual and fusiform gyri, the color vision processing centers of the brain; suggestions to remove color have the opposite effect. Similarly, the intensity and noxiousness of pain are believed to be processed by different regions of the brain, because different areas of reduced blood flow result when each is minimized through hypnosis. The role of the anterior brain regions, such as the frontal lobes, in hypnosis has been shown physiologically by the positive correlation between homovanillic acid concentrations in the cerebrospinal fluid and degree of hypnotizability. The frontal cortex and basal ganglia have a large number of neurons that use dopamine, of which the metabolite is homovanillic acid. This may explain why pharmacological enhancement of hypnotizability, although difficult, is primarily accomplished with dopaminergic agents, such as amphetamine. The increased activation of the basal ganglia may relate to the increased automaticity of hypnotic motor behavior.

CLINICAL ASSESSMENT OF HYPNOTIC CAPACITY Two major procedures exist to clinically evaluate hypnotic capacity: the Stanford Hypnotic Susceptibility Scale and the Hypnotic Induction Profile (HIP) (Table 28.9-2). The Stanford Hypnotic Susceptibility Scale is a long laboratory-based test that has been modified for clinical evaluation and requires approximately 20 minutes to perform. It primarily measures behavioral compliance and suggestibility. The HIP is a shorter test that uses the eye-roll sign as a biological indicator and measures cognitive flow, which differentiates those with no hypnotic capacity because of mental pathology from those mentally normal patients with any inherent hypnotic capacity (Fig. 28.9-1). **FIGURE 28.9-1** Administration of the Hypnotic Induction Profile can be a routine part of the initial visit

and evaluation. The test begins with the eye-roll sign, a presumptive measure of biological ability to experience dissociation. In the test procedure for eye-roll sign measurement, the patient is told “Hold your head looking straight forward; while holding your head in that position, look upward, toward your eyebrows—now toward the top of your head [up-gaze]. While continuing to look upward, close your eyelids slowly [roll].” The up-gaze and roll are scored on a 0 to 4 scale by observing the amount of sclera visible between the lower eyelid and the lower edge of the cornea. If an internal squint occurs, the degree is scored on a 1 to 3 scale. The squint score is added to the roll score. This procedure takes about 5 seconds. The eye-roll is a part of the hypnotic induction, which is also scored as an initial indicator of the potential for hypnotic experience. (Courtesy of Herbert Spiegel, M.D., Marcia Greenleaf, Ph.D., and Davig Spiegel, M.D.)

Table 28.9-2 Hypnotic Induction Profile–Derived Method of Self-Hypnosis

INDUCTION Many different induction protocols follow the same basic principles and pattern, but may be better suited to the patients with different levels of hypnotizability. Doctor: Take a long, deep breath—inhale and exhale; now close your eyes and relax. Pay particular attention to the muscles in and about your eyes—relax them to the point that they just won’t work. Are you trying to do that? Good. If you really have

them relaxed, right at this very moment, no matter how hard you try, they just won’t open. Test them. The harder you try, the faster they stick together, just as if they were glued together. That’s fine! Now you can open your eyes; that’s good. When I tell you to and not before, open and close your eyes once more, and, when you close them this time, you will be ten times as relaxed as you are right now. Go ahead, open and close, and feel that surge of relaxation go through your whole body, from the top of your head to the tip of your toes. Very good! Now once again, open and close your eyes, and this time, when you close them, you will double the relaxation that you now have. Fine. If you have followed my suggestions, right at this very moment, when I lift your hand and let it drop into your lap, it will drop like a wet cloth, heavy and limp. That’s very, very good. You now

have good physical relaxation, but medical relaxation consists of two phases: physical, which you now have, and mental, which I will now show you how to achieve. When I ask you to and not before, I want you to start counting backward from 100. I know you can count; that is not what we're after. I just want you to relax mentally. As you say each number, pause momentarily until you feel a wave of relaxation cover your whole body, from the top of your head to the tip of your toes. When you feel this wave of relaxation, then say the next number, and each time you say a number, you will double the relaxation you had before you said the number. If you do this properly, an interesting thing will happen—as you say the numbers and relax, the succeeding numbers will start to disappear and vanish from your mind. Command your mind to dispel these numbers. Now, aloud and slowly, start counting backward from 100. Patient: One hundred. Doctor: Very good. Patient: Ninety-nine. Doctor: Make them start to disappear now. Patient: Ninety-eight. Doctor: Now they're fading away, and after the next number they'll all be gone. Make them disappear. Let the numbers go. Patient: Ninety-seven. Doctor: And now they're all gone. Are they gone? Fine. If there are any numbers still lurking in your mind, when I lift your hand and drop it, they will all disappear. (Courtesy of William Holt, M.D.)

INDICATIONS A patient's degree of hypnotizability and the technique of hypnosis are clinically useful in diagnosis and in treatment, respectively.

The existence of spontaneous, trance-like states in everyday life and the potential of individuals to uncritically accept emotions and information in these states make a person's degree of hypnotizability a factor in the way the world is viewed and processed. A relation is seen between various conditions and hypnotizability. For example, patients with paranoid personality disorder are low and patients who are histrionic are higher on the hypnotizability spectrum. Patients with dissociative identity disorder are highly hypnotizable. Patients with eating disorders are difficult to hypnotize. A 32-year-old man presented to the emergency department with a severe headache. He was a chronic migraine sufferer and had been unable to control the pain on this occasion with his propranolol (Inderal). The emergency department recognized that he had high hypnotic capacity. The imagery of an icepack being placed on his forehead was suggested. Initially some real ice was placed on his forehead to help. The patient was able to control his pain completely with this imagery. He did not require narcotics, as he had on previous visits. On follow-up several weeks later the patient reported being able to use this strategy to control, as well as prevent, migraine attacks, and he no longer had to rely on frequent emergency department visits for pain relief. (Courtesy of A. D. Axelrad, M.D., D. Brown, Ph.D., and H. J. Wain, Ph.D.)

A 22-year-old male patient was brought to the emergency room with bilateral blindness. Following an evaluation by ophthalmology, it was determined that the blindness was psychogenic. After initial evaluation by psychiatry, a therapeutic alliance was developed, and hypnosis was used to take the patient to a safe place and then back to the time immediately prior to the blindness. After two sessions the patient was able to describe seeing his wife in an adulterous relationship. At that moment the patient vocalized a desire to harm his wife and her suitor. Immediately after this vocalization, he became amnesic for the event and blind. On describing this under hypnosis, he was given a suggestion that when he became alert "He would only remember what he felt comfortable remembering." Subsequent to the patient becoming alert, he had no idea what had occurred, and each day after the hypnotic intervention was initiated the patient's anger was reframed. When the patient felt comfortable he then confronted his wife. The patient became aware that the amnesia was being used to prevent him from acting out. Use of a psychodynamic, cognitive reframing approach with a hypnotic milieu helped this patient to gain control and understanding of his symptoms. The patient and his wife were then referred for marital counseling. (Courtesy of A. D.

Axelrad, M.D., D. Brown, Ph.D., and H. J. Wain, Ph.D.) Therapeutically, hypnosis's effectiveness in facilitating acceptance of new thoughts and feelings makes it useful in treating habitual problems and also with symptom management. Smoking, overeating, phobias, anxiety, conversion symptoms, and chronic

pain are all indications for hypnosis. They can often be treated in a single session, in which a patient is taught to perform self-hypnosis. Hypnosis can also aid in psychotherapy, notably for posttraumatic stress disorder, and it has been used for memory retrieval. A 29-year-old woman was referred for evaluation and treatment of ongoing facial pain that was not responding to traditional methods of intervention. Neurological evaluation showed no objective physical correlations. Her high midrange performance on the HIP added support to the potential of a psychological mechanism for the pain. Initially the pain was controlled by a hypnotic intervention, but it returned 24 hours later. Her self-hypnotic technique ceased to be effective. A decision was made to explore more completely the meaning of the pain. Age regression under hypnosis was used, and the patient was regressed to a time prior to the pain. She related that her brother had been injured by a car while he was running in the street. The patient was babysitting at the time, and her father was so angered that he hit her. Recently her friend's dog ran away, and she felt responsible. As she began to recognize her need to punish herself because of her guilt over what had occurred, she was able to understand her feelings and reframe her thoughts in a more productive manner. An "affect bridge" was also used, and the patient was asked to go back to a previous time when she felt guilty and was punished. She then was able to describe her feelings of being hit by her alcoholic, abusive father. She continued to gain insight and mastery over the past and was able to ablate her pain. (Courtesy of A. D. Axelrad, M.D., D. Brown, Ph.D., and H. J. Wain, Ph.D.) A 42-year-old married mother of three children had been kidnapped and locked in a large packing trunk. After she had freed herself and broken out, her abductors had stabbed her multiple times, tied her up, put her back in the trunk, and thrown her down a cliff. She had eventually managed to break out and crawl to safety. Eventually she had been picked up by a passerby. She reported that others had seen her lying on the road and appeared frightened to approach her. Eventually 911 had been called and she had been transported to a hospital. Following medical stabilization she had been discharged and found herself developing nightmares, reexperiencing avoidance, and having hyperarousal symptoms. She was referred by her internist for treatment and was initially started on 25 mg of sertraline (Zoloft), which was increased to 50 mg 4 days later. She was evaluated on the HIP and determined to be a mid- to high-range hypnotic subject. She was taught to go to a safe place and to use a split-screen technique. She was also given permission to describe her nightmares, reexperiences, and overwhelming anxieties and fears that she faced while being captive, as well as her feelings of abandonment while lying on the road. She was reinforced for her ingenuity in breaking out of the trunk. Her feeling of blame for her capture was reframed while she was under hypnosis. She was taught to calm herself and to reframe her negative feelings about her helplessness. Hypnotic age regression was used to help her master her experiences and facilitate their

becoming like a bad movie. Initially her startle response was used as a signal for her to go to her comfort zone. Age progression was used to help her to rehearse the future. The treatment used the milieu of hypnosis along with exposure, cognitive reframing, psychodynamic approaches, and pharmacology. (Courtesy of A. D. Axelrad, M.D., D. Brown, Ph.D., and H. J. Wain, Ph.D.)

CONTRAINDICATIONS No intrinsic dangers to the hypnotic process exist. Because of the increased

dependence that the hypnotized patient has toward the therapist, a strong transference may occur, however, in which the patient exhibits feelings for the therapist that are inappropriate in regards to their relationship. Strong attachments may occur, and it is important that these are respected and properly interpreted. Negative emotions may also be brought out in the patient, especially those who are emotionally fragile or who have poor reality testing. To minimize the likelihood of this negative transference, caution should be taken when choosing patients who have problems with basic trust, such as those who are paranoid or who require high levels of control. The hypnotized patient also has a reduced ability to critically evaluate hypnotic suggestions and, thus, the hypnotist must have a strong ethical value system. Controversy exists about whether patients can perform acts during a trance state that they would otherwise find repugnant or that run contrary to their moral system.

