22 - 19 Psychotherapy

01 - 19 Psychotherapy

19 Psychotherapy

Chapter 19

Psychotherapy Introduction 882 Assessment for psychotherapy 884 A brief history of Sigmund Freud 886 Other pioneers of psychoanalysis 888 Basic psychoanalytical theory 890 Defence mechanisms 892 Psychosexual development 894 Object relations theory 896 Psychoanalysis 1 898 Psychoanalysis 2 900 Psychodynamic psychotherapy 902 Group psychotherapy 904 Basic learning theory 906 Behaviour therapy 908 Cognitive behavioural therapy 1 910 Cognitive behavioural therapy 2 912 Interpersonal psychotherapy 914 Dialectical behaviour therapy 916 Cognitive analytic therapy 918 Solution-focused therapy 920 Counselling methods 922 Other therapeutic approaches 1 924 Other therapeutic approaches 2 928 881

882 Chapter 19 Psychotherapy Introduction The psychotherapies are a collection of treatments for mental disorders, which employ language and communication, and the relationship with a skilled therapist, as their means of producing change. Psychotherapeutic methods are used both to conceptualize abnormal mental states (to under stand why symptoms have developed in this patient at this particular time) and to treat symptoms and disorders. Generally, the aim of therapy is to enable patients to improve their rela tionships with themselves and others, as well as to manage and treat symp toms. The core components of psychotherapy, regardless of the underlying theoretical basis, are an empathetic and non-judgemental stance towards the patient, an awareness of the importance of the setting in which therapy takes place, and the use of the therapeutic relationship between the therapist and the patient as both a diagnostic and a therapeutic agent. Types of psychotherapy Supportive psychotherapy This form of psychotherapy aims to offer practical and emotional support, an opportunity for ventilation of emotions, and guided problem-solving discussion. There is no explicit attempt to alter underlying cognitions or to dismantle adaptive defence mechanisms. Supportive psychotherapy is sometimes preferred where fundamental behavioural change is not aimed for or where patient factors (e.g. learning difficulty, psychotic illness) pre clude exploratory therapies. Examples include counselling and general psy chiatric follow-up. Psychodynamic psychotherapy This form of therapy aims to produce changes in the individual’s thinking and behaviour by exploring childhood experience, the unconscious mind, including transference (E Basic psychoanalytical theory, p. 890), and the quality and nature of relationships in the past, the present, and the here- and-now with the therapist. The latter receives particularly close analysis, as it allows for understandings to come directly, rather than via a third-party report by the patient. Ideally, patients should be highly motivated, able to tolerate frustration and anxiety, have good impulse control, be able to form meaningful relationships, and be capable of insight and abstract thought. These traits, however, could be regarded as being markers of health, rather than signs that somebody needs treatment and, as such, a balance needs to be

struck between a triad of factors—does the patient want therapy, do they need therapy, and can they use therapy? Cognitive and/or behavioural therapies These are based on learning and cognitive theories, with the rationale that a patient's thoughts, feelings, and actions are interdependent on one an other. Attention in these therapies is directed towards the patient's cur rent thoughts and behaviours, which are closely examined and challenged, with a view to modification to improve symptoms. Unconscious processes, childhood experience, and the specific nature of the therapist–patient rela tionship receive less attention. Cognitive and behavioural therapy sessions are generally more structured than in other psychotherapies and often take

Introduction place over a relatively brief and predetermined period of time. These ther apies are useful in a wide range of disorders, including depression, anxiety disorders (including OCD), and eating disorders, and more recently, they have been applied to psychotic disorders. Psychotherapeutic training As a psychiatric trainee, you are required to gain competency in five areas of psychotherapy—supportive psychotherapy, psychodynamic psycho therapy, brief psychotherapies, CBT, and combined psychopharmacology/ psychotherapy. Training generally consists of formal teaching, experience working with a range of patients, and regular supervision with experienced therapists. It is only through the process of conducting therapy under supervision that you will really understand psychotherapeutic techniques. These notes on general concepts and specific psychotherapies aim to fa miliarize you with theories, guide your referrals, and assist you in explaining the process to patients. Further reading Dewan M, Steenbarger B, Greenburg R (2004) The Art and Science of Brief Psychotherapies. Arlington, VA: American Psychiatric Publishing. Gabbard GO (2000) Psychodynamic Psychiatry in Clinical Practice, 3rd edn. Washington, DC: American Psychiatric Press. Malan D (1995) Individual Psychotherapy and The Science of Psychodynamics. London: Hodder Arnold Publications. Padesky CA, Greenberger D (1995) Mind Over Mood: Change How You Feel By Changing The Way You Think. New York, NY: Guilford Publications. Winston A, Rosenthal R, Pinsker H (2004) Introduction to Supportive Psychotherapy. Arlington, VA: American Psychiatric Publishing.

884 Chapter 19 Psychotherapy Assessment for psychotherapy Indications and contraindications • Psychotherapeutic methods can be useful in the treatment of many psychiatric illnesses, including mild to moderate depressive illness, neurotic illnesses, eating disorders, and personality disorders. • Specific therapies also have a place in the management of patients with learning disabilities and those with psychosexual problems, substance misuse disorders, and chronic psychotic symptoms. • They are generally contraindicated in: • Acute psychosis (due to increasing expressed emotion and the inherent neuropsychological deficits associated with this mental state). • Severe depressive illness (because of psychomotor retardation). • Dementia/delirium (where treatment of organic pathology is first line). • Some individuals where there is acute suicide risk. Goals of assessment The assessment of a patient for psychotherapy has three major goals: • What does the patient expect (or want from therapy)? • Obtaining a careful history/narrative of the problem from the patient (do they need therapy?). • Establishing whether the patient can form a therapeutic relationship and make use of the type of therapy being potentially offered. Different therapies will have a varying focus in the initial assessment, e.g. psychodynamic assessments will often focus more on relational aspects of the patient's life, whereas cognitive behavioural therapists may concentrate more on the (A)ntecedents, (B)ehaviours/(B)eliefs, and (C)onsequences of the patient's behaviours or beliefs. Psychological factors in assessment for psychotherapy 'Psychological mindedness' Refers to the capacity for insight and to understand problems in

psycho logical terms—‘can the patient think about their thoughts?’ If this is lacking, a supportive method may be preferred over a cognitive or exploratory method. Motivation for insight and change Many patients (and trainees!) do not want to ‘get better’ or change. Often we are more comfortable playing by the rules of the game we know, even if this means we find ourselves caught in difficult situations, rather than learning a new game. An important part of assessment is to establish whether the potential patient is willing to take responsibility for their situ ation and use therapy as a means of changing it. Adequate ego strength and reality testing Important when considering exploratory psychotherapies, especially those based on exploring transference dynamics. Includes the ability to sustain feelings and fantasies without impulsively acting upon them, being over whelmed by anxiety, losing the capacity to continue the dialogue, or treating ‘as if’ situations as though they ‘actually are’ real.

Assessment for psychotherapy Ability to form and sustain relationships Where there is inability to enter into trusting relationships (e.g. in para noid personality disorder) or where there is inability to maintain relation ship boundaries (e.g. in borderline personality disorder), this may preclude exploratory methods. Ability to tolerate change and frustration As with any potentially powerful treatment, psychotherapy has the potential to exacerbate symptoms, particularly when maladaptive coping mechan isms are examined and changed. Selection of psychotherapeutic method Local availability In practice, often the main determinant of therapy choice is local availability, and practical availability determined by the length of the waiting list. The waiting times associated with most forms of therapy should encourage all practitioners to exercise care in patient referral. Practitioner experience and view of modality Where the treating psychiatrist also provides psychotherapy, their area of expertise may determine the choice of psychotherapeutic method. Illness factors Varying illnesses and states of mind have been shown, within the evidence base, to respond differentially to different treatments. Patient choice Patients may express a preference for a particular therapeutic model be cause of previous positive experience or having read or been told about the approach. A method which ‘makes sense’ to the patient, given their understanding of their symptoms, is often preferred.

