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section 26 Psychiatric and drug-related disorders 6470 should not be given with any agent likely to potentiate its depressant effect on the white cell count such as carbamazepine, co-trimoxazole, and penicillamine. SSRIs slow the hepatic metabolism and increase blood levels of several antipsychotic drugs, including haloperidol, risperidone, and clozapine. Antianxiety agents Benzodiazepines Benzodiazepines enhance the action of the neurotransmitter γ- aminobutyric acid (GABA) in the central nervous system binding to a specific benzodiazepine receptor located in a complex with a GABA receptor and a chloride ion channel. The pharmacological effects of benzodiazepines are attributed to the facilitation of GABA neurotransmission. Main drugs These are diazepam, lorazepam, and temazepam. Indications and use The prescription of benzodiazepines is decreasing following con- cern about their liability to produce dependence with long-term use. Alternative therapies are available for chronic anxiety related disorders, and it is recommended that benzodiazepine treatment of anxiety and insomnia should be limited to two weeks only. The main indication for the use of benzodiazepines is for patients with acute stress reaction and adjustment disorders in which anxiety and in- somnia are reducing their ability to cope. Patients should be advised that the drug treatment will only be of short duration. All benzodiazepines have hypnotic and anxiolytic properties; the main difference between them of clinical importance is their length of action. Derivatives with short half-lives, such as temazepam, are suitable hypnotics because of their relative lack of a hangover effect. Other benzodiazepines (e.g. diazepam) have long half-lives and are metabolized to active compounds. They either may be used for the treatment of anxiety, in the form of regular dosing, or in the now preferred ‘as required’ basis with an agreed maximum daily dose. Side effects and interactions Benzodiazepines have a low acute

toxicity. Their adverse effects are extensions of their clinical effects and include drowsiness, psycho- motor impairment, dizziness, ataxia, and paradoxical aggression (rare). Benzodiazepines potentiate the effects of other centrally acting sedatives, particularly alcohol. The effects of benzodiazepines are potentiated by cimetidine. Patients who have taken clinical doses of a benzodiazepine for more than a few weeks may show a withdrawal syndrome when the medication is stopped. This syndrome resembles an anxiety state, but perceptual disturbances and dysphoria may also occur. It is thus apparent that benzodiazepines can cause physical dependence, and patients frequently find it difficult to stop their medication. A gradual reduction in dose is usually best. Zopiclone, zolpidem, zaleplon (the Z drugs) The 'Z drugs' are nonbenzodiazepine agents with short half-lives that also increase GABA function by binding to the benzodiazepine - receptor and are licensed as hypnotics. The treatment of insomnia with either benzodiazepines or the Z drugs should be short-term to avoid dependence. Other drugs SSRIs are effective in the management of a range of anxiety dis- orders, including generalized anxiety, and phobic states. SSRIs are also effective in the treatment of obsessive–compulsive disorder. FURTHER READING Baldwin DS, et al. (2014). Evidence-based guidelines for the pharma- cological treatment of anxiety disorders, post-traumatic stress dis- order and obsessive compulsive disorder: a revision of the 2005 guidelines from the British Association of Psychopharmacology. J Psychopharmacol, 28, 403–39. Cleare A, et al. (2015). Evidence based guidelines for treating depres- sive disorders with antidepressants: a revision of the 2008 British Association for Psychopharmacology guidelines. J Psychopharmacol, 29, 459–525. Goodwin GM, et al. (2016). Evidence-based guidelines for treating bipolar disorder: revised third edition—recommendations from the British Association of Psychopharmacology. J Psychopharmacol, 30, 495–553. Harrison P, Cowen P, Burns T, Fazel M (2018). Drugs and other physical treatments. In: Harrison P, et al. (eds), The shorter Oxford textbook of psy- chiatry, OUP, 7th edition, pp. 709–75. Oxford University Press, Oxford. Stahl SM (2013). Essential psychopharmacology, 4th edition. Cambridge University Press, Cambridge. Taylor D, Barnes TRE, Young AH (2018). The Maudsley prescribing guidelines, 13th edition. Wiley Blackwell, Chichester. 26.4.2 Psychological treatments Michael Sharpe and Simon Wessely ESSENTIALS Psychological treatments, sometimes called psychotherapies or talking treatments, refer to the use of psychological, as opposed to pharma- cological or surgical methods, to treat an illness or improve a person's well-being. They may be regarded as general or specific in type. General psychological treatments, such as listening to the patient and providing reassurance, are a core aspect of general medical prac- tice as all medical interactions will have a psychological impact on the patient, whether for good or ill. Specific psychological therapies, which are usually given by trained therapists, are important treatments for psychiatric illnesses such as depression and anxiety. Consequently, it is important that physicians both know how to make their consult- ations generally psychotherapeutic and about specific psychological treatments, so that they can refer patients appropriately for these. What is psychological treatment? Psychological or talking treatments are also referred to as psychotherapies. They target the patient's psychological processes