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10 - 28.10 Interpersonal Therapy

28.10 Interpersonal Therapy

Raz A, Landzberg KS, Schweizer HR, Zephrani ZR, Shapiro T, Fan J, Posner MI. Posthypnotic suggestion and the modulation of Stroop interference under cycloplegia. *Conscious Cogn.* 2003;12:332. Santarcangelo EL, Busse K, Carli G. Frequency of occurrence of the F wave in distal flexor muscles as a function of hypnotic susceptibility and hypnosis. *Brain Res Cogn Brain Res.* 2003;16:99. Spiegel D. Negative and positive visual hypnotic hallucinations: Attending inside and out. *Int J Clin Exp Hypn.* 2003;51:130. Spiegel H, Spiegel D. *Trance and Treatment: Clinical Uses of Hypnosis.* 2nd ed. Washington, DC: American Psychiatric Press; 2004. 28.10 Interpersonal Therapy Interpersonal psychotherapy (ITP), a time-limited treatment for major depressive disorder, was developed in the 1970s, defined in a manual, and tested in randomized clinical trials by Gerald L. Klerman and Myrna Weissman. ITP was initially formulated as an attempt to represent the current practice of psychotherapy for depression. It assumes that the development and maintenance of some psychiatric illnesses occur in a social and interpersonal context and that the onset, response to treatment, and outcomes are influenced by the interpersonal relations between the patient and significant others. The overall goal of ITP is to reduce or eliminate psychiatric symptoms by improving the quality of the patient's current interpersonal relations and social functioning. The typical course of ITP lasts 12 to 20 sessions over a 4-month to 5-month period. ITP moves through three defined phases: (1) The initial phase is dedicated to identifying the problem area that will be the target for treatment; (2) the intermediate phase is devoted to working on the target problem area(s); and (3) the termination phase is focused on consolidating gains made during treatment and preparing the patients for future work on their own (Table 28.10-1). Table 28.10-1 Phases of Interpersonal Psychotherapy

TECHNIQUES Individual Interpersonal Psychotherapy Initial Phase. Sessions 1 through 5 typically constitute the initial phase of ITP. After assessing the patient's current psychiatric symptoms and obtaining a history of these symptoms, the therapist gives the patient a formal diagnosis. Therapist and patient then discuss the diagnosis, as well as what might be expected from treatment. Assignment of the sick role during this phase serves the dual function of granting the patient both the permission to recover and the responsibility to recover. The therapist explains the rationale of ITP, underscoring that therapy will focus on identifying and altering dysfunctional interpersonal patterns related to psychiatric symptomatology. To determine the precise focus of treatment, the therapist conducts an interpersonal inventory with the patient and develops an interpersonal formulation based on this. In the interpersonal formulation, the therapist links the patient's

psychiatric symptomatology to one of the four interpersonal problem areas—grief, interpersonal deficits, interpersonal role disputes, or role transitions. The patient’s concurrence with the therapist’s identification of the problem area and agreement to work on this area are essential before beginning the intermediate treatment phase.

Intermediate Phase. The intermediate phase—typically sessions 6 to 15— constitutes the “work” of the therapy. An essential task throughout the intermediate phase is to strengthen the connections the patient makes between the changes he or she is making in his or her interpersonal life and the changes in his or her psychiatric symptoms. During the intermediate phase, the therapist implements the treatment strategies specific to the identified problem area as specified in Table 28.10-2. Table 28.10-2 Treatment of Interpersonal Problem Areas Termination Phase. In the termination phase (usually, sessions 16 through 20), the therapist discusses termination explicitly with the patient and assists him or her in understanding that the end of treatment is a potential time of grief. During this phase, patients are encouraged to describe specific changes in their psychiatric symptoms, especially as they relate to improvements in the identified problem area(s). The therapist also assists the patient in evaluating and consolidating gains, detailing plans for maintaining improvements in the identified interpersonal problem area(s), and outlining remaining work for the patient to continue on his or her own. Patients are also encouraged to identify early warning signs of symptom recurrence and to identify plans of action. Ms. G is a 51-year-old woman who presented for treatment of binge eating disorder. She is college educated, has her own business, and is a divorced mother of one adult son in his early 20s. Before treatment, she had a body mass index (BMI) of 42 and had been binge eating approximately 10 to 15 days per month for the past 8 years. Along with her current diagnosis of binge eating disorder, Ms. G struggled with recurrent major depression. During the initial phase, Ms. G and her therapist began to review her history and the interpersonal events that were associated with her binge eating. Ms. G shared that she began overeating and gaining weight at age 14. When she was 18 years of age,

she moved to a foreign country with her parents. Soon after the move, Ms. G’s father left her and her mother to return to the United States. Ms. G was enraged at her father for leaving them and still gets very tearful and angry when discussing the separation. She and her mother decided to stay abroad because she had started university and her mother was working. Both had developed strong social ties and felt comfortable in their new home. During this time, Ms. G continued to gain weight and started dieting. Shortly after graduating from university, Ms. G met and married a foreign national and, at the age of 28, delivered their only son. Two years later, she and her husband went through a very bitter divorce. Although Ms. G described this as a terrible time in her life, she maintained close ties with her friends and her mother. During this time, she began to diet and reached her lowest adult weight. At the age of 35, when her mother died of a heart condition, Ms. G had her first episode of major depression, which was treated and resolved with antidepressants and a brief course of psychotherapy. Although she had previous cycles of weight loss and weight regain, she did not evidence any sign of eating disturbance at this point. She continued to maintain close social ties and enjoyed her close relationship with her son. When Ms. G was in her early 40s, an economic downturn in her adopted country forced her to return to the United States. Having lost all of her savings, she struggled financially while she looked for work. During this time, she started binge eating and gaining weight. Within 1 year of this move, Ms. G’s son decided to return to live with his father (who was very wealthy). Ms. G felt angry and betrayed. Yet, when her son would visit, she would assume a subservient role with him, because she was

afraid of losing his affection. He, in turn, became quite demanding and critical of her. Before seeking treatment, her heightened feelings of isolation and loneliness were leading to increased binge eating, depression, and weight gain. By session 3 of the initial phase, Ms. G's therapist began to consider which problem area would be the focus of the remainder of treatment. Ms. G had a history of important relationship losses and subsequent grief—the loss of her father, her husband, her mother, and, most recently, her son. However, none of these losses was associated with the development of binge eating problems (although her dieting was clearly linked to her feelings of anger after the divorce from her husband and her depression was intimately linked with her mother's death). Ms. G's anger at her son for returning to live with the enemy was clearly a role dispute, yet her binge eating had begun 2 years before his departure (although it clearly worsened after he left). Because neither of these problem areas was directly linked to the onset of the eating disorder, Ms. G's therapist decided that the focus of treatment would be to assist her in managing her role transition. Her move back to the United States, with the subsequent loss of her support and friendship networks, was clearly associated with the onset and continued maintenance of her binge eating. During session 4 of the initial phase, Ms. G's therapist shared her formulation of the problem area with her: "From what you have described, your binge eating really began after you returned to the United States. After that transition, you were more isolated and alone than you have ever been. It seems that binge eating was a way for you to manage that

transition and the subsequent feelings of isolation and loneliness. Your transition has also had a negative impact on your relationship with your son. Even though you are a very social person and enjoy the company of others, you have yet to develop the kind of support that you had before you moved. Although you have struggled with some very significant issues over the course of your life—your father leaving, the pain of the divorce, and the death of your mother—your friends and support systems sustained you. If we work together to help you find and develop more intimate and supportive relationships here, I believe you will be much less likely to turn to food and binge eating as a source of support or comfort." Ms. G agreed with the formulation and worked with her therapist to establish some treatment goals to help her resolve the problem area. First, she was encouraged to become more aware of her feelings (especially isolation and loneliness) when she was binge eating and of how binge eating seemed to be the way she managed those feelings. A second goal was for her to take steps to increase her social contacts and develop more friendships. The third goal, which was identified as a secondary problem area, centered on helping Ms. G resolve the role dispute with her son. Specifically, the therapist developed a goal with her to help her establish a clearer parental role with her son. During the intermediate phase, the therapist helped Ms. G grieve the loss of her previous role and the extensive support that she once had. Ms. G and her therapist worked to identify several sources of support and friendships of which she had not been aware. Soon after, Ms. G reported significant progress in initiating and establishing relationships with others. This change appeared to help give her confidence in her new roles. In fact, she had begun to receive a few social invitations. She was more attuned to the ways that she would rely on food, especially when she felt lonely or felt that she was not receiving enough time from others. The connection between the lack of supportive contacts and binge eating was becoming very clear to her in these intermediate sessions. During this phase, the therapist also assisted her in setting appropriate limits in her relationship with her adult son and in recognizing his adult-like responses in return. By the termination phase, Ms. G reported that she no longer felt so lonely and isolated and that her binge eating had all but disappeared. She remarked how the quality of her relationship with her son had changed dramatically. He was more supportive and

respectful, visited more frequently, and stayed with her for longer periods of time. In the final sessions, she talked about her need to let go of the past and move on with her life as it is now, assuming her new roles more fully. She worked closely with her therapist to develop a plan to maintain the gains that she had made in treatment and used the final session to review the important work that she had accomplished. (Courtesy of D. E. Wilfley, Ph.D., and R. W. Gynnn, M.D.) Interpersonal Psychotherapy Delivered in a Group Format