886 Chapter 19 Psychotherapy A brief history of Sigmund Freud Freud remains, far and away, the world’s best known psychiatrist, and his image of a scholarly bearded man sitting behind a distressed patient lying on a couch is many lay people’s archetype for our profession. He made a huge contribution to our understanding of the mind, but many of his ideas are now so much a part of our general view of the world that it is easy to overlook the breakthroughs they originally were. He was born in 1856 in Moravia (now part of the Czech Republic, but then part of the Austro-Hungarian Empire). He moved to Vienna when he was a child and lived there until his last year. On entering medical training, he was influenced by scientific empiricism—the belief that, through careful observation, the un-understandable could be understood. On qualification, he began laboratory work on the physiology of the nervous system under Brücke, later entering clinical medical practice after his marriage in 1882. He chose neurology as his specialty and received a grant to study at the Salpêtrière in Paris where he was exposed to the ideas of Charcot, who interested Freud in the study of hysteria and the use of hypnosis. In Paris with Charcot, and later in Nancy with Liébault, he studied the behaviour of hysterical patients under hypnosis and developed his ideas of the uncon scious mind and its role in normal and disordered behaviour. Returning to Vienna, Freud began collaboration with Josef Breuer on the study of hysteria. The subsequent development of psychoanalysis was prompted by the case of Anna O, treated by Breuer between

1880 and 1882. This patient, a 21-yr-old woman (real name Bertha Pappenheim), presented with a range of hysterical symptoms, including paralysis, visual loss, cough, and abrupt personality change. These symptoms had developed while her father was terminally ill. Breuer observed that her symptoms re solved during hypnotic trances. Breuer also noted that not only did the symptoms recur after the sessions ended, but that after he terminated the treatment relationship, she also suffered a full-blown relapse. Breuer wrote up the case after discussing it with his younger colleague. Later they pub lished Studies in Hysteria, detailing their ideas on the aetiology and treatment of hysterical symptoms. This book postulated that trauma is unacceptable to the patient and hence was repressed from conscious memory. This re pression produces an increase in 'nervous excitation'—which is expressed eventually as hysteria—with a conscious remnant, often in a disguised form, which can be accessed and resolved during hypnosis. Freud explored these ideas during his clinical practice in the 1890s, using a variety of methods to uncover the repressed memories. Later he devel oped the technique of free association where the patient is encouraged to say whatever comes to mind. Experience in the 1890s led Freud to develop the ideas of repression of unacceptable memories and their expression as hysterical symptoms. The initial memory was generally of a sexual nature. At first, Freud thought this was a real, remembered assault but later real ized that, in the majority of cases, the patients were describing a sexualized fantasy towards parental figures. Freud described these ideas in his most famous book The Interpretation of Dreams, published in 1900. It described the basis of his psychoanalytic technique, including analysis of the content of dreams, descriptions of defence mechanisms, and his topographical model

A brief history of Sigmund Freud of the mind. Freud's early insights tended to come directly from clinical ex perience, particularly from patients with hysteria. His later ideas were more theoretical and aimed to develop a model of the normal and abnormal development of the mind through psychoanalytical ideas. His drive theory postulated the existence of basic drives, which included the libido, the sexual drive, and the eros and thanatos (the drives towards life and death). He described the pleasure principle, the drive to avoid pain and experience pleasure, and its modification through the reality principle. In 1905, he published Three Essays on the Theory of Sexuality, describing his theories regarding childhood development, including the ideas of devel opmental phases and the Oedipal and Electra complexes and their relation ship with the development of adult neuroses. The Ego and the Id, published in 1923, saw the replacement of the topographical model with the struc tural model of the mind. He described his theories of ego psychology and the production of anxiety symptoms in Inhibitions, Symptoms and Anxiety in 1926. Although he recognized the importance of unconscious defences in response to anxiety, the first systematic account of these mechanisms was written by Freud's daughter Anna in The Ego and the Mechanisms of Defence in 1936. Freud's repeated revision of his own theories was mirrored by repeated disagreements and splits in the psychotherapeutic movement and the formation of separate psychotherapeutic 'schools', usually strongly as sociated with one charismatic individual. Freud died from cancer in England in 1939 after fleeing Vienna, following the rise to power of the Nazis. His daughter Anna continued to refine and publicize her father's work, which has recently been retranslated and reprinted in full.

888 Chapter 19 Psychotherapy Other pioneers of psychoanalysis Anna Freud (1895–1982) Although Freud recognized the importance of un conscious defences, the first systematic account of these mechanisms was written by his daughter Anna in The Ego and the Mechanisms of Defence in 1936.

She also helped to develop child psychoanalysis and play therapy. Carl Jung (1865–1961) Associated with Freud until their views over the sexual aetiology of the causes of neuroses differed, and he founded his own school of analytic psychology. Key concepts include the ‘collective unconscious’, in which humanity’s shared mythological and symbolic past is represented in the unconscious mind of an individual by symbols called ‘archetypes’. He also described 16 personality types, including the differen tiation between ‘introverted’ and ‘extroverted’ types. Erik Erikson (1902–1994) Expanded Freud’s developmental theory by explaining that there were not only sexual conflicts at each phase, but also a conflict related to how individuals adapt to their social environ ment. Described eight stages of psychosocial development of the identity throughout the lifespan, characterized by the following conflicts: trust vs mistrust (infancy), autonomy vs shame and doubt (early childhood), initia tive vs guilt (play age), industry vs inferiority (school age), identity vs role confusion (adolescence), intimacy vs isolation (early adulthood), genera tivity vs stagnation (middle adulthood), and integrity vs despair (old age). Alfred Adler (1870–1937) Theorized that all people are born with an ‘in feriority complex’, an unconscious sense of inadequacy, which may lead them to over-compensate. Disagreed with Freud’s emphasis on sexuality in the development of both normal personality and the neuroses. Melanie Klein (1882–1960) A controversial figure and one of the founders of the object relations school. She demonstrated that a child’s unconscious development can be understood by observing the child at play—felt to be analogous to free association. While her resulting developmental theories are not widely accepted by contemporary psychologists, play therapy is still commonly practised. She emphasized primitive defence mechanisms such as projection/projective identification, introjection, and splitting, as well as the emotions of love, hate, anger, and envy. Donald W Winnicott (1897–1971) Another object relations theorist who studied the infant’s growth of a sense of self. He described the ‘transitional object’, which was an item such as a teddy or blanket that aided the infant’s transition to independence by standing in for the mother–infant object re lationship. He described the ‘good-enough mother’ to refer to the envir onment needed for normal psychological development. He also developed the concept of true and false selves—the true self responds instinctively and spontaneously, but when parenting is not ‘good enough’, a false self- persona may develop to maintain relatedness with the parents while pro tecting the more vulnerable true self. Wilfred R Bion (1897–1979) A pioneer in thinking about groups whose ‘basic assumptions’ describe three ways in which groups may function: de pendency, fight–flight, or pairing. He moved away from emphasizing the content of patients’ narratives to thinking about how we structure the world around us through our thinking and how this, in turn, allows our in ternal worlds to develop.

Other pioneers of psychoanalysis Carl Rogers (1902–1987) Worked on the therapeutic technique. He con ceived ‘client-centred therapy’. He felt that the therapeutic attributes of genuineness, unconditional positive regard, and accurate empathy could help patients achieve what he called ‘self-actualization’, a complete sense of self, which was beneficial to their recovery. John Bowlby (1907–1990) Worked on the attachment theory, which has been developed from ethological studies and empirical research in humans such as observing infants’ behaviours when separated from, and then re united with, their mothers. Attachment theory stresses the importance of the feelings of closeness and security an infant develops with the caregiver, as well as the role the caregiver plays in helping the infant to form these feelings. The child can, if such feelings have developed, then use the mother as a ‘secure base’ from which to explore and then return to when their anxiety increases. Bowlby delineated four different attachment styles, which have been found to be transmitted from parent to child with reasonable reliability: secure, ambivalent, avoidant, and

disorganized.

890 Chapter 19 Psychotherapy Basic psychoanalytical theory Topographical model of the mind In The Interpretation of Dreams, Freud theorized that the mind consisted of the unconscious, the preconscious, and the conscious. Only those ideas and memories in the conscious mind are within awareness. The preconscious contains those ideas and mem ories capable of entering the conscious mind. The preconscious performs a 'censorship' function by examining these ideas and memories and sending those which are unacceptable back to the unconscious ('repression'). The unconscious mind acts according to the 'pleasure principle'—the avoidance of pain and the seeking of gratification. This is modified by the 'reality prin ciple' of the conscious mind—that gratification often must be postponed in order to obtain other forms of pleasure. Freud's psychoanalytic techniques would attempt to interpret unconscious content based on access to pre conscious content such as free associations, the content of dreams, trans ference, jokes, and 'parapraxes' (E Examination of parapraxes, p. 899). Structural model of the mind Freud reconfigured the topographical model in light of his clinical experience. In the structural model, an infant's mind comprised the id ('the it', which wishes to pursue its own desires, regardless of the constraints of morality or external reality) which is entirely uncon scious. As time goes on and development occurs, the mind further differ entiates into the ego and then the superego. The ego ('the me') is mostly conscious, emerges during infancy, and is the part of the personality which negotiates between the 'three harsh masters': the desires of the id, the hold of reality, and the superego. The superego (the 'conscience') is the conscious and unconscious internalization of the morals and strictures of parents and society, which provides judgements on which behaviours are acceptable and which are not. When the ego is unable to successfully mod erate between the id and superego, it may defend the individual's sense of self by repressing the impulse to the unconscious where its presence may produce disturbance. Alternatively, the ego may be tormented by an over- harsh superego. Drive theory Freud postulated the existence of basic drives, which in cluded the 'libido', the sexual drive (E Psychosexual development, p. 894), which made up part of 'eros', the life drive, in opposition to 'thanatos', and the drive towards death. He described the pleasure principle and the drive to avoid pain (or unpleasure) and experience pleasure, as well as its modifi cation through the reality principle. Additionally, he described the repetition compulsion—the tendency of people to compulsively repeat their early ex periences throughout their lives.
Transference reactions Transference—the unconscious development, in the patient, of feelings, thoughts, attitudes, and patterns of behaviour towards the therapist, which recapitulate earlier life relationships, most usually the patient's relationships with their parents. Transference is viewed as a defence against the reality of relationships with others. The analysis of the transference is a prime feature of psychoanalysis. Countertransference—describes the equivalent reaction in the therapist towards the patient, although this concept has now been extended by