26.4.2 Psychological treatments 6471 with the aim of improving their well-being. They are delivered mainly by listening and talking, and increasingly also via digital media. They aim to help patients to change their understanding, emotional response to and behaviour towards their illness or situation. General psychological treatments, such as listening to the patient and pro- viding reassurance, are a core aspect of general medical practice as all medical interactions will have a psychological impact on the pa- tient, whether for good or ill. In this sense, all doctors, whether

they know it or not, are in the business of delivering psychotherapy. Specific psychological treatments are more intensive and tailored interventions designed to treat specific problems or illnesses. There is a wide variety of ‘psychotherapies’ including counselling, psycho- dynamic, and various forms of cognitive behavioural therapy (CBT). Specific psychological treatment is an important and evidence- based method of treating many psychiatric illnesses and other psychological problems, including those that may complicate general medical care. The psychotherapeutic medical consultation The medical consultation is a psychotherapeutic opportunity. This was perhaps better understood when physicians had less to offer, and indeed to do, in terms of carrying out biological investigations and treatments. There was then a greater need, and opportunity, to seek benefit from simply listening to and talking with the patient. However, despite the power of modern medicine’s pharmacological and surgical treatments, psychotherapeutic aspects of the consult- ation remain important to the effective practice of medicine. This is especially the case when there is diagnostic uncertainty, a need for the patient to adhere to a treatment regimen, or when the patient has coexisting psychiatric illness or distress. Psychotherapeutic consultations (doing good) Key requirements for a positively psychotherapeutic consultation are shown in Box 26.4.2.1. Although many medical encounters are suboptimal in delivering these ingredients, they can be easily improved by simply fol- lowing the recommendations summarized in Table 26.4.2.1 and described next. Preparing well If possible read the patient’s notes in advance and decide how you can best use the consultation therapeutically, and not simply to gather data (much of which may already be recorded). Pay attention to the physical arrangements for the consultation. The days when patients were told that they have cancer on an open ward round may have gone, but many consultations still offer scant privacy and provide little real opportunity for the patient to ask ques- tions. Preparation for the right place and time helps to make best use of the consultation. It is important that the need for time and privacy is recognized and if necessary insisted on by the physician despite institutional pressures. Time with the patient is an essen- tial therapeutic tool that, like a drug, will only work if given in an appropriate dose. Listening well Taking an interest in the patient’s symptoms (even those that are not of diagnostic value) and their fears about these (even if they appear illogical) is important for two reasons. First, it helps the pa- tient to feel that their concerns have been heard, resulting in better adherence to the physician’s advice. Second, effective reassurance requires learning what it is that the patient fears. Time spent on such matters is therefore a critical means for helping the patient to feel better. Explaining well A clear explanation of the physician’s understanding of the patient’s problem is required. While it may sound obvious, this requires a clear statement and explanation of the diagnosis when- ever possible. All too often patients complain that doctors have told them what they did not have, but not what they did have. This most often happens when the patient’s complaints are not adequately explained by identifiable disease (medically unex- plained) (see Chapter 26.3.3). Making a shared plan Even when a clear diagnosis or specific treatment cannot be given, a positive plan of action usually can. There is evidence that such a positive approach has a beneficial effect. The provision of hope, the agreement on a practical plan, and an expectation of improvement in at least some aspects of the illness, have long been key ingredients of an effective doctor–patient relationship. Although the hope offered should not be false (e.g. if the patient has a terminal condi- tion, it is clearly unhelpful to pretend otherwise), the message given to the patient can still be a positive one (e.g. the symptoms will be managed and the doctor will provide ongoing help). A written sum- mary of the plan, perhaps as a copy of the letter to another doctor, is usually helpful. Box 26.4.2.1 Psychotherapeutic imperatives for the medical consultation • Establish a good, confiding, and collaborative relationship with the patient. •

Convince the patient that whatever the nature of their problem, you can be trusted to help with it. • Offer an acceptable and convincing explanation for what is wrong. • Provide a positive and credible plan of action for addressing the problem. Table 26.4.2.1 Tasks for the physician in the medical consultation Prepare Ensure adequate time and privacy for the consultation, and that you have the information you need. Listen Listen to the patient's concerns about symptoms and accept these as problems in their own right and not only as pointers to disease. Explain Explain what you understand to be wrong, including a diagnosis. Reassure about unfounded worries and provide appropriate optimism. Plan Agree a plan with the patient with actions for both them and for you. Ensure that they both understand and feel understood. Summarize the plan in writing.