A recent approach in the ongoing development of ITP has been its use in a group format. ITP delivered in a group format has many potential benefits in comparison with individual treatment. For example, a group format in which membership is based on diagnostic similarity (e.g., depression, social phobia, eating disorders) can help alleviate patients' concerns that they are the only one with a particular psychiatric disorder, while offering a social environment for patients who have become isolated, withdrawn, or disconnected from others. Given the number and different types of interpersonal interactions in a group setting, the interpersonal skills that are developed may be more readily transferable to the patient's outside social life than are the relationship patterns that are addressed in a one-on-one setting. Moreover, a group modality has therapeutic features not present in individual psychotherapy (e.g., interpersonal learning). The group format also facilitates the identification of problems common to many patients and provides a cost-effective alternative to individual treatment. Table 28.10-3 links the phases of ITP to the stages of group development. Table 28.10-3 Stages of Group Development in Interpersonal Psychotherapy (ITP) Timeline and Structure of Treatment. The typical course of group ITP lasts 20 sessions over a 5-month period. It is recommended that group size range from six to nine members, with one or two group leaders, depending on resources and training needs. The three individual meetings (pregroup, midgroup, and postgroup), sequenced to correspond with critical time points in the three phases of ITP, in combination with other techniques, were designed to maintain the exclusive and strategic focus on individual patients' interpersonal problem areas—the hallmark of ITP. Pregroup Meeting. The pretreatment meeting is crucial for facilitating a patient's individualized work in the first phase of group ITP. The focus of the 2-hour pretreatment meeting is to identify interpersonal problem areas, establish an explicit treatment contract to work on problem areas, and prepare patients for group treatment. After identifying a patient's interpersonal problem(s) (i.e., interpersonal deficits, role disputes, role transitions, or grief), the therapist works collaboratively with the patient to formulate concrete prescriptions for change, in addition to the specific steps the

patient will take to improve social relationships and patterns of relating. These goals of treatment are expressed in language that is as specific and personally meaningful to the patient as possible. Before the start of the group, each group member is given a written summary of his or her goals and told that these goals will guide his or her work in the group. Another important element of the pregroup meeting involves adequately preparing patients for group treatment. That is, patients are encouraged to think of the group as an "interpersonal laboratory" in which they can experiment with new approaches to handle challenging interpersonal situations. In this regard, patients are informed about the important interpersonal skills that are learned while participating in a group (e.g., interpersonal confrontation, honest communication, expression of feelings) and are encouraged to learn from others as they see changes occur. The therapist stresses to patients the importance of keeping their work in the group focused on changing their current interpersonal situations or intensifying important existing relationships and not using the group as a substitute

social network. Initial Phase. The first five sessions of the group treatment comprise the initial phase in group ITP. During this phase, the therapist works to cultivate positive group norms and group cohesion, while emphasizing the commonality of symptoms among members and how they will be addressed in the group context. During this phase, group members are encouraged to review their goals with the group and begin to make some initial changes in their respective interpersonal problem areas. As members begin to experiment with the changes outlined in their goals, the therapist works collaboratively with each group member to refine and make any alterations in the target areas before the beginning of the intermediate phase. Intermediate Phase. During the intermediate “work” phase of group ITP (sessions 6 through 15), the therapist works to facilitate connections among members as they share the work on their goals with one another. In contrast to other interactive group approaches, the group interpersonal psychotherapist is much less likely to focus on intragroup processes and relationships unless they are specific to the work on a member’s interpersonal problem area (e.g., interpersonal deficits). The therapist, however, consistently and continuously encourages group members to practice newly acquired interpersonal skills both inside and, most importantly, outside the group. As is the case with individual ITP, an essential task throughout the intermediate phase is to strengthen the connections the group members make between difficulties in their interpersonal lives and their psychiatric problems. MIDTREATMENT MEETING. The midtreatment meeting is held midway (usually between sessions 10 and 11) through the intermediate phase. This meeting provides an opportunity to conduct a detailed review of each group member’s progress on his or her individual problems and to refine interpersonal goals. The therapist(s) recontracts with group members during this meeting as a means of outlining and emphasizing the work

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that remains, both inside and outside of the group, before the conclusion of treatment. Termination Phase. In the termination phase (sessions 16 through 20), the therapist discusses termination explicitly with the group members and begins to help them recognize that the end of treatment is a time of possible grief and loss. The therapist helps members recognize their own progress and the progress made by other group members. During this phase, group members are encouraged to describe the specific changes in their psychiatric symptoms, especially as they relate to improvements in the identified problem area(s) and relationships. Although it is common for group members to want to keep meeting on their own or to have frequent reunions, group members are encouraged to use this phase of the group to formally say goodbye to one another and to the therapist(s). The therapist(s) also uses this time to encourage members to detail their plans for maintaining improvements in their identified interpersonal problem area(s) and to outline their remaining work. POSTTREATMENT MEETING. The posttreatment meeting is scheduled within 1 week after the final group session. The therapist(s) uses this final individual meeting to develop an individualized plan for each group member's continued work on his or her interpersonal goals. The therapist(s) reviews the group experience and the changes the patient has made in his or her interpersonal problem area and significant relationships. REFERENCES Binder JL, Betan EJ. Essential activities in a session of brief dynamic/interpersonal psychotherapy. *Psychotherapy*. 2013;50(3):428-432. Bolton P, Bass J, Neugebauer R, Verdelli H, Clougherty KF, Wickramaratne P, Speelman L, Ndogoni L, Weissman M. Group interpersonal psychotherapy for depression in rural Uganda: A randomized controlled trial. *JAMA*. 2003;289:3117. Gilbert SE, Gordon KC. Interpersonal psychotherapy informed treatment for avoidant personality disorder with subsequent depression. *Clin Case Stud*. 2013;12(2):111-127. Huibers MJ, van Breukelen G, Roelofs J, Hollon SD, Markowitz JC, van Os J, Arntz A, Peeters F. Predicting response to cognitive therapy and interpersonal therapy, with or without antidepressant medication, for major depression: a pragmatic trial in routine practice. *J Affect Disord*. 2014;152-154:146-154. Markowitz JC. Interpersonal psychotherapy for chronic depression. *J Clin Psychol*. 2003;59:847. Miller MD, Frank E, Cornes C, Houck PR, Reynolds CF 3rd. The value of maintenance interpersonal psychotherapy (IPT) in older adults with different IPT foci. *Am J Geriatr Psychiatry*. 2003;11:97. Spinelli MG, Endicott J. Controlled clinical trial of interpersonal psychotherapy versus parenting education program for depressed pregnant women.

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More than anything else psychiatrists do, they listen to stories. These stories so saturate the clinical encounter that it would be impossible to imagine a clinical encounter without them. In the very first meeting between psychiatrist and patient, the psychiatrist begins with an open-ended invitation to a story: "What brings you here?" or "What seems to be the problem?" Patients respond to these questions by telling psychiatrists about their lives, their troubles, when the troubles began, what seems to have caused them, how they create difficulty, and what kinds of problem solving they have tried. Such stories may be rudimentary, they may be only partially worked out, and they may even be baffled and confused. The patient may even be perplexed enough to answer "I don't know why I came" or "I'm not really sure what's wrong, my family sent me." Nonetheless, the patient's response to the psychiatrist's initial questions always involves a story. Narrative psychotherapy emerges out of this increased interest in clinical stories. The two main tributaries that lead to narrative psychotherapy come from the two different sides of psychiatry: narrative medicine and narrative psychotherapy. Narrative psychiatrists are psychiatrists who combine the wisdom of these two domains. Following the lead of narrative medicine, narrative psychiatrists recognize that psychiatric patients, like medical patients, come to clinics with intense stories to tell. Contemporary narrative medicine has developed from 30 years of work in bioethics and medical humanities devoted to humanizing the clinical encounter through a better understanding of patient stories. The term narrative medicine comes from Rita Charon, an internist and literary scholar, who used it to describe an approach to medicine that uses narrative approaches to augment scientific understandings of illness. Narrative medicine brings together insights from human-centered medical models, such as George Engel's biopsychosocial model and Eric Cassel's person-centered model, with research and insights from phenomenology, the humanities, and interpretive social sciences. Narrative medicine uses these resources to better understand the illness experience, "to recognize, absorb, interpret, and be moved by the stories of illness." As Charon argued, when clinicians possess narrative competency, they can enter the clinical setting with a nuanced capacity for "attentive listening. . . , adopting alien perspectives, following the narrative thread of the story of another, being curious about other people's motives and experiences, and tolerating the uncertainty of stories." She further argued that doctors "need rigorous and disciplined training" in narrative reading and writing not just for their own sake (helping them to deal with the strains and traumas of clinical work), but also "for the sake of their practice." Without such narrative competency, clinicians lack the ability to fully understand their client's experience of illness. For Charon and others in narrative medicine, narrative study is not a mere adornment to a doctor's medical training; it is a crucial and basic science that must be mastered for medical practice. A major task of narrative medicine, and therefore narrative psychotherapy, is to be a good listener and to connect empathically with the patient's story. A narrative psychiatrist, like a narrative physician, seeks to understand the patient first and foremost. This understanding brings patient and clinician together into a shared

experience of the patient's world. This narrative understanding is much more than a causal explanation of problem A or problem B that the patient might have. It does not simply abstract

from the person's situation a categorical label that groups problems under a well-known abstract grid. Instead, narrative understanding tunes in to the uniqueness of the individual and the unrepeatability of the person's experience and difficulties. Narrative understanding, in short, is a deep appreciation of the person as a whole—what it feels like for this person, in this particular context, going through these particular problems. In addition to following the lead of narrative medicine colleagues, narrative psychiatrists also follow the lead of contemporary colleagues in narrative psychotherapy. The history of narrative psychotherapy goes back to Sigmund Freud's early work at the inception of psychoanalysis. At that time, Freud lamented about how his case histories sounded more like narrative fictions than hard science. Contemporary narrative psychotherapy's motivation for returning to the role of narrative comes partly from the broader turn to narrative in humanities, psychology, and social science and partly from the history of psychotherapy since Freud. The past century of psychotherapy has been a century of strife, with one faction after another splitting off from psychoanalysis. Leading alternatives to psychoanalysis included behavioral, humanistic, family, cognitive, feminist, and interpersonal, just to name some. All of these splits are characterized by further splits within splits, which has fragmented the field of psychotherapy to the point that there are now more than 400 active approaches to psychotherapy. Narrative approaches emerge at this particular moment as part of an important trend away from further fragmentation and toward psychotherapy reintegration. Narrative approaches are invaluable for psychotherapy integration because they provide a metatheoretical orientation from which to understand and practice psychotherapy. METAPHOR Metaphor performs this function by allowing us to understand and experience one thing in terms of something else. The metaphor selects, accentuates, and backgrounds aspects of two systems of ideas so that they come to be seen as similar: "Men are seen to be more like wolves after the wolf metaphor is used, and wolves seem to be more human." Understanding metaphor in this way connects to broader work in continental linguistic philosophy, and that work, as a whole, shifts standard ideas about truth and objectivity. It allows us to sidestep the usual binary traps between relativism (anything goes) and realism (there is only one correct or true way to describe the world). When the role of language is understood as a mediator between our concepts and the world, it no longer makes sense to think in these highly modernist either/or terms. Rather than using the rigid binary distinction between true and false, it becomes possible to think instead in a postmodern language of semiotic realism and pluridimensional consequences.

PLOT Plot works like metaphor in that it also orders experiences and provides form for narratives. Plot, or the process of emplotment, adds to metaphor two key dimensions: (1) it brings together what would otherwise be separate and heterogeneous elements, and (2) it organizes understanding and experience or time, or what could be called temporal perception. The critical function of plot for narrative is that plot creates a narrative synthesis between multiple individual events and brings them together into a single story. It allows an intelligible connection to be made between them. Remarkably, plot can create a synthesis between events and elements that are surprisingly incongruous or heterogeneous—events that do not seem to fit together. Plot also configures these multiple elements into a temporal order. This temporal order is of two sorts. First, each plot is comprised of a discrete series of incidents, of theoretically infinite nows. Second, each plot takes these infinite nows, proceeding one after another in succession, and organizes them into a humanly manageable experience. CHARACTER In narrative theory, the concept of character connects directly to contemporary controversy surrounding the related and, some may argue, more basic concept of identity. The controversy around identity may be understood as a tension

between essentialist and nonessentialist approaches. Essentialist notions of identity tell us that each person has a fixed personality, perhaps biologically stamped, that authentically belongs to that person and that is at the core of that person's being. This "true self" or "core self" may be distorted or covered over, but it is nonetheless there for the discovery if individuals apply themselves patiently and persistently to the task. Nonessentialist critiques, however, have deconstructed this ideal of identity and its notion of an integral, originary, and unified self. One of the most productive ways to navigate the tension between essentialist and nonessentialist understandings of identity is to draw a comparison between identity (in life) and character (in fiction). Rather than adopting a linear logic that understands identity as a more fundamental concept to character, this approach uses a circular logic to argue that people understand themselves in the same way they understand characters. Narrative approaches to identity allow people to navigate the tension between essentialist and nonessentialist identities because narrative identity allows for a kind of continuity over time, a relative stability of self, without implying a substantial or essentialist core to this stability. People's interpretations of themselves use the cultural stories with which they are surrounded to tell a story of self that escapes the two poles of random change and absolute identity. In this way, a narrative identity is also a cultural identification. A person's identification may seem original, but he or she narrates them with the resources of history, language, and culture.