Basic psychoanalytical theory some schools to encompass all thoughts, feelings, imagery, etc. that patients evoke and engender in therapists. The examination of transference and countertransference is a central part of dynamic psychotherapies and guides diagnostic formulation and the exploration of the patient's pathology. Thought processes Dreams were felt by Freud to be the product of the unconscious mind as they occur when the internal censor is relaxed by sleep. They allow insight into the unconscious thought process, which is described as primary process thinking. In this form of thought, there is no negation (yes and no can mean the same thing), there is no sense of time, ideas can be condensed into single symbols, and it is primarily

symbolic and non-linear. Secondary process thinking, in contrast, is found within preconscious and conscious parts of the mind and is orientated to time, operates in a linear fashion, and is predomin antly word-orientated, and negation applies (i.e. yes is not no). Psychoanalytical techniques Free association—the fundamental rule within psychoanalysis is for the pa tient to say whatever comes into their mind and then associate from this. Resistance—blocks to free association, e.g. forgetting or changing the sub ject, demonstrate where resistance, and hence psychological problems, is present, i.e. the mind says ‘don’t even go there!’ These points of resistance are to be analysed, thus making the unconscious conscious, or more fam ously ‘where it is, let ego be’. Evenly suspended attention—as a corollary to the patient’s free asso ciation, the analyst is asked to maintain themselves in a state of ‘evenly suspended’ attention to allow themselves to hear both what the patient is saying and what they are not. Defence mechanisms Freud conceived the idea of repression acting as a defence to prevent un acceptable thoughts from reaching conscious awareness. Subsequently, other defence mechanisms were described, viewed as developing to pre vent conflict between the conscious mind and unconscious desires and developing in the course of normal maturation. Mental disorder can be characterized by the persistence of primitive defence mechanisms, with im mature defences seen in early childhood, and mental illness and personality disturbances and neurotic defences seen in older children or adults experi encing stress or anxiety. Mature defences are seen in functioning adults. A full list of defence mechanisms is given in E Defence mechanisms, p. 892.

892 Chapter 19 Psychotherapy Defence mechanisms Primitive defence mechanisms Denial—remaining unaware of difficult events or subjective truths which are too hard to accept by pushing them into the unconscious. Introjection—our perceptions of significant figures in our lives are intern alized where they form the part of the structure of the personality (e.g. someone who was raised by a hostile and critical father may themselves feel persecuted by the introjection of this object but also may ‘become like’ this object at other times). Freud’s theory on depression suggests that it is caused by introjection of the aspects of others that make the depressed patient feel anger, leading to ‘anger turned inwards’. Projection—attributing one’s own internal unacceptable ideas and im pulses to an external target, such as another individual, and reacting ac cordingly to them (e.g. an angry child looks at his dog and accuses it of being angry). Projective identification—behaving towards another in a manner that causes them to take on one’s own internal unacceptable ideas and impulses. Not to be confused with projection. Whereas during projection, an indi vidual with a certain emotion might perceive someone else as feeling the same way, in projective identification, the individual causes the other to feel that emotion (e.g. an angry child behaves in such a way that his mother becomes angry with him). Idealization and denigration—perceiving others as ideal in order to avoid conflicting feelings about them. Humans find it less anxiety-provoking to avoid ambivalence and grey areas within people. The converse of idealiza tion is denigration where only bad is seen within others. Splitting—separating polarized and contradicting perceptions of self or others in order to disregard awareness of both simultaneously (e.g. a pa tient believing that a doctor is ‘the best doctor they have ever had’ at one point, and ‘the worst doctor they have ever had’ at another). This utilizes both idealization and denigration. Splitting can also happen intrasubjectively where patients split off parts of themselves that they find unacceptable and project these parts onto another person. Acting out—literally acting out in ways that may reveal unconscious de sires (e.g. a patient self-harming to express disgust at themselves). Regression—responding to stress by reverting to a level of functioning of a previous maturational point (e.g. a teenager sucking their thumb around exam time). Neurotic

defence mechanisms Repression—preventing unacceptable aspects of internal reality from coming to conscious attention. (A victim of childhood abuse may not have conscious awareness of the abuse as an adult.) The associated emotional reaction may remain in the conscious mind, but divorced from its accom panying memory. Identification—taking on the characteristics, feelings, and/or behaviours of someone else as one's own. Differs from introjection in a similar manner to the way projective identification differs from projection. Whereas in introjection, one may perceive themselves as being like someone else, in

Defence mechanisms identification, one may actually feel the way someone else does and be come more like the other person. An extension of this is found in the de fence of identification with the aggressor wherein those who have been victims of aggression become aggressive themselves, as this feels to the person like a less vulnerable position (e.g. a young man who was physically abused may grow up to be violent to others, rather than remain in the vul nerable position of victim). Intellectualization—focusing on abstract concepts, logic, and other forms of intellectual reasoning to avoid facing painful emotions (e.g. a victim of a traumatic abuse experience may discuss the statistics of abuse, instead of talking about the particular experience). Isolation of affect—separating an experience from the painful emotions associated with it (e.g. a victim describing a traumatic abuse experience without displaying any of the affect the experience has evoked). Rationalization—justifying feelings or behaviours with a more acceptable explanation, rather than examining the unacceptable explanation known to the unconscious mind (e.g. a mourner stating that the deceased person is 'in a better place now' in order to ease feelings of guilt associated with the death). Reaction formation—externally expressing attitudes and behaviours which are the opposite of the unacceptable internal impulses (e.g. being extra po lite to a person to avoid expressing anger towards them). Undoing and magical thinking—the former is found when performing an action which has the effect of unconsciously 'cancelling out' an unaccept able internal impulse or previous experience. The action symbolizes the opposite outcome of the impulse or experience. Magical thinking is found when one attributes magical properties to thoughts or behaviours, e.g. 'if I throw this piece of paper in the bin five times in a row, then I'll pass my exams'. Both these defences are associated with OCD. Displacement—transferring the emotional response to a person to someone else that, in some way, resembles the original but is not associated with as much conflict or risk (e.g. a boy feeling anger towards a man who reminds him of his father, rather than towards his father). Mature defence mechanisms Humour—finding aspects of an unpleasant experience funny or ironic in order to manage the experience without the associated painful emotions. Altruism—attending to the needs of others above one's own needs. Compensation—developing abilities in one area in response to a deficit in another. Sublimation—expressing unacceptable internal impulses in socially acceptable ways.

894 Chapter 19 Psychotherapy Psychosexual development Freud theorized that everyone is born with an instinctive sex drive called the libido, a primary source of tension if unsatisfied. He developed a theory that attempted to explain the development of the personality during infancy and childhood. His five phases were characterized by particular satisfactions and conflicts. Infants progressed from a state of primary narcissism, finding gratification in their own body processes, to 'object love', more clearly sep arating themselves from other 'objects' or people. Inability to resolve the conflicts of a particular stage could lead to a lack of psychosexual develop ment, while regression to an earlier state could result in the development of neurotic symptoms (see Table 19.1

and Box 19.1). Table 19.1 Phases of psychosexual development Phase Source of pleasure Conflicts Oral phase Birth to 15–18mths Suckling and investigation of objects by placing them in the mouth Love for breast of nursing mother vs ‘aggressive’ urge to bite or spit Anal phase 15–18 to 30–36mths Anal sensations, production of faeces, and later, ability to withhold faeces Need to control the sphincter enough to avoid shame of making a mess (related to pleasing authority and keeping orderly), but not so much that there is faecal retention Phallic phase 30–48mths to around the end of the fifth year Manipulation of the penis Boys: move through the Oedipal phase (see Box 19.1) Girls: ‘penis envy’, leading to feelings of inferiority (note: this theory has been rejected or modified by many modern dynamic theorists), and pass through the Electra complex (the inverse of the Oedipal complex) Oedipal phase 48mths–6yrs Fantasies of sexual intercourse with the opposite-sex parent, with a corresponding wish to kill the same- sex parent Boys: love for mother vs fear of castration by father, leads to ‘castration anxiety’—unconscious desires characterized by ‘Oedipus complex’ Girls: desire for a baby leads to attachment to father as someone who potentially can give her one. Called the ‘Electra complex’ Latency phase 6yrs until puberty Period of relative quiescence of sexual thoughts The anxieties from the previous phase are repressed. The sexual drive remains latent through this period Genital phase Adult sexuality, beginning at puberty The sexual drive returns with greater strength than before Improper resolution of previous phases may be manifest in symbolic ways