section 26 Psychiatric and drug-related disorders 6472 Psychological iatrogenesis (doing harm) Like all treatments, the consultation has the potential to do psycho- logical harm as well as good. Iatrogenesis can result not only from prescribing the wrong drug or doing the wrong operation, but also from what doctors say to their patients. Poor listening Appearing not to hear and accept the patient's account of their suffering can cause harm. For example, by telling a patient with medically unexplained symptoms, 'there is nothing wrong with you'. This may not only damage your relationship with the patient, but may also send him or her into the arms of less scrupulous practitioners. Unhelpful explanations Ill-considered or unhelpful explanations for the illness; for example, telling the person who is depressed that it's 'probably a virus', or a person with back pain that they have a 'weak ligament' send false messages about why they are unwell. It will also influence what treatment they should seek and may worsen the clinical outcome by influencing their behaviour. Unrealistic prognostication Both excessively optimistic predictions; for example, telling a pa- tient who has not yet been adequately assessed 'I'm sure it's nothing serious' and excessively pessimistic predictions (e.g. telling a person with possible multiple sclerosis 'it's probably best if you just come to terms with the idea of a wheelchair now') may be harmful. Both risk loss of credibility of the physician if the predictions are not fulfilled. They may also lead to the patient acting on inaccurate information and to unnecessary distress. Harmful advice Poorly thought out or ill-informed advice can do more harm than might be imagined. A compelling demonstration of this type of problem was found in a study of schoolchildren whose parents were told (sometimes incorrectly) that their children had abnormal hearts and should avoid exertion: at follow up many years later, the children with normal hearts whose parents were warned incorrectly about activity were restricting their activity as much as those with heart disease. Specific psychological treatments Specific psychological treatments may be broadly divided into the following types: (a) simple brief therapies, usually given over one to less than 10 sessions by a person with modest training; (b) more complex but usually brief psychotherapies, such as CBT, which may be given over 6 to as many as 20 sessions and require a highly trained therapist; (c) longer-term treatments such as psychodynamic psy- chotherapy, which may be given over months or years and require a very high level of therapist skill. See Table 26.4.2.2. Specific psychotherapies are an important tool in the treat- ment of psychiatric illnesses. They also have a potentially im- portant role in the management of medical illness by providing evidence-based treatments for symptoms such as fatigue and pain, reducing emotional distress, and improving adherence to medical treatments. There is a strong argument that many patients would benefit from better integration of these psychotherapies into their medical care. Simple brief therapies Brief counselling Counselling, usually given by trained councillors, can help patients to express distress and talk through problems such as a diagnosis of cancer. However, basic counselling should also be regarded as a gen- eric skill that all doctors and nurses are able to provide.

Motivational interviewing This is a simple technique to encourage behaviour change. It aims to help the patient clarify what they want to achieve, then to con- sider the advantages and disadvantages of specific behaviours as ways of achieving it. It can be delivered during a single extended consultation. Originally developed to help people reduce problem drinking, it has wider application to many situations where behav- iour change is required, such as improving adherence to medical treatment. Problem solving therapy A brief (typically six to eight sessions) simple psychological treat- ment that aims to help patients feel more in control of the practical problems they face. It teaches them to define their problems clearly, to tackle them one at a time, and to work out clear strategies to over- come them. It is effective for treating depression. Behavioural activation
A simple therapy that helps patients to become generally more ac- tive and specifically to overcome avoidance of important activities. When given by a trained therapist, it is effective in the treatment of depression. Complex but usually brief therapies Cognitive behaviour therapy (CBT)
CBT is a complex therapy usually given over 6–20 sessions. It re- quires a skilled therapist. The cognitive part refers to helping the patient to re-evaluate and optimize their thinking, for example, countering excessive pessimism about their medical condition. Table 26.4.2.2 Commonly used psychotherapies Simple brief therapies • Brief counselling • Motivational interviewing • Problem solving • Behavioural activation Complex but usually brief therapies • Cognitive behaviour therapy • Acceptance and commitment therapy • Mindfulness training • Interpersonal therapy Longer-term treatments • Long-term counselling • Psychoanalysis • Long-term forms of CBT