NARRATIVE PSYCHOTHERAPY With this brief introduction into narrative medicine, narrative psychotherapy, and narrative theory, it is possible to draw out further the meaning of narrative for psychiatry. Fortunately, one of the most helpful aspects of narrative theory for psychiatry is that it provides an overarching, or metatheoretical, rationale for understanding how these many psychotherapies work. From a narrative perspective, all therapies involve a process of story telling and story retelling. No matter which style of psychotherapy one uses, the process of therapy involves an initial presentation of problems that the client is unable resolve. The client and therapist work together to bring additional perspectives to these problems, allowing the client to understand them in a new way. These additional perspectives vary greatly depending on which style of psychotherapy is used. It matters, in other words, whether the therapy is psychodynamic, cognitive, humanistic, feminist, spiritual, or expressive. From the vantage point of narrative theory, however, what these different approaches all have in common is that they rework, or "re-author," the patient's initial story into a new story. This new story allows new degrees of flexibility for understanding the past and provides new strategies for moving into the future.

FUTURE DIRECTIONS Recent work in narrative medicine, narrative psychotherapy, and narrative theory has opened the door for the development of narrative psychiatry. This development provides a critical corrective to contemporary psychiatric practice that helps to bring psychiatry back from its current obsessions with science and scientific method. This corrective is not a return to psychoanalysis nor does it demolish the progress of scientific psychiatry. When psychiatrists take a narrative turn, they do not throw out their other skills and knowledge. The shift to narrative is, as much as anything else, an attitude shift and an opening out to additional sources of information. It starts by bringing to the foreground that the clinical encounter is a human encounter, and it follows by opening out to colleagues in the humanities, interpretive social sciences, and the arts to help to better understand this human encounter. Most of all, narrative psychotherapy joins with other contemporary efforts in psychiatry—such as the recovery movement—to make clinical encounters much more client focused and collaborative. Narrative psychotherapy, at its core, recognizes that there are many ways to tell the story of one's life. The choice among these different options is a key way in which

people create their identity. These choices should not be reduced to expert choices or scientific choices because they are always also personal and ethical choices. In the end, they are choices about what kind of life one wants to live. Furthermore, clinicians must come to understand the value of biography, autobiography, and literature for developing a repertoire of narrative frames and options. In the end, narrative competency in psychiatry means a tremendous familiarity

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with the many possible stories of psychic pain and psychic difference. The more stories clinicians know, the more likely they are to help their clients to find a narrative frame that works for them. For patients and potential service users, a narrative understanding means that there is a range of possible therapists and healing solutions that might be helpful. An approach that is right for one person may not be right for another. There must be a fit between the person and the approach, and people should feel empowered to take seriously their intuitions and feelings. If the person getting help does not feel this fit, he or she is likely right. There may well be another approach that would work better with the person's proclivities. Like everything else, however, judgment is critical. Therapeutic experiences of all kinds can be frustrating, slow, and uncertain. How, for example, does one know when an approach misses his or her needs and when it is something that will take time, patience, and perseverance to be helpful? From a narrative perspective, there can be no gold standard or simple answers. Only judgment, wisdom, and trial and error can decide.

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Psychiatric Rehabilitation

Psychiatric rehabilitation denotes a wide range of interventions designed to help people with disabilities caused by mental illness improve their functioning and quality of life by enabling them to acquire the skills and supports needed to be successful in usual adult roles and in the environments of their choice. Normative adult roles include living independently, attending school, working in competitive jobs, relating to family, having friends, and having intimate relationships. Psychiatric rehabilitation emphasizes independence rather than reliance on professionals, community integration rather than isolation in segregated settings for persons with disabilities, and patient preferences rather than professional goals. VOCATIONAL REHABILITATION Impairment of vocational role performance is a common complication related to schizophrenia. Studies across the United States show that less than 15 percent of patients with severe mental illnesses, such as schizophrenia, are employed. Nevertheless, studies also show that competitive employment is a primary goal for 50 to 75 percent of patients with schizophrenia. Because of patient interests and historical factors, vocational rehabilitation has always been a centerpiece of psychiatric rehabilitation. Antonio is a 45-year-old man who has been a client of a mental health agency for more than 10 years. He attended the rehabilitative day treatment program until it was converted to a supported employment program. His case manager encouraged him to think about the possibility of working part time. Antonio told his case manager that he could not work because of his schizophrenia and because he was helping to raise his two kids and needed to be home at 3 P.M., when they returned from school every day. The case manager explained to Antonio that getting a job does not necessarily mean working 40 hours a week and that lots of people in the agency's supported employment program were working in part-time jobs, even jobs that only require a few hours a week. Antonio agreed to meet one of the employment specialists to discuss the possibility of work. Over the next couple of weeks, the employment specialist met with Antonio several times, read his clinical record, and talked with his case manager and psychiatrist. The employment specialist learned that Antonio loved to drive his car. He also learned that Antonio had attendance problems in past jobs because he felt unappreciated. The employment specialist found Antonio to be a sociable and likable person. Antonio told the employment specialist that he was willing to do any job. He did not have one specific job in mind. After discussing options with Antonio and with the team, the employment specialist suggested a job at Meals on Wheels as a driver for the lunch delivery. Antonio was hired and loved it right from the start. Absenteeism was never a problem, because he liked driving around and knew that people were counting on him for their meals. The hours were perfect (10 A.M. to 2 P.M.), so he

could be at home when his kids returned from school. He became good friends with the other workers. He told his case manager that it was wonderful to be bringing home a paycheck again. And best of all, he said, was that his kids saw him going to work just like their friends' dads.

(Courtesy of Robert E. Drake, M.D., Ph.D., and Alan S. Bellack, Ph.D.) SOCIAL SKILLS

REHABILITATION Social dysfunction is a defining characteristic of schizophrenia. People with the illness have difficulty fulfilling social roles, such as worker, spouse, and friend, and have difficulty

meeting their needs when social interaction is required (e.g., negotiating with merchants, requesting assistance to solve problems). Social dysfunction is semiindependent of symptomatology and plays an important role in the course and outcome of the illness. As shown in Table 28.12-1, social competence is based on three component skills: (1) social perception, or receiving skills; (2) social cognition, or processing skills; and (3) behavioral response, or expressive skills. Social perception is the ability to read or decode social inputs accurately. This includes accurate detection of affect cues, such as facial expressions and nuances of voice, gesture, and body posture, as well as verbal content and contextual information. Social cognition involves effective analysis of the social stimulus, integration of current information with historical information, and planning an effective response. This domain is also referred to as social problem solving. Table 28.12-1 Components of Social Skill

Methods The primary modality of social skills training is role play of simulated conversations. The trainer first provides instructions on how to perform the skill and then models the behavior to demonstrate how it is performed. After identifying a relevant social situation in which the skill might be used, the patient engages in role play with the trainer. The trainer next provides feedback and positive reinforcement, which are followed by suggestions for how the response can be improved. The sequence of role play followed by feedback and reinforcement is repeated until the patient can perform the response adequately. Training is typically conducted in small groups (six to eight patients), in which case patients each practice role playing for three to four trials and provide feedback and reinforcement to one another. Teaching is tailored to the individual—for example, a highly impaired group member might simply practice saying “no” to a simple request, whereas a less cognitively impaired peer might learn to negotiate and compromise. Richard was a single white man first diagnosed with schizophrenia at age 22, when he was a freshman at college. He was hospitalized briefly but was unable to return to school and moved back home with his parents. He attended a day treatment program intermittently over the next 6 years, before he was referred for help with getting a job and dating. Richard had missed out on a critical period of adult development and had never learned dating skills or the social skills needed to get or maintain a job. He was

appropriately groomed and did not present himself as a patient, but he seemed quite uncomfortable in social interactions. He scarcely made eye contact, staring at the floor when he spoke, and did not initiate conversation, responding to questions with brief answers. Richard was invited to participate in a social skills training group for 3 months with six other patients. The focus of the group was employment skills. Patients were taught critical social skills for getting and maintaining a job, such as how to participate in job interviews; how to approach a supervisor to understand how to do a job or for help with work-related problems; how and when to make requests or explain problems, such as getting to work late because of traffic or needing to leave early to go to a doctor’s appointment; and socializing with coworkers. Simultaneously, Richard was enrolled in a supported employment program and worked with a case manager to find a job as a computer support person. He found a 24-hour-per-week job at a small company and continued to attend the skills group, using the sessions to work on interpersonal issues at work, including engaging in casual conversation with coworkers and dealing with unreasonable requests from people. When the vocational skills group ended, Richard was scheduled for a dating group with seven other male and female patients who had similar interests. This group focused on finding someone to date, dating etiquette, asking someone out (or being asked out), appropriate

conversation for dates, sexual interactions, and safe sex practices. In addition to role play and discussion, the group shared ideas on how to meet people and what to do on dates. Richard responded well to treatment. He had maintained the computer job at follow-up, 6 months after he concluded the dating skills group. His case manager also reported that he had a girlfriend, a woman whom he had met at his church group. He had also expressed an interest in enrolling in college classes at night. He was still living at home with his parents, but, for the first time, was seriously considering what he would need to do to move out. (Courtesy of Robert E. Drake, M.D., Ph.D., and Alan S. Bellack, Ph.D.)

Goals In a treatment setting, there are four major goals of social skills training: (1) improved social skills in specific situations, (2) moderate generalization of acquired skills to similar situations, (3) acquisition or relearning of social and conversational skills, and (4) decreased social anxiety. Learning, however, is tedious or almost nonexistent when patients are floridly ill with positive symptoms and high levels of distractibility. Some findings limit the applicability of social skills training. It is more difficult to teach complex conversational skills than to teach briefer, more discrete verbal and nonverbal responses in social situations. Because complex behaviors are more critical for generating social support in the community, methods have been developed to improve the learning and durability of conversational skills. These training methods, focusing on

training in social skills and information-processing skills, are discussed below.