Psychosexual development Box 19.1 The Oedipus story (Sophocles 7430 BC) The oracle at Delphi tells King Laius of Thebes that his son will kill him and marry his wife. When his wife Jocasta gives birth to a boy—Oedipus, he orders a slave to abandon the child on a mountain. The slave takes pity on the child and, instead of leaving him to die, gives him to a shepherd, who brings him to the King of Corinth who is childless. Oedipus grows up, thinking that Polibus, King of Corinth, is his father. As a youth, Oedipus visits the oracle at Delphi and is told that he will grow up to kill his father and marry his mother. At this, Oedipus vows never to return to Corinth and sets out for Thebes instead. On a narrow part of the road, he meets an old man in a chariot who angrily orders him aside and strikes him with a spear. Oedipus seizes the spear to defend himself and strikes the old man on the head, killing him. The man is Laius, King of Thebes, his real father. Approaching Thebes, Oedipus meets the Sphinx, which is terrorizing the city. The monster is stopping passers-by and challenging them with its riddle; all who fail to answer the riddle are devoured. Oedipus solves the riddle of the Sphinx, and the monster jumps to its death. He enters the city as a hero. He is told that the king has been murdered and is offered the throne, along with the hand of Jocasta in marriage. Oedipus is a wise and successful king, and Jocasta bears him two sons and two daughters. Many years later, Thebes is afflicted by a terrible plague. The people appeal to Oedipus to save them, and he sends his brother-in-law to the oracle at Delphi for advice. The oracle states that the plague will abate when the murderer of Laius is banished. Oedipus promises to bring the murderer to justice and forbids the people of Thebes from offering him any shelter. Oedipus asks the prophet Teiresias to help him discover the killer’s identity. Teiresias tries to dissuade him from pursuing the matter, but he persists, eventually accusing the prophet of being a fraud. Teiresias angrily tells him that before nightfall, he will find himself ‘both a brother and a father to his children’. The king is bewildered, and Jocasta tries to com fort him by telling him about the prophecy given to Laius—that he would be killed by his son, when, in fact, his son had died as an infant and he had been killed by bandits—hence, prophecies could not be trusted. The story only increases Oedipus’s worry, as he suspects that he murdered Laius but does not yet realize that Laius was his father. When a messenger arrives to inform him of the death of the King of Corinth, Oedipus also discovers that he

was adopted and begins to sus pect that he is Laius’s son. He ignores the pleas of Jocasta, who has al ready realized the whole truth, and when he eventually finds the shepherd who took him to the household of the King of Corinth, the full truth is revealed. At this point, he hears anguished cries coming from the palace and rushes to his apartments. Breaking down the door of the royal bed chamber, he finds the queen, his wife and mother, has hanged herself. He seizes her dress pin and gouges out his eyes, so as not to have to look at the atrocity he has unwittingly committed. He enters into exile, having failed to avoid the fate laid out for him.

896 Chapter 19 Psychotherapy Object relations theory In the mid-twentieth century, Winnicott, Klein, Fairbairn, and others de veloped the object relations theory, which emphasized the importance of relationships, rather than drives such as sexuality and aggression, in affecting the mind. This theory describes a model of infant psychological develop ment, links abnormal early experiences to symptoms in later life, and uses this as a basis for interpretation in therapy. Object relations theory remains significant in modern psychoanalytical practice. Essence Our ‘sense of self’ and our adult personality are developed as a result of the relationships we form in our lives. The earliest, and hence the most important, relationship is that between mother and child. Our early relationships form a template for future relationships, with abnormal early experiences being associated with psychological symptoms and abnormal relationships later in life. Theory The mind is viewed as blank at birth, with the newborn unable to distinguish between ‘myself’ and ‘everything else’. Then the infant begins to view the external world as a series of (initially unconnected) ‘objects’. These objects may be things (e.g. a toy, a blanket), people (e.g. mother, father), or parts of people or things (e.g. the mother’s breast, the mother’s face). The infant creates an internal representation of each object and has relationships with, and feelings towards, the internal, as well as the external, objects. There are three primitive emotions (or ‘affects’) which an infant can display towards each object: attachment, frustration, and rejection. There is a tendency for a single affect to become associated with one object. Inevitably, even a caring mother will create some feelings of frustration and rejection—mothers comfort their children and provide food and love, but also scold, punish and are sometimes simply unable to meet their child’s needs. Consequently, the child will view the mother as comprising a number of objects, some of which he views positively and some with hostility. The child will initially deal with this by keeping the ‘good objects’ (as sociated with attachment) separate from the ‘bad objects’ (those causing frustration and rejection)—a phenomenon known as ‘splitting’. This is the initial primitive defence mechanism—the ‘paranoid–schizoid position’. As the child develops, this defence becomes increasingly untenable, and in normal development, the child will unify the good and bad maternal objects to a single ‘mother object’ containing both good and bad—the so-called ‘depressive position’. The relationships we form later in life have a strong tendency to echo relationships from earlier in our development. Interestingly, we can take on either role in these recapitulated relationships. Hence, a child, one of whose parental relationships was with an aggressive/abusive father, can take on a ‘victim’ posture in some later relationships but may instead take on the role of the aggressor in others.

Object relations theory In therapy The therapist’s neutral stance provides an ideal environment for the recapitulation of previous relationships. Most relationships are moulded by both parties, but in therapy, the therapist aims to allow the re lationship model to be developed by the patient. Subsequent examination of the role and relationship forced onto the therapist (the transference) is a key part of therapy. Most therapies incorporating the object relations theory help the patient

resolve the pathological qualities of the transference through the experience of the real relationship between the therapist and the patient. Once these relationships are identified, they can begin to ex plore with the patient how the relationship in the consulting room reflects the patient’s experience growing up, as well as their current life situations.

898 Chapter 19 Psychotherapy Psychoanalysis 1 Dynamic therapies, including psychoanalysis or psychodynamic psycho therapy and group analysis, are derived from the psychoanalytic principles and practice of Sigmund Freud and those who have subsequently devel oped his ideas. Most therapies which conceptualize an unconscious mind affecting our perceptions and actions can be considered part of the school of dynamic psychotherapies. Rationale Traumatic experiences, particularly those in early life, give rise to psycho logical conflict. The greater part of mental activity is unconscious, and the conscious mind is protected from the experience of this conflict by in built defences, designed to decrease ‘unpleasure’ and to diminish anxiety. These defences are developmentally appropriate, but their continuation into adult life results either in psychological symptoms or in a diminished ability for personal growth and fulfilment. Conflict can be examined with regard to the anxiety itself, the defence, or the underlying wish or memory. The individual’s previous family and personal relationships will have sym bolic meaning and be charged with powerful emotions. Representations of these relationships will emerge during therapy and provide a route towards understanding and change. How illness is viewed Both mental illness and normal psychological development can be under stood using psychoanalytic theories. In psychoanalysis, overt symptoms are viewed as merely the external expression of an underlying psychic abnor mality. Symptoms continue, despite the suffering they cause to the indi vidual, because of what Freud called primary gain. This is the benefit to the individual of not having unacceptable ideas in the conscious mind. While a typical descriptive assessment of a patient by a psychiatrist may categorize patients into groups using diagnostic criteria, a dynamic assessment of a patient uses the psychoanalytic theory to explore the unique layout of the individual patient’s conscious and unconscious mind. Techniques Psychoanalysis is an intense therapy that usually involves 1–5 50-min sessions per week, possibly for a number of years. Psychoanalysis typically features traditional techniques to attempt to interpret the unconscious content, including the ‘fundamental rule’ of free association, analysis of the transfer ence/countertransference, the interpretation of dreams and ‘parapraxes’, and the symbolism of neurotic symptoms. Therapists of different schools will utilize these techniques in slightly different ways, e.g. by choosing what to interpret and why. The three mainstays of analyst–analysand interaction are enquiry, clarification, and interpretation. Free association—the patient agrees to reveal everything which comes to mind, no matter how embarrassing or socially unacceptable (i.e. ‘speaking without selfcensorship’). Traditionally, the patient is speaking in a reclining position, with minimal eye contact with the therapist, i.e. ‘on the couch’. The therapist assumes a position of neutrality, in which reassurance and

Psychoanalysis 1 directive advice are withheld. Areas where free association ‘breaks down’ and areas of resistance to pursue associative thought may represent difficul ties which are important to explore. Exploration of transference/countertransference (E Basic psychoanalytical theory, p. 890) The intense and frequent nature of psychoanalysis often results in a pa tient forming powerful feelings towards a therapist, who adopts a stance of neutrality—a blank screen on which the patient can project their in ternal world. Important repressed aspects of past relationships and defence mechanisms used by the patient in current relationships find expression in the transference relationship. Through adopting a mindset called ‘rêverie’ (similar to evenly suspended

attention), psychoanalysts, through monitoring their own countertransference, attempt to avoid fulfilling the patient's un conscious expectations that they will act like the people from their past, as well as using thoughts that enter consciousness as information about the patient's inner world. Examination of dreams Dreams are traditionally viewed as being formed by a mix of daytime mem ories, nocturnal stimuli, and representations of unconscious desires, which are then distorted by the ego to protect us from conscious knowledge of the content. The actual or 'latent' dream is eventually reconstructed from the 'manifest' dream, the portions of the dream that patients remember in therapy, by a process of symbolization and elaboration which can poten tially expose the hidden unconscious meanings. Examination of parapraxes A parapraxis is a slip of the tongue, which today is often referred to as a 'Freudian slip'. They may reveal unconscious desires, thoughts, and feelings. Examination of symbolism In individual patients, neurotic symptoms may have symbolic meaning which can be usefully explored. Symbolism may also be analysed in child psycho therapy when observing play and drawings. Interpretation Expression of the therapist's understanding of the meaning of what is occurring in therapy. Interpretations commonly include descriptions of defence mechanisms, explanations for current anxiety in the context of underlying desires, and making links between what is happening in the here- and-now of the transference relationship between patient and therapist and how that connects to their earlier experiences.