 The behavioural part involves helping them to cope more ef- fectively by reducing unhelpful behaviours such as excessive checking of symptoms or avoidance of activities. It is effective in the treatment of patients with depression, anxiety, and panic disorders and in the treatment of medically unexplained or func- tional symptoms. Mindfulness training Mindfulness is not really a therapy, but rather training in a skill. It aims to help the patient develop ‘mindfulness’; the psychological pro- cess of focusing attention on only those internal and external experi- ences occurring in the present moment and accepting rather than judging these. It requires prolonged diligent practice. It is currently being widely advocated for several problems. The strongest evidence of its efficacy is in the prevention of relapse in patients with depres- sion. The evidence to support its many other potential applications, such as the treatment of symptoms and occupational stress, is weaker. Acceptance and commitment therapy This is a form of CBT, which also includes elements of mindfulness. It has two main components: the first is helping the patient to ac- cept their thoughts, emotions, and symptoms and not to challenge or struggle against them. The second is to encourage the patient to commit to changing their behaviour, however they feel. An example might be accepting pain as incurable; to accept rather than resent it and to commit to re-establishing previously valued activities, even if this increases pain. The evidence of efficacy is strongest in the man- agement of chronic pain. Interpersonal therapy This short-term therapy focuses on helping the patient to under- stand their personal relationships and how these relate to the prob- lems they have. They are then helped to make necessary changes. An example may be a patient gaining understanding of how they allow themselves to become excessively passive when ill, in part as a response to an oversolicitous partner. The evidence of efficacy is strongest for depression. Complex longer-term therapies Long-term counselling This is supportive listening for someone with a long-term problem. Sessions may be spread over a long period, perhaps monthly for a year or more. It may be of value in prolonged adjustment disorders such as to a severe illness. It is not an effective treatment for more severe problems such as major depressive disorder. Psychodynamic therapy For people with problems not amenable to a brief

therapy, such as those with major personality difficulties, there is a case for longer- term psychological therapy. One well-established type of long- term therapy is psychodynamic psychotherapy. This is a modern derivative of classical psychoanalysis and typically focused on the relationship of current difficulties to experiences in childhood and relationships with parents. It may last for many months or even years. However, the availability of such therapy is limited and the evidence for its effectiveness is modest. Long-term forms of CBT Not all forms of CBT are brief. Long-term CBT is used to treat more severe problems such as personality disorder. For example, there is evidence that a form of CBT called dialectic behaviour therapy helps to improve the functioning of people with a form of personality disorder called borderline personality disorder. This therapy uses the relationship between patient and therapist to produce therapeutic change and requires a high level of skill to deliver. Making a referral for a specific psychological treatment When considering a referral of a patient for psychological treatment, the first requirement is to find out what services are available and what types of referrals are accepted by these services. The second requirement is to make sure that the patient understands why they have been referred. The third requirement is to explain the referral to the patient in a way that makes it likely that they will attend, at least for an initial assessment. Identifying psychological treatment services Psychological treatment services would ideally be located in or- ganizational and geographical proximity to where medical con- sultations takes place; a psychotherapist in every clinic. In reality they rarely are. It is therefore desirable for the physician to famil- iarize themselves with what is provided by other organizations, how long the patient will have to wait, and what kind of refer- rals are likely to be accepted, before the need to make a referral arises. Making the referral It is often helpful to discuss the type of problem being referred with the service to ensure it will be accepted, before telling the patient. For example, the patient's psychological problems may appear ob- viously in need of treatment to the physician, but regarded as an untreatable personality disorder by a service providing only brief therapy. If medical investigation or treatment is ongoing, it will help if any uncertainties in diagnosis or prognosis are made explicit in the referral letter, together with the physician's plan for follow up of the patient. Explaining the referral to the patient While telling the patient that they are being referred sounds simple, it is most likely to be successful if care is taken when doing it. First, and perhaps most important, is the need to make it clear that you are not implying that the illness is 'imaginary' or 'all in the mind'. Rather, it can be explained that, as with almost all sick people, there is an understandable psychological aspect to their problems that deserves attention. Second, it helps to convey a positive attitude towards psy- chotherapy as a sensible treatment approach with a good chance of helping. It is even better if you can explain to the patient what they can expect during the therapy. Finally, it is important, if appropriate, to make sure the patient knows that, if required, you will see them after the psychological treatment has finished, thereby making it

section 26 Psychiatric and drug-related disorders 6474 clear that you regard the referral as a useful addition to care and not simply as a way of 'getting rid of the patient'. FURTHER READING Burns T (2015). Psychotherapy: a very short introduction (very short introductions). Oxford University Press, Oxford. Farias M, Wikholm C, Delmonte R (2016). What is mindfulness-based therapy good for? Lancet Psychiatry, 3, 1012–3. Frank JD (1967). Persuasion and healing: a comparative study of psycho- therapy. The Johns Hopkins University Press, Baltimore, MD. Miller WR, Rollnick S (2013). Motivational interviewing: helping people change, 3rd edition. The Guilford Press, New York, NY. Thomas KB (1987). General practice consultations: is there any point in being positive? BMJ, 294, 1200–2.

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