Social Perception Skills Recently, efforts have been made to develop strategies for training patients in affect and social cue recognition. Patients with chronic psychotic disorders, such as schizophrenia, often have difficulty perceiving and interpreting the subtle affective and cognitive cues that are critical elements of communication. Social perception abilities are considered the first step in effective interpersonal problem solving; difficulties in this area are likely to lead to a cascade of deficits in social behavior. Training skills in social perception address these deficits and help provide a foundation for developing more specific social and coping skills. Despite attending several social gatherings, Matt felt apart from the rest of the group. He reported that these events seemed like “a jumble of sights and sounds.” His therapist, recognizing Matt’s difficulty with social perception, gave him a series of questions designed to help him organize and give meaning to the social stimuli he encountered. For example, when Matt was confused about a conversation someone was having with him, he would ask himself, “What is this person’s short-term goal? At what level of disclosure should I be? Should I be talking now or listening?” Identifying the rules and goals of a particular social interaction provided a template for Matt to recognize, and react to, a greater variety of social cues, thus enhancing his behavioral repertoire. (Courtesy of Robert Paul Liberman, M.D., Alex Kopelowicz, M.D., and Thomas E. Smith, M.D.)

Information-Processing Model of Training. Methods of training that follow a cognitive perspective teach patients to use a set of generative rules that can be adapted for use in various situations. For example, a six-step problem-solving strategy has developed as an outline for helping patients overcome interpersonal dilemmas: (1) adopt a problem-solving attitude, (2) identify the problem, (3) brainstorm alternative solutions, (4) evaluate solutions and pick one to implement, (5) plan the implementation and carry it out, and (6) evaluate the efficacy of the effort and, if ineffective, choose another alternative. Although the step-wise, structured, linear process of problem solving occurs intuitively, without conscious awareness in normal persons, it can be a useful interpersonal crutch to help cognitively impaired mental patients cope with the information needed to fill their social and personal needs.

MILIEU THERAPY The locus of milieu is a living, learning, or working environment. The defining characteristics of treatment are the use of a team to provide treatment and the time the patient

spends in the environment. Recent adaptations of milieu therapy include 24-

hour-a-day programs situated in community locales frequented by patients, which provide in vivo support, case management, and training in living skills. Most milieu therapy programs emphasize group and social interaction; rules and expectations are mediated by peer pressure for normalization of adaptation. When patients are viewed as responsible human beings, the patient role becomes blurred. Milieu therapy stresses a patient's rights to goals and to have freedom of movement and informal relationship with staff; it also emphasizes interdisciplinary participation and goal-oriented, clear communication. Token Economy The use of tokens, points, or credits as secondary or generalized reinforcers can be seen as normalizing a mental hospital or day hospital environment with a program mimicking society's use of money to meet instrumental needs. Token economies establish the rules and culture of a hospital inpatient unit or partial hospitalization program, offering coherence and consistency to the interdisciplinary team as it struggles to promote therapeutic progress in difficult patients. These programs are challenging to establish, however, and their widespread dissemination has suffered because of the organizational prerequisites and the additional resources and rewards needed to create a truly positively reinforcing environment. Table 28.12-2 lists behaviors that can be reinforced by tokens. Table 28.12-2 Contingencies of Reinforcement in the Token Economy Used at the Camarillo-UCLA Clinical Research Unit

COGNITIVE REHABILITATION Increased recognition of the prevalence and importance of neurocognitive deficits over the past decade has stimulated increasing interest in remediation strategies. Much of the work in this area has focused on psychopharmacological approaches, especially on the new-generation antipsychotics. New-generation medications appear to have a positive effect on neurocognitive test performance, but the effect size for any of the medications is small to medium, and little evidence indicates that these medications have a clinically meaningful impact on neurocognitive functioning in the community. As a result, a parallel interest has arisen in the potential for rehabilitation or cognitive remediation. This body of work is distinguished from cognitive-behavioral therapy and cognitive therapy, which focus on reducing psychotic symptoms. A study at the National Institutes of Health (NIH) found that patients with schizophrenia were unable to benefit from explicit instructions and practice on the Wisconsin Card Sorting Test (WCST), a widely used test of executive functioning. The study was linked to data demonstrating that patients had diminished prefrontal blood flow in dorsolateral prefrontal cortex while responding to the WCST, implying that

schizophrenia was marked by an unmodifiable abnormality of the dorsolateral prefrontal cortex. The NIH work stimulated a series of mostly successful laboratory demonstrations that WCST performance deficits, albeit widespread, are neither endemic to the illness nor immutable. For example, one study demonstrated that WCST performance could be enhanced by financial reinforcement and specific instructions. Other laboratories have since produced comparable and enduring effects using similar training strategies and extended practice alone. **ETHICAL ISSUES** The ethics of conducting rehabilitation strategies are generally the same as for conducting other psychotherapies. Two issues come up regularly, however: avoiding infantilization and maintaining confidentiality. The first concerns the risk of viewing the patient as unable to make adult choices, such as whether to participate in rehabilitation, where to live, whether or not to work, and whether or not to use drugs and alcohol. Although it may be more of a value than an ethical standard,

psychiatric rehabilitation is based on the assumption that the practitioner and the patient are in a partnership to facilitate recovery and improve quality of life. The basic model involves collaboration and shared decision making and does not portray the practitioner as an authority or parental figure. When patients make what appear to be bad choices, the practitioner must consider the patient's right to choose and whether the choice is dangerous versus simply not the choice the practitioner would make. If the choice, in fact, is potentially harmful, a collaborative process of considering alternatives is more likely to produce good choices than an authoritative, admonitory approach. Failure to consider the patient as a partner also leads to violations of confidentiality. Practitioners sometimes assume that they are the primary arbiters of what information to share with parents, other clinicians, and other agencies. In fact, in most circumstances that do not involve the safety of patients or others, the patient should be the arbiter of what information is shared with whom. For example, in supported employment, the patients always determine whether to disclose information about their illnesses to employers.

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28.13 Combined Psychotherapy and Pharmacotherapy

The use of psychotropic drugs in combination with psychotherapy has become widespread. In fact, it has become the standard of care for many patients seen by psychiatrists. In this therapeutic approach, psychotherapy is augmented by the use of pharmacological agents. It should not be a system in which the therapist meets with the patient on an occasional or irregular basis to monitor the effects of medication or to make notations on a rating scale to assess progress or side effects; rather, it should be a system in which both therapies are integrated and synergistic. In many cases, it has been demonstrated that the results of combined therapy are superior to either type of therapy used alone. The term pharmacotherapy-oriented psychotherapy is used by some practitioners to refer to the combined approach. The methods of psychotherapy used can vary immensely, and all can be combined with pharmacotherapy when indicated.

INDICATIONS FOR COMBINED THERAPY

A major indication for using medication when conducting psychotherapy, particularly for those patients with major mental disorders such as schizophrenia or bipolar disorder, is that psychotropics reduce anxiety and hostility. This improves the patient's capacity to communicate and to participate in the psychotherapeutic process. Another indication for combined therapy is to relieve distress when the signs and the symptoms of the patient's disorder are so prominent that they require more rapid amelioration than psychotherapy alone may be able to offer. In addition,

each technique may facilitate the other; psychotherapy may enable the patient to accept a much needed pharmacological agent, and the psychoactive drug may enable the patient to overcome resistance to entering or continuing psychotherapy (Table 28.13-1). Table 28.13-1 Benefits of Combined Therapy The reduction of symptoms, especially anxiety, does not decrease the patient's motivation for psychoanalysis or other insight-oriented psychotherapy. In practice, drug-induced symptom reduction improves communication and motivation. All therapies

have a cognitive base, and anxiety generally interferes with the patient's ability to gain cognitive understanding of the illness. Drugs that decrease anxiety facilitate cognitive understanding. They can improve attention, concentration, memory, and learning in patients who suffer from anxiety disorders. NUMBER OF TREATING CLINICIANS Any number of clinicians can be involved in treatment of a psychiatric disorder. In oneperson therapy, the psychiatrist provides individual psychotherapy and medication treatment. Multiperson therapy is a form of treatment in which one therapist (who may be a psychiatrist, psychologist, or a social worker) conducts psychotherapy while the other therapist (always a psychiatrist) prescribes medications. Other therapists may oversee marriage or family therapy or group therapy. The terms cotherapy or triangular therapy are sometimes used to describe permutations of multiperson therapy. COMMUNICATION AMONG THERAPISTS Whenever more than one clinician is involved in treatment, there should be regular exchanges of information. Some patients split the transference between the two; one therapist may be seen as giving and nurturing, and the other may be seen as withholding and aloof. Similarly, countertransference issues, such as one therapist's identifying with the patient's idealized or devalued image of the other therapist, can interfere with therapy. Those issues must be worked out, and the cotherapists must be compatible and respectful of each other's orientation, so that the therapy program can succeed. A therapist may have some concerns about the quality of the psychopharmacology or that the existing regimen needs to be reconsidered. For example, a patient may not be doing well on medication, experiencing significant side effects, or showing lack of sufficient improvement. Some patients may also be taking many different medications. When and if it is deemed in the patient's interest to question the medication regimen or the prescriber's skill, these misgivings should not be shared with the patient without first conferring with the prescribing physician. If the therapist or pharmacologist, after a good-faith effort to understand the methods and course of treatment, still has misgivings about treatment, he or she should inform his or her counterpart that a second opinion would be useful. This should then be suggested to the patient without necessarily raising undue alarm. Communication between treating clinicians should take place as frequently as needed. No standard exists for how frequent that should be. ORIENTATIONS OF TREATING CLINICIANS The orientation of the treating psychiatrist or other clinician can influence the therapeutic process during combination treatment. Clinicians invariably bring a theoretical bias to the treatment setting. Some, for example, are oriented, by preference

and training, to practice a specific form of psychotherapy, such as psychoanalysis, cognitive-behavioral therapy (CBT), or group therapy. To these clinicians, psychotherapy is seen as the primary treatment modality, with pharmacological agents being used as an adjunct. Conversely, to a psychopharmacologically oriented psychiatrist, psychotherapy is seen as augmenting the use of medication. Although disagreement may arise on which approach represents the most active ingredient in clinical response, the optimal use of both modalities should complement each other. In addition to having extensive training in one or more psychoanalytic or psychotherapeutic techniques, the psychiatrist who practices pharmacotherapy-oriented psychotherapy must have a

comprehensive knowledge of psychopharmacology. That knowledge must include a thorough understanding of the indications for the use of each drug, the contraindications, the pharmacokinetics and pharmacodynamics, the drug– drug interactions (with all pharmacological agents, not only the psychoactive agents), and the adverse effects of medications. The psychiatrist must be able both to identify adverse effects and to treat them. Nonpsychiatric physicians often use psychoactive agents inaccurately (too small or too large a dose for too short or too long a course), because they lack the requisite psychopharmacological knowledge, training, and experience. Psychotherapists who work with primary care physicians instead of psychiatrists should understand the limitations in depth of knowledge that these practitioners have and should seek a consultation with a psychiatrist if a patient is not responding to, or tolerating, medication. In some situations, it is preferable for psychotherapy and pharmacotherapy to be carried out by the same clinician; however, this is often not possible for a variety of reasons, including therapist availability, time limitations, and economic restraints, among others (Table 28.13-2). Table 28.13-2 Clinical Situations in Which It Is Advantageous for One Psychiatrist to Provide Medication and Psychotherapy

Therapist Attitudes Psychiatrists trained primarily as psychotherapists may prescribe medication more reluctantly than those who are more oriented toward biological psychiatry. Conversely, those who view medication as the preferred intervention for most psychiatric disorders

may be reluctant to refer patients for psychotherapy. Therapists who are pessimistic about the value of psychotherapy or who misjudge the patient's motivation may prescribe medications because of their own beliefs; others may withhold medication if they overvalue psychotherapy or undervalue pharmacological treatments. When a patient is in psychotherapy with someone other than the clinician prescribing medication, it is important to recognize treatment bias and to avoid contentious turf battles that put the patient in the middle of such conflict.