900 Chapter 19 Psychotherapy Psychoanalysis 2 Phases of treatment Assessment and early sessions The analyst will typically explain the methods of therapy, establish bound aries (e.g. about times of sessions), and begin to produce a psychodynamic formulation of the case. The therapist will assess patient suitability and mo tivation, while exploring potential risk factors. Middle sessions As the patient progresses in psychoanalysis, the therapist, who will typically work with a supervisor (providing a valuable third-position view of the case outwith the close relationship between analyst and analysand), identifies unconscious defence mechanisms, key conflicts, personality structure, pat terns of object relations, and transference/countertransference. Later sessions The therapist may use more interpretive techniques, which may increase anxiety. Towards the end of therapy, which is in the main mutually negoti ated, increasing focus will be placed on the patient's thoughts, feelings, and attitudes to termination of therapy, as loss and abandonment are often key areas in patients' pathology. Indications and contraindications (See also E Assessment for psychotherapy, p. 884.) • Commonly chosen by the patient, rather than prescribed, although this may be due to its lack of availability through the public sector. • Not reserved only for specific mental illnesses—those with relatively sound mental health may find it improves the quality of their lives. • Commonly sought by patients where there are anxious or emotional symptoms such as mild to moderate depressive symptoms, somatic symptoms, and dissociative or other neurotic symptoms. • Patients with substantial personality difficulties are increasingly seen. • May be a good choice for patients who are looking for change, motivated to explore past experiences, and are emotionally stable and willing to re-experience some emotional challenges in doing so. • Psychoanalysis is not absolutely contraindicated for drug or alcohol dependence, suicidal thoughts or harmful/violent behaviours, psychotic illness, severe depressive features, and limited cognitive ability, but most practitioners would be aware of the potential pitfalls present in each of these classes of patient. Efficacy and limitations of dynamic therapies Evidence base? Studies have demonstrated benefits in d symptoms, d need for medication, as well as long-term and enduring improvements in personality-disordered individuals. The volume, validity, and reliability of the evidence, however, is limited. Some clinicians criticize all dynamic therapies because they have arisen primarily from theory and clinical observations, instead of

evidence- based medicine. This may not reflect on the inefficacy of psychodynamic

Psychoanalysis 2 therapies as much as it reflects the inherent difficulties in designing research studies. There are a lack of standardization in diagnosis and the method of therapy delivery (as by its very nature, it is delivered by individuals to other individuals, both of whom are bewilderingly complex), and problems with gaining sufficient numbers of patients and controls for statistical ana lyses to be viable and determining how improvement is measured, as even Freud regarded the task as converting ‘neurotic misery into ordinary un happiness’. Psychodynamic researchers also stress the point that much of psychoanalysis is process-, and not outcome-, orientated. Nonetheless, the future may bring more of an evidence base to support dynamic therapies, both alone and in combination with psychotropic medications. Studies may also show more support for the theories behind psychodynamic therapies. There is already experimental psychological research to support that mental activity can be unconscious such as studies that show initiation of action by the prefrontal cortex begins before ‘consciousness’ in the frontal areas is involved. Possible harm? While dynamic therapies do not have the biological side effects of psychi atric medications, they are not free of risk. These therapies aid in increasing the insight of the patient, which may involve the removal of defence mech anisms that play a protective role, and therefore must be done with cau tion, especially with patients whose ‘psychic scaffolding’ is integral to their managing day-to-day life. The risks and benefits of such phenomena are a subject of study and controversy, although most dynamic therapists would agree that patient readiness determines when to explore painful experi ences in therapy. Training Involves education in psychoanalytic history, theory, and practice, exten sive supervised case work, and personal psychoanalysis for the therapists themselves. Many major British and Irish cities have a local psychoanalytic institute that may offer formal psychoanalytic training to those with doc toral or master’s degrees in mental health and 2yrs of clinical experience. Training usually consists of a 5-yr postgraduate curriculum specifically in psychoanalysis. For doctors, this training would typically be completed after completion of a basic specialist psychiatric training. Most institutes also offer supervision and classes for therapists who are interested in dynamic psy chotherapy but have not chosen the 5-yr psychoanalytic programme.

902 Chapter 19 Psychotherapy Psychodynamic psychotherapy Psychodynamic psychotherapy is an intervention where the concepts of symptom development are based on those of psychoanalysis, but the methods of therapy are adjusted for a reduced frequency of sessions and d number of total sessions. Supporters of this type of therapy state that some of the insights and opportunity for change and growth available from long- term psychoanalysis can be achieved in a shorter time and that introducing directive elements and focus on particular topics does not reduce overall effectiveness. Rationale and how illness is viewed As for psychoanalysis (E Psychoanalysis 1, p. 898). Techniques • Psychodynamic psychotherapy is modified from psychoanalysis in that it often involves active therapy where the therapist may say more, in an attempt to allow therapy to be more structured. It can vary in length, depending on both the therapist and the needs of the patient. It may be significantly more brief than psychoanalysis, often lasting 6mths or 1yr, with the termination date decided at the outset. Shorter treatments (of around 16 sessions) may be placed under the heading of ‘brief psychodynamic psychotherapy’. The frequency may be 1–2 sessions a week. • The therapist usually develops a working psychodynamic formulation early on, which is then referred to throughout the therapy. • Methods employed are similar to those of psychoanalysis (E Psychoanalysis 1, p. 898), but with therapist–patient eye contact (i.e. both sitting

on chairs, rather than the patient lying on a couch) and more verbal interaction from the therapist. • Both transference and countertransference give the therapist valuable information about the nature of past relationships (E Exploration of transference/countertransference, p. 899). • The therapist will help the patient to explore symptom precipitants and associated early trauma and avoidance. • The therapist may guide therapy by use of interpretation at an earlier point than in psychoanalysis. • In the case of patients with more severe mental illness, such as psychosis, or in acute crisis or decompensation, these techniques are sometimes further modified to be less focused on improving insight, and instead the emphasis is more supportive, particularly focusing on encouraging the expression of emotions. This can be combined with drug treatment. Phases of treatment Initial assessment Diagnosis, including consideration of appropriateness of this method of therapy in this patient. Consideration of appropriate use of medication.

Psychodynamic psychotherapy Early sessions Identification of main problems, goals, and issues. Limited comments from the therapist. Usually there is positive transference due to expectation of ‘magical’ change. Identification of main defences, coping styles, and ability to accept and work with interpretations. Middle sessions Exploring present emotions and emotions evoked by past experiences. Exploration of transference, countertransference, and resistance in discus sion with the supervisor. Closing sessions Exploring anticipation of termination. Arrangements for aftercare. Indications and contraindications (See E Assessment for psychotherapy, p. 884 and E Efficacy and limita tions of dynamic therapies, p. 900.) • Indications and contraindications are similar to those of psychoanalysis (E Psychoanalysis 2, p. 900). • Particular emphasis on the ability and motivation to form a collaborative relationship with the therapist. Training Similar to training for psychoanalysis, including education in psychoanalytic history, theory, and practice, supervised case work, and personal psycho analysis. Local psychoanalytic institutes may offer courses varying in length and required time commitment.

 Group psychotherapy Group psychotherapy is a form of treatment in which selected individuals are brought together under the guidance of a therapist, with the goals of re ducing distress and symptoms, increasing coping, or improving relationships. Group methods were first developed in the early twentieth century, fol lowing observations of beneficial group effects with TB patients. Like indi vidual psychotherapy, the term group psychotherapy encompasses a range of modalities, settings, and techniques. Groups may be homogenous or heterogenous (e.g. in terms of diagnosis, age, gender) and may vary as to the frequency and duration of meetings, the degree of therapist involvement, and whether they are time-limited or ongoing. The basic tasks of the therapist include making decisions about these factors, preparing and assessing patients for the therapy, formulating goals for therapy, and building and maintaining a therapeutic environment that promotes group interaction. Yalom1 described a set of therapeutic factors common to many types of group: instillation of hope, universality, imparting information, altruism, corrective recapitulation of the primary family group, development of so cializing techniques, imitation of adaptive behaviour, interpersonal learning, group cohesion, catharsis, and existential factors. Indications and contraindications Group therapy generally requires that members: • Are able to tolerate the task of interacting in a group. • Have problem areas that are compatible with the goals of the group. • Are consciously motivated for change. While most patients may benefit from some form of group therapy, exclu sion criteria include: • Inability to comply with the group norms for acceptable behaviour (e.g. assaults on other patients or the therapist). • Inability to tolerate a group setting (e.g. paranoid ideas). • Severe incompatibility with

one or more group members (which may only be discernible after members have joined the group). Types of group therapy Supportive groups Features • Focus on promoting and strengthening adaptive defences, giving advice, and providing encouragement. • Goals include re-establishing and/or maintaining function, and improving coping. Indications May be useful in psychotic disorders and anxiety disorders, and in a self-help context. 1 Yalom ID (1995) The Theory and Practice of Group Psychotherapy, 4th edn. New York, NY: Basic Books.