Linkage Phenomenon At some point, patients may view the improvement being made in therapy as the result of a conscious or unconscious linkage between the psychopharmacological agent and the therapist. In fact, after being weaned from medication, patients often carry a pill with them for reassurance. In that sense, the pill acts as a transitional object between the patient and the therapist. Some patients with anxiety disorders, for example, may carry a single benzodiazepine tablet, which they take when they think they are about to have an anxiety attack. Then, the patient may report that the attack was aborted—before the medication could even have been absorbed into the bloodstream. In other cases, the pill is never taken, because the patient knows that the pill is available and gains reassurance from that fact. The linkage phenomenon is usually not seen unless the patient is in a positive transference to the therapist. Indeed, the therapist may use this phenomenon to his or her advantage by suggesting that the patient carry medication to use as needed. Eventually, the behavior has to be analyzed, and it is often found that the patient has attributed magical properties to the therapist that are then transferred to the medication. Some clinicians believe the effect to be the result of conditioning. After repeated trials, the sight of the medicine can decrease anxiety. The positive transference may also cause transference cure or flight into health, in which the patient feels better in an unconscious attempt to meet the presumed expectations of the prescribing physician. Therapists should consider this phenomenon if the patient reports rapid improvement well before a particular medication may reach its therapeutic level. Rachel, a 25-year-old white woman, presented with depressive symptoms and abdominal pain. After an extensive psychiatric and medical evaluation, she was diagnosed with major depression of moderate severity and irritable bowel disorder. She began a course of CBT targeting her negative attributional style and

low self-esteem, and she was taught relaxation and distraction techniques for her pain. After a 12-week trial, she experienced only partial remission of her symptoms and was offered an antidepressant, citalopram (Celexa) at 20 mg per day. Her depressive symptoms remitted within 1 month, and she was able to function better at work but socially remained hesitant to engage with her peers. Her abdominal pain persisted, and she began to exhibit a pattern of disordered eating, severely restricting her intake to 500 calories per day due to the "pain." She experienced a 15-pound weight loss

over the next several months. An intensive behavioral plan to target eating was begun, as well as continued probing of her negative cognitions relating to eating, pain, and newly emerging concerns that she would regain the weight too quickly and would become "fat." She did not meet weight loss criteria for anorexia nervosa, although her cognitive distortions about her body image were extreme. These new concerns resulted in a relapse of her depressive symptoms, including suicidal ideation, and her citalopram was increased to 40 mg per day. She reported severe akathisia on this dose and refused to take any more medication, including an antidepressant of another class. Rachel did agree to intensify her therapy to twice weekly, and this allowed her to explore some of her conflicts, feelings, and thoughts that fostered her treatment-refractory illness. A combination of psychotherapy and hypnosis was used for this work. Over the next 6 months, Rachel revealed that she had been sexually abused as a child and this made her feel that she did not "deserve" to live or to eat and that the pain served to "punish" her for being bad. She also admitted that she resisted the medication "psychologically" because she felt that she did not deserve to get well. Her newly found insight, as well as the coping skills she developed in therapy, resulted in a reduction of her depressive symptoms, marked improvement in her eating habits with normalization of her weight, and decreased abdominal pain. She maintained these gains over the next year, including normalization of her daily functioning, a promotion at work, and the ability to tolerate the intimacy of a boyfriend. (Courtesy of E. M. Szigethy, M.D., Ph.D., and E. S. Friedman, M.D.)

COMPLIANCE AND PATIENT EDUCATION Compliance is the degree to which a patient carries out the recommendations of the treating physician. Compliance is fostered when the doctor-patient relationship is a positive one, and the patient's refusal to take medication may provide insight into a negative transference situation. In some cases, the patient acts out hostilities by noncompliance, rather than by becoming aware of, and ventilating, such negative feelings toward the doctor. Medication noncompliance may provide the psychiatrist with the first clue that a negative transference is present in an otherwise compliant patient who had appeared to be agreeable and cooperative. Patients should know the target signs and symptoms that the drug is supposed to reduce, the length of time they will be taking the drug, the expected and unexpected adverse effects, and the treatment plan to be followed if the current drug is unsuccessful. Although some psychiatric disorders interfere with patients' abilities to comprehend that information, the psychiatrist should relay as much of the information as possible. The clear presentation of such material is often less frightening than are patients' fantasies

about drug treatment. The psychiatrist should tell patients when they may expect to begin to receive benefits from the drug. That information is most critical when the patient has a mood disorder and may not observe any therapeutic effects for 3 to 4 weeks. Some patients' ambivalent attitudes toward drugs often reflect the confusion about drug treatment that exists in the field of psychiatry. Patients often believe that taking a psychotherapeutic drug means they are not in control of their lives or they may become addicted to the drug and have to take it forever.

Psychiatrists should explain the difference between drugs of abuse that affect the normal brain and psychiatric drugs that are used to treat emotional disorders. They should also point out to patients that antipsychotics, antidepressants, and antimanic drugs are not addictive in the way in which, for example, heroin is addictive. The psychiatrist's clear and honest explanation of how long the patient should take the drug helps the patient adjust to the idea of chronic maintenance medication if that is the treatment plan. In some cases, the psychiatrist may appropriately give the patient increasing responsibility for adjusting the medications as the treatment progresses. Doing so often helps the patient feel less controlled by the drug and supports a collaborative role with the therapist.

ATTRIBUTION THEORY Attribution theory is concerned with how persons perceive the causes of behavior. According to attribution theory, persons are likely to attribute changes in their own behavior to external events, but are likely to attribute another's behavior to internal dispositions, such as that person's personality traits. Research on drug effects by attribution theorists has shown that, when patients take medication and their behaviors change, they attribute it to the drug and not to any changes that occur within themselves. Accordingly, it may be unwise to describe a drug as extremely strong or effective, because if it does have the desired effect, the patient may believe that is the only reason he or she got better; if the drug does not work, the patient may assume his or her condition is incurable. Therapists do best by presenting the use of drugs and psychotherapy as complementary or adjunctive, as neither standing alone and both being needed for improvements or cure to occur.

MENTAL DISORDERS **Depressive Disorders** Some patients and clinicians fear that medication covers over the depression and that psychotherapy is impeded. Instead, medication should be viewed as a facilitator in overcoming the anergia that can inhibit the communication process between doctor and patient. The psychiatrist should explain to the patient that depression interferes with interpersonal activity in a variety of ways. For instance, depression produces withdrawal and irritability, which alienate significant others who may otherwise gratify the strong dependency needs that make up much of depressive psychodynamics.

If medication is stopped, the psychiatrist should be alert for signs and symptoms of a recurrent major depressive episode. Medication may have to be reinstated. Before doing so, however, carefully review any stress, especially rejections, that could have precipitated recurrent major depressive disorder. A new episode of depression may occur because the patient is in a stage of negative transference, and the psychiatrist must try to elicit negative feelings. In many cases, the ventilation of angry feelings toward the therapist without an angry response can serve as a corrective emotional experience, and a major depressive episode necessitating medication can thereby be forestalled. Depressed patients are generally maintained on their medication for 6 months or longer after clinical improvement. The cessation of pharmacotherapy before that time is likely to result in a relapse. Combined treatment has been shown to be superior to either therapy used alone in the treatment of major depression. It is associated with improved social and occupational functioning and improved quality of life compared with either therapy alone.

Bipolar I Disorder Patients taking lithium (Eskalith) or other treatments for bipolar I disorder are usually medicated for an indefinite period of time to prevent episodes of mania or depression. Most psychotherapists insist that patients with bipolar I disorder be medicated before starting any insight-oriented therapy. Without such premedication, most patients with bipolar I disorder are unable to make the necessary therapeutic alliance. When those patients are depressed, their abulia seriously disrupts their flow of thoughts, and the sessions are nonproductive. When they are manic, their flow of associations can be rapid, and their speech can be so pressured that the therapist could be flooded with material and may be unable to make appropriate interpretations or

to assimilate the material into the patient's disrupted cognitive framework. The practice guideline of the American Psychiatric Association (APA) for bipolar disorder recommends combined therapy as the best approach. It increases compliance, decreases relapse, and reduces the need for hospitalization. Substance Abuse Patients who abuse alcohol or drugs present the most difficult challenge in combined therapy. They are often impulsive, and, although they may promise not to abuse a substance, they may do so repeatedly. In addition, they frequently withhold information from the psychiatrist about episodes of abuse. For that reason, some psychiatrists do not prescribe any medication to such patients, especially not those substances with a high abuse potential, such as benzodiazepines, barbiturates, and amphetamines. Drugs with no abuse potential, such as amitriptyline (Elavil) and fluoxetine (Prozac), have an important role in treating the anxiety or depression that almost always accompanies substance-related disorders. The psychiatrist conducting psychotherapy with such patients should have no reservations about sending the patient to a laboratory for

random urine toxicological tests. Anxiety Disorders Anxiety disorders encompass obsessive-compulsive disorder (OCD), posttraumatic stress disorder (PTSD), generalized anxiety disorder, phobic disorders, and panic disorder with or without agoraphobia. Many drugs are effective in managing distressing signs and symptoms. As the symptoms are controlled by medication, patients are reassured and develop confidence that they will not be incapacitated by the disorder. That effect is particularly strong in panic disorder, which is often associated with anticipatory anxiety about the attack. Depression can also complicate the symptom picture in patients with anxiety disorders and has to be addressed pharmacologically and psychotherapeutically. Studies have shown that patients with anxiety disorders who receive ongoing psychotherapy are less likely to experience relapse compared with patients who receive medication alone. Schizophrenia and Other Psychotic Disorders Included in the group of schizophrenia and other disorders are schizophrenia, delusional disorder, schizoaffective disorder, schizophreniform disorder, and brief psychotic disorder. Drug treatment for those disorders is always indicated, and hospitalization is often necessary for diagnostic purposes, to stabilize medication, to prevent danger to self or others, and to establish a psychosocial treatment program that may include individual psychotherapy. In attempting individual psychotherapy, the therapist must establish a treatment relationship and a therapeutic alliance with the patient. The patient with schizophrenia defends against closeness and trust and often becomes suspicious, anxious, hostile, or regressed in therapy. Before the advent of psychotropics, many psychiatrists were fearful for their own safety when working with such patients. Indeed, many assaults occurred. Individual psychotherapy for schizophrenia is labor intensive, expensive, and not often attempted. The recognition that combined psychotherapy and pharmacotherapy have a greater chance of success than either type of therapy alone may reverse that situation. The psychiatrist who conducts such combined therapy must be especially empathic and must be able to tolerate the bizarre manifestations of the illness. The patient with schizophrenia is exquisitely sensitive to rejection, and individual psychotherapy should never be started unless the therapist is willing to make a total commitment to the process. OTHER ISSUES Evidence suggests that therapy can induce physical changes in the nervous system. Eric Kandel has provided elegant proof, winning the Nobel Prize for demonstrating that environmental stimuli produce lasting changes in the synaptic architecture of living organisms. Imaging studies have begun to show that patients who show clinical

improvement from psychotherapy show changes in brain metabolism that are similar to that seen in patients successfully treated with medications. Still, some patients do well on only one form of treatment. Even with identical diagnoses, not all patients respond to the same treatment regimens. Success may be as dependent on the knowledge and quality of the clinician as on the potential benefit of a particular drug. A real dilemma when combining treatment is the additional direct costs of two treatments. Although successful treatment results in reduced costs to society, the cost of treatment is usually narrowly defined by the patient as out-of-pocket expenses and by insurance and managed care companies as payments to the physician or hospital. Restrictions placed on the frequency and cost of visits to mental health professionals by managed care organizations, however, encourage the use of medication rather than psychotherapy.

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14 - 28.14 Genetic Counseling

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28.14 Genetic Counseling Medical geneticists and specially trained and qualified genetic counselors have traditionally provided genetic counseling to patients in need of such help. Many psychiatrists, however, are also well placed to provide genetic education and counseling because they often have knowledge of their clients' needs and family histories and have ongoing therapeutic relationships. The ideal approach for providing psychiatric genetic counseling is through a multidisciplinary team approach, with collaboration between genetics and mental health professionals. Genetic professionals often seek collaboration with a psychiatrist for those with difficult psychiatric medical or family histories. Genetic professionals also seek collaboration or referral for persons with a psychiatric disorder; those who are having difficulty adapting to a genetic-related diagnosis; those dealing with the death of a family member; or those who are experiencing persistent difficulty with decision making regarding prenatal diagnosis or genetic testing. In turn, genetic professionals can be available for professional consultation regarding risk assessment, the collection and construction of complicated family medical histories, and the availability and limitations of genetic or genomic testing.

DEFINITIONS Genetic counseling is the process of helping people to understand and adapt to the medical, psychological, and familial implications of genetic contributions to disease. According to the National Society of Genetic Counseling, it integrates three factors: (1) interpretation of family and medical histories to assess the chance of disease occurrence or recurrence; (2) education about inheritance, testing, management, prevention, resources, and research; and (3) counseling to promote informed choices and adaptation to the risk or condition. The process aims to minimize distress and facilitate adaptation, to increase one's feeling of personal control, and to facilitate informed decision making and life planning. Genetic counseling is not limited to considerations of the genetic contributions of disease. Genetic counseling also considers environmental components of the presenting disease along with genetic ones. Table 28.14-1 lists common terminology used in the field of genetic counseling. Figure 28.14-1 illustrates a complex family medical history

presented in the form of a pedigree. FIGURE 28.14-1 Pedigree of a family with velocardiofacial (VCF) syndrome. ADHD, attention deficit/hyperactivity disorder; Dx, diagnosed; MR, mental retardation. (From Sadock BJ, Sadock VA, Ruiz P, eds. Kaplan & Sadock's Comprehensive Textbook of Psychiatry. 9th ed. Philadelphia: Lippincott Williams & Wilkins, 2009, with permission.) Table 28.14-1 Genetic Terminology

GENETICS AND MENTAL HEALTH Disorders can recur in families for many reasons, including the functioning of genes (single genes vs. polygenic) (Table 28.14-2), shared environmental exposures, a combination of genetic and environmental factors (multifactorial), and cultural transmission. Single gene disorders are caused by defects in one particular gene, and they often have simple and predictable inheritance patterns. By contrast, most psychiatric disorders are multifactorial in etiology, influenced by multiple genes as well as environmental factors, making them more difficult to predict. Table 28.14-2 Examples of Psychiatric Disorders Recognized as Having a Genetic Component to Their Etiology

Two phenomena that further complicate genetic counseling include penetrance and expressivity. Penetrance refers to the portion of individuals with a specific genotype who also manifest that genotype at the phenotype level. If all individuals who carry the dominant gene show any phenotype of the gene, the gene is said to be completely penetrant. Currently, only rare examples exist of known genes for mental disorders that demonstrate complete penetrance of symptoms in the presence of a single gene. One such example is early-onset familial Alzheimer's disease resulting from mutations in the amyloid precursor protein (APP) located on the long arm of chromosome 21. In contrast, expressivity refers to the extent to which a genotype is expressed. In the case of variable expressivity, the trait can vary in expression from mild to severe, but is never completely unexpressed in individuals who have the gene. The genes that result in most mental disorders are believed to regulate a wide spectrum of traits demonstrating variability of expression (spectrum disorders). **COMPONENTS OF THE GENETIC COUNSELING PROCESS** Requests for genetic counseling are often initiated by the client's or relatives' questions about the disorder that is present in the family. In the case of mental illness, the questions are often posed to the treating psychiatrist. The client's questions are most effectively addressed through an interactive process that provides the client, as well as the professional, with information pertinent to the next step in the communication process. The basic components of genetic counseling are outlined in Table 28.14-3. Table 28.14-3 Steps and Process of Genetic Counseling Contracting Contracting is a vital portion of the psychiatric genetic counseling session. Often the goals of the session will vary based on the consultand's histories and reason(s) for concern. The provider should work with the consultand at the beginning of the session to define mutual goals.

Documentation of Diagnosis, Collection, and Review of Family Medical History A family medical history (FMH) is collected, and at least a three-generation pedigree is constructed. The collection of FMH begins with the individual seeking information. The consultand (or client) is the individual seeking information. Proband is the term used to identify the affected person within the family who first brought the family to medical attention. The FMH should be comprehensive and include the following information: ages (or dates of birth) of each family member, the age at which the diagnosis was made for individuals with the disorder, pregnancy losses (including the gestational length along with the recognized cause, if known), the recognized cause and age of any deceased family members, and ethnic backgrounds (Table 28.14-4). Table 28.14-4 Topics Included in the

Family Medical History Confirmation or clarification of the diagnosis is essential to the provision of valid information within the session. This usually requires obtaining medical records to clarify or to confirm the suspected diagnosis in the relatives. Depending on the situation, genetic testing may be available for at-risk members in families with single-gene disorders; but because DNA (deoxyribonucleic acid) testing for most mental disorders is not yet an option, risk assessment is based solely on analysis of the pedigree. The collection and review of the FMH with the patient might elicit or recall intense feelings of sadness, guilt, anxiety, or anger. Furthermore, the graphic presentation of the family history may bring to light a more concrete realization of an individual's risks; therefore, attention to the patient's affect is important throughout the process. Specific issues that may hinder an accurate psychiatric family history and may increase consultant affect related to family history are listed in Table 28.14-5. Table 28.14-5 Issues that Can Hinder an Accurate Psychiatric Family History

Communication of Risk and Decision Making Individuals vary in their level of understanding risks. The provision of risk information is best approached in a balanced and accurate manner that is tailored to the patient as much as possible. There is the temptation to use nonnumeric phrases of probability (e.g., often, rarely, most likely); however, the meaning of these nonnumeric phrases is highly subjective and their use in the genetic counseling session introduces the potential for bias. Ideally, risks should be presented in several different ways, taking clues from interactions with the client that inform the approach. Some examples of approaches to assist the client's understanding of risks include stating numeric risks as percentages (25 percent) and as fractional risks (one-in-four chance). It is important to frame risks from the perspective of a negative and a positive outcome; for example, there is a 1 percent chance that the test will result in a complication and a 99 percent chance that there will be no complication. Owing to the high rate of co-occurring disorders and the wide phenotypic range of psychiatric disorders, patients should be informed of potential risks for disorders other than those that brought them to genetic counseling. An example of this is the risk to first-degree relatives of an individual diagnosed with bipolar disorder. In this situation, the risk for bipolar disorder is increased for first-degree relatives, as are the risks for unipolar disorder, schizoaffective disorder, and cyclothymia. It should be made clear that the risks are determined from populations and not derived from individuals and, therefore, are estimates at best. Table 28.14-6 provides a compilation of recurrence risks from various referenced sources in the literature. Table 28.14-6 Empirical Risks for Selected Mental Disorders

PSYCHOSOCIAL COUNSELING AND SUPPORT Setting the stage for the inclusion of psychological and emotional issues can occur early in the process by verbalizing the intent to provide factual information, as well as fostering a discussion of the client's reaction to the information. Insight into the client's perspective and experiences with the disorder, values, beliefs, and family dynamics can begin to be obtained through asking what brings the client to the genetic counseling session. Eliciting this personal information provides a relational context from which the provider can assess concerns and emotional issues. Collection of the FMH can also provide a backdrop of the client's and family's experiences with the disorder. The

exchange of information that occurs during the collection of the FMH can identify underlying risk and perceptions, family beliefs or myths regarding the disorder, and existing support system within the family. A couple in their mid-30s with a 10-year history of infertility had been trying to adopt a child for a number of years. Recently, the adoption agency they were working with told them of a

baby who was being placed for adoption because the biological mother was affected with bipolar disorder and did not feel that she could provide adequate care for the baby. The FMH collected on the newborn baby did not identify others in his family with mental disorders. The recurrence risk for bipolar disorder to the newborn was, therefore, estimated to be between 5 and 20 percent, with additional risks for other mental disorders. The couple individually reacted quite disparately to the estimated risks. In attempting to help them clarify the factors contributing to their feelings regarding the risks, the husband shared his experience with a childhood neighbor who had “some kind of mental illness” and detailed the “torment and agony” that the child brought to the family. Retorting, the woman shared the fact that her coworker also had bipolar disorder and did “just fine” at work with the help of medication. She therefore did not feel that the risks for mental disorders were of concern. The psychiatrist facilitated the couple’s discussion of the spectrum and meaning of mental illness, along with recurrence risks in the context of a genetic education and counseling session. Although the couple did not come to agreement at that meeting over the potential for adopting the child, they did feel that the information and sharing of experiences and perspectives about mental disorders were beneficial. They agreed to return in 1 week after further considering the issues in an effort to reach a decision regarding the adoption. (Courtesy of Holly L. Peay, M.S., and Donald W. Hadley, M.S.)