Group psychotherapy Problem-focused cognitive–behavioural groups Features • Useful where the goal is modification of dysfunctional thoughts, feelings, and behaviours such as in anxiety and depressive, and eating disorders. • Focus is on psychoeducation, mutual support, and group examination of strategies for change within a CBT framework, rather than on the nature of interpersonal interactions between members. • The therapist takes on an active and central role. • Peers may be experts at identifying resistance and rationalization for avoiding change in other group members. Indications Can include anxiety or anger management, assertiveness training, acute or chronic depression, alcohol or drug dependence. Psychodynamic groups, including group analysis Features • The individual is viewed as embedded in a social network or 'matrix'. • Members' interactions with each other and the therapist reflect their interactions with others outside the group (i.e. the interpersonal difficulties which have brought them to therapy). An individual's range of relationship styles derives from early experience (e.g. the position they tended to take up within the family, at school, etc.). Examination of interactions between group members and with the therapist aims to increase patients' understanding of this repeating repertoire of contact with people and to change dysfunctional patterns. • Techniques include close examination of transference, countertransference, resistance, and unconscious conflict. • Goal is lasting change through modification of personality factors. Indications (See E Psychoanalysis 2, p. 900.) Activity groups Generally helpful for patients with intellectual impairment, or severe and persistent mental illness. Examples include art, music, computing, exercise, and social activity groups. Can foster social skills and adaptive behaviours. Helpful for psychosocial and vocational rehabilitation. Self-help groups Strictly speaking, not a form of group therapy, although may have bene ficial therapeutic effects. Groups tend to be organized around a specific problem, have strong peer support and group cohesion, and be led from within the group. Examples include AA, Narcotics Anonymous, Gamblers Anonymous, Overeaters Anonymous, and Sex Addicts Anonymous.

906 Chapter 19 Psychotherapy Basic learning theory Behavioural psychology is a method for understanding the development of knowledge and behaviours in organisms. In an individual organism, these are shaped by environmental influences and can change as a result of ex perience. Learning theory concerns the testing of methods to produce be havioural adaptation through changing environmental influences. The two basic learning processes are classical (Pavlovian) conditioning—involuntary behaviours, which become associated with stimuli, and operant (Skinnerian) conditioning—learning to obtain reward and avoid punishment related to vol untary behaviours. Although most abnormal mental processes and mental illnesses are not amenable to understanding purely in terms of conditioning, understanding of learning theory is helpful in conceptualizing the develop ment and maintenance of abnormal mental processes and provides a ra tionale for behavioural and cognitive–behavioural treatment approaches.
Classical conditioning In his initial experiment, Pavlov presented a dog with food, which produced the response of salivation. The food is the unconditioned stimulus (US), and salivation is the unconditioned response (UR). A neutral stimulus, such as a bell ringing, is not associated with any

UR. However, if a bell is rung im mediately before the food is presented, after a number of repetitions, the dog will salivate in response to the bell alone. Now the bell is a conditioned stimulus (CS), producing a conditioned response (CR)—salivation. Acquisition The development of the association between the UR and the US producing a CR. In animal experiments, this can take between three and 15 pairings. Where there is sufficient emotional involvement, acquisition can occur with as few as one pairing. • Extinction—loss of the association between the CR and the CS. Occurs when the CS is repeatedly not followed by the US. • Generalization—when stimuli similar to the initial CS produce the same response. The subject demonstrates the CR to these similar stimuli (e.g. to a buzzer, as well as a bell). Higher-order conditioning Process in which conditioned trials cause the subject to demonstrate the CR to new stimuli by pairing them with the CS (e.g. where the dog has been conditioned to salivate to a bell, pairing the bell with a light stimulus so the dog becomes conditioned to salivate to the light). • Spontaneous recovery—during extinction trials, following a rest period, the CR often briefly reappears. • Habituation—the subject becomes accustomed and less responsive to a stimulus after repeated exposure. Note: for emotional disorders, the response is usually an emotion, rather than a behaviour. For example, an initial encounter with a large, barking dog which bites the individual can produce the CR of fear to the generalized CS of seeing a dog. The affected individual may then avoid all contact with dogs and so avoid the unpleasant CR. However, because there is no occasion when the CS of seeing a dog is not paired with the CR of fear, there is no opportunity for extinction to take place.

Basic learning theory Techniques based on classical conditioning concepts • Systematic desensitization (E Behaviour therapy, p. 908)—presentation of situations more similar to the CS is paired with relaxation techniques, in order to eventually break the association between the CS and the CR. Frequently used in the treatment of phobic anxiety disorders. • Flooding (E Behaviour therapy, p. 908)—presentation of full CS without the possibility of withdrawal from the situation. The initial unpleasant experience of the CR gradually diminishes, and the patient learns that they can survive exposure to the feared situation without coming to harm. Operant conditioning The experimental techniques and rules of operant conditioning were de veloped by Thorndike and Skinner. The basic principles of operant condi tioning are that if a response to a stimulus produces positive consequences for the individual, it will tend to be repeated, while if it is followed by nega tive consequences, it will not. In the original experiments, rats were placed in a box containing a lever which, when pressed, delivered a pellet of food. Eventually, the rat would press the lever and be rewarded. The rat would then press the lever with increasing frequency. (Note: operant conditioning does not rely on the rat having insight.) Acquisition The linkage of the response (pressing the lever) with the reinforcer (re ceiving the food). • Reinforcement—can be positive (behaviour is followed by a desirable outcome) or negative (behaviour is followed by removal of an aversive stimulus). Can occur after every response (continuous reinforcement) or only after some responses (partial reinforcement). Behaviours conditioned by partial reinforcement extinguish at a much slower rate than those conditioned by continuous reinforcement. • Punishment—in positive punishment, an operant response is followed by the presentation of an aversive stimulus to decrease the likelihood of a behaviour occurring in the future. In negative punishment, an operant response is followed by the removal of an aversive stimulus. • Shaping Used to produce a complex behaviour, which is not in the organism’s initial repertoire. Initially, component parts of the desired behaviour are rewarded, then reward is limited to behaviour which approximates the desired result. As appropriate behaviour appears, it is only rewarded if it is ‘in the right direction’, and further reward is contingent upon continued advancement until the organism is only rewarded

once the entire behaviour is performed. • Extinction—occurs over time when the response is no longer followed by the reinforcer. Techniques based on operant conditioning concepts (E Behaviour therapy, p. 908.) • Behaviour modification. • Aversion therapy.

908 Chapter 19 Psychotherapy Behaviour therapy Techniques based on learning theory are used in order to extinguish mal adaptive behaviours and substitute more adaptive ones.
Systematic desensitization Holds as a central tenet the principle of reciprocal inhibition (i.e. anxiety and relaxation cannot coexist). Systematic graded exposure to the source of anxiety is coupled with the use of relaxation techniques (the 'desensi tization' component). Effective for simple phobias, but less so for other phobic/anxiety disorders (e.g. agoraphobia). The process in a typical case is as follows: • Patient identifies the specific fear (e.g. cats). • Patient and therapist develop a hierarchy of situations, listing the most anxiety-provoking situation at the top (e.g. stroking a cat on one's knee

> touching a cat > having a cat in the room > looking at pictures of cats thinking about cats). • Patient is instructed in the relaxation technique. • Patient experiences the lowest item on the hierarchy, while practising the relaxation technique, and remains exposed to the item until the anxiety has diminished. • The process is repeated until the item no longer produces anxiety. • The next item in the hierarchy is tackled in a similar fashion. Flooding/implosive therapy High levels of anxiety cannot be maintained for long periods, and a process of 'exhaustion' occurs. By exposing the patient to the phobic object and preventing the usual escape or avoidance, there is extinction of the usual (maladaptive) anxiety response. This may be done in vivo (flooding) or in imagination (implosion). Behaviour modification Based on operant conditioning. Behaviour may be shaped towards the de sired final modification through the rewarding of small, achievable inter mediate steps. This can be utilized in behavioural disturbance in children and patients with learning disability. Other forms of behavioural modification include the more explicit use of secondary reinforcement, such as 'token economy', in which socially desirable/acceptable behaviours are rewarded with tokens that can be exchanged for other material items or privileges, or 'star charts' where children's good behaviour is rewarded when a certain level is achieved. May also be used for less voluntary actions such as child hood nocturnal enuresis. Aversion therapy and covert sensitization Use of negative reinforcement (the unpleasant consequence of a particular behaviour) to inhibit the usual maladaptive behavioural response (extinc tion). True 'aversion' therapy (e.g. previously used to treat sexual deviancy) is not used today; however, covert techniques (e.g. use of Antabuse® in alcohol dependency) can be (at least partially) effective.

Behaviour therapy 909

910 Chapter 19 Psychotherapy Cognitive behavioural therapy 1 The theory and method of CBT were developed by Aaron Beck and out lined in a series of papers published in the 1960s.2 CBT

development was prompted by the observation that patients referred for psychotherapy often held ingrained, negatively skewed assumptions of themselves, their future, and their environment. Treatment is based on the idea that disorder is caused not by life events, but by the view the patient takes of events. It is a short-term, collaborative therapy, focused on current problems, the goals of which are symptom relief and the development of new skills to sustain recovery. Rationale A person's emotions, thoughts, behaviours, physiological sensations, and their external environment all exist together in equilibrium. Altering any component of this system will bring about change in the others. While pathological emotions may not be directly amenable to change, the un helpful cognitions and behaviours associated with these emotions may be examined and modified, leading to a change in the underlying emotion. CBT aims to 'change how you feel by changing the way you think'.3 The cognitive model is a guide for therapy, not a comprehensive model of illness caus ation, and precludes neither neurochemical or other factors as important in symptom development nor the use of pharmacological treatments. How illness is viewed In some personality types and in mental illness, there are errors in the evalu ation and processing of information (i.e. cognitive distortions). These dis tortions relate to the self, the world, and the future (Beck's cognitive triad) and originate from the child's early learning and experience of the world around him. Cognitive errors are associated with unpleasant emotions and maladaptive behaviour. An example of this vicious circle is: an event (friend does not call when she said she would) l negative automatic thought ('friend doesn't like me because she thinks I'm a loser') l emotional response (sadness) l mal adaptive behaviour l (avoiding friend l self-isolation l worsening of low mood) = pathology (depression). In CBT with this patient, the therapist would facilitate their recognition of the faulty cognitive appraisal (cognitive error) and then teach skills to address it (see Boxes 19.2 and 19.3). Modes of delivery CBT can be delivered on an individual basis, in groups, or as self-help via books or computer programs (including online). As such, it is a cost- effective treatment, with evidence of good efficacy. It is worth stressing that CBT is at its most effective when delivered 'by the book', following estab lished protocols. Sessions by trainees are therefore often taped to ensure adherence to a standard regimen. 2 Wright JH (2006) Cognitive behaviour therapy: basic principles and recent advances. Focus 4:173–8. 3 Padesky CA, Greenberger D (1995) Mind Over Mood. New York, NY: Guilford.

Cognitive behavioural therapy 1 Box 19.2 Cognitions Cognitions are appraisals of events. They may be elicited by asking the pa tient about thoughts, ideas, or images in their head. CBT describes three types of thoughts or beliefs: • Automatic thoughts—are the most superficial and accessible. They are involuntary and appear plausible, but may be distorted, e.g. 'My friend phoned to cancel meeting me tomorrow—she must not like me any more.' • Underlying assumptions—are a person's 'rules' for behaving, based on fundamental beliefs and shaped by experience, e.g. 'I can't enjoy myself unless I'm with other people.' • Schemas or core beliefs—are a person's most fundamental beliefs about themselves and the world around them, e.g. a neglected child believing 'I am unlovable.' Box 19.3 Common types of cognitive error • Selective abstraction—drawing a conclusion based only on part of the information, e.g. 'My whole dinner party was a failure because my dessert didn't turn out as I'd hoped.' • Arbitrary inference—drawing an unjustified conclusion, e.g. 'My partner appears stressed, s/he must be about to leave me.' • All-or-nothing thinking—seeing things only as extremes of black or white, with no shades of grey, e.g. 'I must win, or else I'm a failure.' • Magnification/minimization—emphasizing negatives and playing down positives, e.g. 'My career hasn't been successful, even my few achievements weren't all that impressive.' • Disqualifying the positive—e.g. 'I only came first by chance.' •

Personalization—assuming responsibility for all negative events, e.g. ‘My sister is in a bad mood, she must be angry with me.’ • Catastrophic thinking—e.g. ‘I embarrassed myself in front of my colleagues—I’ll never be able to face them again.’ • Over-generalization—viewing a single negative event as the norm, e.g. ‘I made a mistake, therefore I’m incompetent to do my job.’ • Emotional reasoning—using emotions as evidence, e.g. ‘I feel very anxious, therefore that spider must be really dangerous.’ • Jumping to conclusions—mindreading or fortune-telling, e.g. ‘I know the exam will ask about topics I haven’t had time to study.’

912 Chapter 19 Psychotherapy Cognitive behavioural therapy 2 Techniques The CBT therapist works together with the patient in a spirit of scientific inquiry to explore the problem and possible solutions. Through a process of psychoeducation and guided discovery, the therapist assists the patient in monitoring cognitions and their associated emotions and behaviours; identifying and challenging cognitive distortions; and exploring alternative strategies for approaching distressing situations. Progress is measured against objective rating scales (e.g. the BDI),4 as well as the patient’s own goals for therapy. Phases of treatment Initial assessment is usually followed by 6- to 20-hr-long sessions. There may be a review after six sessions to share a formulation, take stock of progress so far, and refocus goals if therapy is to continue. Attention is primarily focused on events in the ‘here and now’. Each session generally proceeds as follows: deal with emergencies; jointly set an agenda; review the home work task; focus on specific items guided by current problems; suggestion of cognitive or behavioural techniques (see Box 19.4); and jointly agree on the homework task. Indications and contraindications CBT is an active treatment requiring patient understanding and collabor ation (see Box 19.4). Patients should be motivated and be able to recog nize, articulate, and link their thoughts and emotions (i.e. be psychologically minded). The general contraindications to psychotherapy (E Assessment for psychotherapy, p. 884) apply. It is indicated for: • Mild to moderate depressive illness. • Eating disorders. • Anxiety disorders. • Bipolar disorder (reduce the risk of relapse). • Substance abuse disorders. • Schizophrenia and other chronic psychotic disorders as an adjunct to pharmacotherapy, for both positive and negative symptoms. • Chronic medical conditions, such as fibromyalgia, chronic fatigue, or chronic pain, where there may be a psychological component and misinterpretation of physiological phenomena. Efficacy There is good evidence for effectiveness in depressive illness, eating dis orders, and anxiety disorders. CBT is at least as effective as pharmaco therapy in mild to moderate depression and may be more effective in long-term follow-up (e.g. in preventing relapse). 4 Beck AT, Ward C, Mendelson M (1961). The Beck Depression Inventory (BDI). Arch Gen Psychiatry 4:561–71.

Cognitive behavioural therapy 2 Box 19.4 CBT techniques for depression and anxiety Depression • Psychoeducation, including reading material about depression and introducing the cognitive model—a useful first homework. • Activity diary: over a week, ask the patient to record what they did in the morning, afternoon, and evening of each day. The patient may rate the sense of pleasure associated on a scale of 0–10, and assign a score of 0–10 for their mood each day. • Activity and pleasant event scheduling: make plans for the week in advance to increase general physical activity and enjoyable events, both of which are often reduced and contribute to the vicious cycle of depression. Goals should be small and achievable. • Thoughts diary: ask the patient to make a record at the times when they feel particularly distressed, noting the trigger situation, their mood rating, and the thoughts which they experience. • Teach the patient to identify cognitive errors in automatic thoughts. • Socratic questioning to elicit further thoughts (‘If that were true, what would it mean? . . . and what would that mean? . . . etc.’). • Examine the evidence for and against the

patient’s faulty beliefs, and generate rational alternatives. • Behavioural experiments: designed collaboratively to test the hypothesis that the patient’s beliefs are true, e.g. inviting a friend for coffee to test the thought ‘My friends don’t want to know me’. Anxiety • Psychoeducation, introducing the cognitive model of anxiety. • Diary keeping: to record and monitor episodes of anxiety, their triggers, the intensity of anxiety on a scale of 0–10, and the associated thoughts and physical symptoms. • Relaxation techniques, e.g. through breathing or progressive muscular relaxation. • Distraction to divert the cognitive focus elsewhere. • Challenge negative thoughts by examining the evidence for and against them, generating rational alternatives, and identifying cognitive errors. • Construct a hierarchy of the patient’s most anxiety-provoking situations, consisting of many small steps. • Graded exposure: starting with the least threatening step of the hierarchy, coupled with relaxation techniques. Role play/rehearsal or attempting an activity together with the therapist (e.g. going into a shop) may be helpful. • Behavioural experiments, e.g. recording anxiety repeatedly during exposure to a stressful situation, to challenge the patient’s assumption that, unless they escape, their anxiety will continue to rise.