CHALLENGES POSED BY PRESYMPTOMATIC AND SUSCEPTIBILITY GENETIC TESTING

Psychiatrists will be on the front line for receiving requests for genetic counseling and testing because of their established relationship between patients and families with mental disorders. The identification of these risks will most likely occur before the discovery or availability of preventative options. The option of knowing risks without preventative options raises concerns regarding the impact of such knowledge on the individual’s mood, anxiety, distress, self-image, reproductive decisions, career decisions, family relationships, insurability, employment, and, potentially, other areas. A model for the provision of presymptomatic genetic testing is provided through the protocol developed for Huntington’s disease (see the Hereditary Disease Foundation web site at www.hdfoundation.org). This model recommends conducting education, counseling, and evaluative sessions over an extended period of time (3 to 4 months), during which time information is provided, questions are addressed, and counseling is initiated, thus maximizing informed decision

making. The process is most appropriately undertaken in the absence of other stressful events (e.g., death of a family member, diagnosis of the disease in another family member, job loss, and divorce). Studies suggest that most individuals receiving information of their increased risk for the disease in their family experience significantly more anxiety, depression, and psychological distress and have poorer perception of their health over the short term (within 1 month after receiving test results) compared with their baseline levels, but no difference over the long term (as long as 1 year after the receipt of results) compared with pretest levels. Consideration should also be given to the impact of such information on the spouse, because initial studies have suggested that the spouse may experience higher levels of depression related to the presymptomatic diagnosis than the client. Furthermore, partners of gene-positive individuals may experience increased levels of intrusive thoughts, avoidance, and hopelessness over the short and long term compared with baseline levels.

ETHICAL, LEGAL, AND SOCIAL CONSIDERATIONS

Certain individuals and families may experience significant levels of stigma associated with the identification of a genetic disorder, a situation already familiar to individuals and families with mental illness. The added knowledge of a hereditary component may heighten stigmatization. Conversely, having an identified, biological basis may supplant current public perceptions that mental illness is somehow

a personal or family failure in moral, spiritual, or attitudinal perspectives. Questions frequently arise about the privacy of an individual's genetic information, the ability of employers or insurers to access such information, and the potential of using the information against them by denying insurance, raising rates to unreasonable levels, or denying jobs, and a host of other possible concerns. Currently, no overarching federal laws comprehensively protect citizens of the United States from the potential of these abuses, although significant efforts are continuing in this regard. The status of existing and proposed state and federal laws can be reviewed through the web site of the National Human Genome Research Institute (www.genome.gov).

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Goldman JS, Hahn SE, Catania JW, Larusse-Eckert S, Butson MB, Rumbaugh M, Strecker MN, Roberts JS, Burke W, Mayeux R, Bird T. Genetic counseling and testing for Alzheimer disease: Joint practice guidelines of the American College of Medical Genetics and the National Society of Genetic Counselors. *Genet Med.* 2011;13:597. Hodgson J, Gaff C. Enhancing family communication about genetics: Ethical and professional dilemmas. *J Genet Couns.* 2013;22(1):16-21. Klitzman R, Chung W, Marder K, Shanmugham A, Chin LJ, Stark M, Leu CS, Appelbaum PS. Attitudes and practices among internists concerning genetic testing. *J Genet Couns.* 2013;22:90. Lawrence RE, Appelbaum PS. Genetic testing in psychiatry: A review of attitudes and beliefs. *Psychiatry.* 2011;74:315. Mitchell PB, Meiser B, Wilde A, Fullerton J, Donald J, Wilhelm K, Schofield PR. Predictive and diagnostic genetic testing in psychiatry. *Psych Clin North Am.* 2010;33:225. Monaco LC, Conway L, Valverde K, Austin JC. Exploring genetic counselors' perceptions of and attitudes towards schizophrenia. *Public Health Genomics.* 2010;13(1):21-26. Moseley KL, Nasr SZ, Schuette JL, Campbell AD. Who counsels parents of newborns who are carriers of sickle cell anemia or cystic fibrosis? *J Genet Couns.* 2013;22(2):218-225. Peay HL, Hadley DW. Genetic counseling for psychiatric disorders. In: Sadock BJ, Sadock VA, Ruiz P, eds. *Kaplan & Sadock's Comprehensive Textbook of Psychiatry.* 9th ed. Philadelphia: Lippincott Williams & Wilkins; 2009:2562. Potokar DN, Stein CH, Darrah OA, Taylor BC, Sponheim SR. Knowledge and attitudes about personalized mental health genomics: Narratives from individuals coping with serious mental illness. *Comm Ment Health J.* 2012;48:584.

28.15 Mentalization-Based Therapy and Mindfulness Mentalization is a relatively new term that has been defined as the process of thinking and feeling about oneself and others. Mindfulness is somewhat similar except that it applies only to oneself. In both modalities the person attempts to stay aware of thoughts, feelings, affects, moods, and somatic sensations; but in mentalization that exercise extends to another person as well. It is an interpersonal transaction. The origins of mentalization-based therapy (MBT) have been attributed to two psychologists, Jon Allen and Peter Fonagy, and one psychiatrist, Anthony Batemen, who described the process in their book *Mentalizing in Clinical Practice*, much of which formed the basis for this section. From a theoretical perspective, MBT is eclectic in that it combines theories from a number of analytic and nonanalytic schools of thought: Sigmund Freud and psychoanalysis; John Bowlby and attachment theory; Aaron Beck and cognitive therapy; Carl Rogers and client-centered therapy; and Gerald

Klerman and interpersonal therapy. The amalgam of these techniques developed into the unique method of treatment known as mentalization. Mindfulness has its origins in Buddhist philosophy and the term was used in the 19th century to refer to a meditative technique in which the person stayed in the moment focusing on innermost feelings and states of mind. Mindfulness and mentalization rely on the same process; the person focuses on being in the “here and now.” Some have described the differences between MBT and mindfulness by stating that in MBT one is “mindful of mindfulness.”

The novel focus of a mindfulness approach is on present-moment, nonjudgmental awareness of consciousness, that is, noticing one’s thoughts and feelings in the moment and accepting them without judging or trying to change them. In many ways, mindfulness is a variation of self-monitoring in which patients attend to and increase awareness of thoughts, feelings, and behaviors. However, increased awareness of these phenomena from a mindfulness perspective does not involve analyzing them to determine how best to modify them. Instead, patients might be asked to imagine their thoughts and feelings as if they were written on cards carried by marchers in a parade or as if they were pieces of luggage on a conveyor belt. They are asked to observe internal phenomena without reaction. THERAPEUTIC APPROACHES Freud believed that all action was preceded by thought (conscious or unconscious), and in mentalization the therapist helps the patient “capture” the thought so that actions are understood more fully. Bowlby saw attachment of the infant to the mother or to the primary caregiver as the basis for a sense of security later in life. In mentalization, the therapist relies on a secure attachment with the patient to enable him or her to explore the inner world of emotions and the outer world of action, both of which elicit anxiety. Beck proposed that cognitive distortions of the self (e.g., “She doesn’t like me”) could be reversed by positive cognitions (e.g., “I don’t know if she likes me; many people do”). The mentalization therapist corrects distortions through interpretation and helps the patient test the validity of negative thoughts. The patient is encouraged to use the mechanism of empathy to step into the shoes of the other and to experience what that person may be thinking or feeling. It is the antithesis of self-centeredness. Klerman emphasized transference distortions—a Freudian concept—that interfere with interpersonal relationships. The mentalization therapist attempts to strengthen the patient’s capacity to see the other as he or she really is by not “mind reading” or fantasizing about what the other person thinks. Rogers emphasized the autonomy of the patient vis-à-vis the therapist who was not to be seen as all knowing and omnipotent. The mentalization therapist relies on a certain degree of self-disclosure to reinforce that concept. In that sense, the therapist serves as a role model for coping with the anxieties of daily living and the vicissitudes of life. The task of the therapist is neither to judge nor advise. He or she takes a “mentalizing stance,” which is neutral and allows the patient to resolve conflict using innate resources that were previously unrecognized. MBT also allows the patient to mentalize the future by anticipating events and his or her reactions to them. In MBT emotion is experienced in a controlled and modulated manner, which can be a valuable therapeutic experience for persons whose affect is restricted because of fear. Fonagy has described what he calls the mentalizing stance as “an attitude of openness, inquisitiveness and curiosity about what’s going on in the others’ mind and in your own.” In that sense, the use and development of empathy is a core component of the process. Mindfulness is the practice of paying attention in a particular way—on purpose, in

the present moment, and without judgment. Mindfulness skills include the ability to observe, describe, and participate fully in one’s actions in a nonjudgmental, mindful, and effective manner.

Some of the work in mindfulness-based approaches centers on decreasing what is known as experiential avoidance or the unwillingness to experience negative feelings, thoughts, and sensations. Persons who are skilled and well practiced in mindfulness are more adept at taking their automatic thoughts “with a grain of salt.” Upset by a series of interpersonal disappointments, a person may think “I am never going to let myself care about people ever again.” However, as he or she takes stock of this thought, the individual quickly concludes that this self-statement is neither realistic nor constructive. Instead, the person recognizes that the emotional pain of the moment is tied up in biased thinking, and that the solution to recovering from negative life events requires learning from the difficult situations and moving on. Mindfulness approaches are aimed at improving patients’ abilities to regulate their emotions and tolerating distress may then be considered, in effect, exposure exercises. Although techniques that increase patients’ nonjudgmental awareness of internal sensations may be considered at odds with attempts to change thoughts in a way that is typical within cognitive therapy, the techniques may be considered comparable to exposure-based procedures that help patients to reduce anxiety and distress associated with certain types of thoughts and images through repeated exposure to those thoughts and images. The overlap between cognitive-behavioral treatments and mindfulnessbased approaches continues to be hotly debated.

INDICATIONS Mentalization has been applied to a number of clinical disorders, one of which is autism. In autism, both child and adult are impaired socially because they are less sensitive to emotional cues given by others. They have difficulty empathizing, which makes their social interactions awkward and stilted. Mentalization focuses on teaching empathy and improving social engagement with others. Patients with antisocial personality disorder may also benefit from MBT. Such patients are manipulative, give no thought to the results of their actions, lack the capacity for loyalty, and are unable or unwilling to empathize with others. MBT focuses on the core issues of their psychopathology. If a secure attachment can be made between patient and therapist the basic trust that is lacking in the antisocial person may be developed for the first time. MBT has also been of use in patients with borderline personality disorder. Mindfulness-based treatments have been demonstrated to be effective for a wide range of psychological problems, including borderline personality disorder, anxiety, chronic pain, depression, and stress. The approaches also have been used to reduce dysfunction in patients with medical conditions (e.g., cancer, multiple sclerosis) and to increase general well-being. Patients also learn to develop a greater tolerance for feelings of anxiety or depression and recognize that those states are often transitory, which may enable them to deal with conflict with greater confidence.

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