914 Chapter 19 Psychotherapy Interpersonal psychotherapy IPT was developed in the 1970s by Klerman and Weissman as a treatment for depressive illness and later developed for use in other disorders. Its development followed the observation that depression is frequently as sociated with impaired interpersonal functioning. IPT aims, by improving interpersonal functioning, to improve emotional symptoms. It is a practical, short-term psychotherapy, which may be offered in conjunction with medi cation and is suitable for delivery by a variety of healthcare professionals. It is described in a manual for practitioners5 and a guide for patients.6 Rationale Emotional disturbance (e.g. depression) tends to be associated with ‘here and now’ deficits in interpersonal functioning. Emotional problems are best understood by studying the interpersonal context in which they arise. Life events related to illness development include: grief, interpersonal disputes, change of role, and interpersonal deficits. These events are not viewed as directly causing the episode of illness, but helping the patient to understand their role in the evolution of illness, and resolving the interpersonal problem is seen as a route to recovery. How illness is viewed Illnesses are viewed as medical disorders, diagnosed according to standard criteria (e.g. ICD-10) and rated in severity by rating scales (e.g. BDI). Depressive symptoms, regardless of aetiology (biological or psychosocial), are viewed as modifiable through the application of IPT techniques. In fact, psychoeducation about both is key, and the use of antidepressant medica tion is encouraged when indicated. Techniques After a thorough assessment, patient and therapist contract to meet weekly for 12- to 16-hr-long individual sessions. A key feature of IPT involves ‘giving the sick role’ to the patient—this entails educating them about the depres sive illness, ascribing their symptoms to the current episode of depression, offering appropriate treatment, and giving the patient responsibility for change. Depending on the focus, specific techniques are applied, as out lined in the IPT manual. The relationship between symptoms, interpersonal functioning, and personality factors is common to all four foci. Depressive symptom reduction is reviewed weekly and linked to changes in attitude or behaviour in the interpersonal arena. A focus in one of the following four areas is mutually agreed upon: • Role transitions (difficulty with life changes, e.g. graduating from school, marriage, job change, childbearing, or retirement). • Interpersonal disputes (differing opinions and expectations about relationship roles between the patient and another person, e.g. a partner, a family member, or in the workplace). 5 Klerman GL, Weissman MM, Rounsaville BJ, et al. (1984) Interpersonal Psychotherapy of Depression. New York, NY: Basic Books Inc. 6 Weissman MM (1995) Mastering Depression: A Patient Guide to Interpersonal Psychotherapy. Albany, NY: Graywind

Publications.

Interpersonal psychotherapy • Grief (abnormal reactions to bereavement). • Interpersonal deficits (long-standing difficulties with impoverished social environment and unfulfilling relationships). The IPT therapist is an active advocate and facilitator to encourage the pa tient to see their problems from different perspectives, to make attempts at change, and to return to discuss their successes or failures at subsequent weekly sessions. Transference interpretations are avoided in order to keep the patient focused on how to negotiate better with people in their current life outside of therapy. Phases of treatment • Phase I (sessions 1–2): standard psychiatric history; risk assessment; communication of diagnosis to the patient; assessment of need for psychotropic medication; establishment of the 'sick role'; completion of interpersonal inventory (description of current relationships); setting of the patient's depression within their interpersonal context; identification of focus for therapy; explanation of rationale for treatment and its aims and processes; agreement of therapeutic contract. • Phase II (sessions 3–12): commence work on the focus, utilizing specific techniques outlined in the IPT manual. These include: facilitation of the grieving process; mourning the loss of the old role and learning to embrace the challenges of the new role in the role transition focus; teaching of specific communication, problem-solving, or conflict resolution skills; and role play. Review progress in depressive symptom reduction weekly. Review overall progress at the 'halfway point', which encourages sustained effort before 'time runs out'. • Phase III (final 3–4 sessions): anticipate termination as scheduled from the outset in the contract, with encouragement to continue to apply what the patient has learnt from therapy in their real-life interpersonal sphere. The IPT therapist points out that progress towards better coping (leading to reduced depressive symptoms) has been 'earned' by the patient who did the work of changing. The therapist also reminds the patient that the therapist's own role was merely to facilitate that, which the patient now knows they can do for themselves. Indications Non-psychotic depressive disorders. Adaptations of IPT have been applied to various subgroups such as adolescents, geriatric patients, primary care clinic patients, and patients with HIV, bulimia, panic disorder, bipolar dis order, dysthymic disorder, bereavement, post-partum depression, social phobia, and insomnia. Modifications of IPT for groups, couples therapy, maintenance therapy, and via telephone have been developed. IPT is not indicated for treating substance abuse or personality disorders. Efficacy Several RCTs in adults, adolescents, elders, and primary care patients have demonstrated efficacy for IPT, either alone or in combination with anti depressant medication.

916 Chapter 19 Psychotherapy Dialectical behaviour therapy DBT7 was introduced in 1991 by Linehan8,9 and colleagues as a treatment for BPD. Patients with BPD are supported in understanding their own emo tional experiences and are taught new skills for dealing with their distress through a combination of group and individual therapy sessions. By learning more adaptive responses to distress and more effective problem-solving techniques, patients' quality of life and functioning may be improved, and their morbidity and mortality reduced. Rationale Patients with BPD suffer from significant psychiatric morbidity and mortality related to completed suicide. They are a difficult group of patients to treat, as their characteristic patterns of behaviour tend to challenge therapeutic progress and exhaust therapist resources ('burnout'). Such individuals can, however, learn more adaptive responses later in life, with subsequent im provement in functioning and quality of life and reduction in morbidity and mortality. How illness is viewed BPD occurs as a product of emotional vulnerability (which may have a bio logical basis) and childhood experience of an 'invalidating environment'. The child's experiences and emotions

are repeatedly disqualified or invali dated by others, and their difficulties with self-control or problem-solving are not acknowledged. As a consequence, the child grows up with difficulty in recognizing, understanding, and trusting their emotions, and in order to have feelings acknowledged and needs for care met, they may display ex tremes of emotion and behaviour. As certain skills (e.g. tolerating emo tional distress, problem-solving) have not been taught, the individual tends to set unrealistic goals and respond with shame and self-loathing when they cannot be met. These patterns are reinforced as the child grows and de velops, with self-harming behaviour frequently emerging as a way to cope with the intense extremes of emotion experienced. Techniques DBT is a complex treatment combining CBT interventions with Eastern meditative practice, notably mindfulness (in which a person intentionally becomes aware of their thoughts and actions in the 'here and now'). • Individual therapy—where the therapist validates the patient's responses (recognizing their distress and behaviours as legitimate and understandable, but ultimately harmful), reinforces adaptive behaviours, and facilitates analysis of maladaptive behaviours and their triggers. 7 Dialectic refers to a means of arriving at the truth by examinating the argument (the 'thesis' and the contradictory argument the 'antithesis') in order to resolve them into a coherent 'synthesis'. 8 Linehan MM (1993) Cognitive-Behavioral Treatment of Borderline Personality Disorder. New York, NY: Guilford Press. 9 Linehan MM (1993) Skills Training Manual For Treating Borderline Personality Disorder. New York, NY: Guilford Press.

Dialectical behaviour therapy • Group skills training—where the following modules are taught in a group context: • Mindfulness skills. • Interpersonal effectiveness skills (e.g. problem-solving, assertiveness training, communication skills). • Emotion modulation skills (to change distressing emotional states). • Distress tolerance skills (e.g. distraction, self-soothing strategies). • Telephone contact—according to the contract agreed between the patient and therapist, to support the patient in applying DBT skills in real-life situations between sessions and find alternatives to self-harming. • Therapist consultation groups—where therapists support each other, according to the DBT model, to prevent 'burnout'. Phases of treatment Each stage of treatment has specific targets, arranged hierarchically by im portance. Within each session, targets should also be attended to in this order, e.g. addressing episodes of self-harm first. Each stage of therapy must be completed, with the targeted behaviours for that stage modified, before progressing to the next stage. DBT takes a hierarchical view of treat ment aspirations, with the focus first on reducing behaviours which cause self-harm, then on reducing those behaviours which interfere with therapy, and finally aiming to reduce behaviours which diminish the quality of life and personal relationships. • Pre-treatment: assessment, orientation to therapy, commitment to therapeutic contract. • Stage 1: focuses on reducing life-threatening behaviour (episodes of deliberate self-harm with or without suicidal intent), behaviour which may interfere with the progress of therapy (e.g. inappropriate use of telephone contact, unreliable attendance for therapy), and behaviour which interferes with the quality of life (e.g. substance misuse, interpersonal conflicts). In individual therapy sessions, exploration of internal and external antecedents to these behaviours, and generation of possible solutions. Weekly DBT skills group introduces basic skills. • Stage 2: focuses on emotional processing of previous traumatic experiences, to target post-traumatic stress-related symptoms such as flashbacks. Examines underlying historical causes of dysfunction, including exposure to memories of abuse or trauma, in combination with distress tolerance techniques. • Stage 3: aims to develop self-esteem and establish future goals— individual targets negotiated with the patient. Indications and contraindications DBT methods are described specifically for patients with BPD. Efficacy The original DBT group produced RCT evidence of reduced rates of de

liberate self-harm and admission to hospital, and improved retention in therapy, compared with ‘treatment as usual’. Subsequent RCTs have sup ported the efficacy of DBT, including studies in other patient populations (e.g. substance abusers) for whom it has been adapted.

918 Chapter 19 Psychotherapy Cognitive analytic therapy Cognitive analytic therapy (CAT) is a therapy method introduced by Anthony Ryle in 1990. It aims to bring together ideas from dynamic cogni tive and behavioural therapies by attempting to explain psychoanalytic ideas in cognitive terms. Rationale Problems such as depression, anxiety disorders, and interpersonal difficul ties cause emotional suffering and also hinder the ability of the individual to make positive change. These problems can often be understood in the con text of an individual’s history and early experiences and can be prolonged by habitual coping mechanisms. Through collaborative therapy, these mech anisms can be identified, understood, and changed. How illness is viewed Traumatic childhood and adolescent experiences can give rise to coping mechanisms to protect the individual from conscious distress. These mal adaptive mechanisms can be inappropriately maintained into adult life when they give rise to emotional symptoms such as anxiety and depression and destructive behaviours such as self-harm. Although harmful, these behav iours are maintained by ‘neurotic repetition’. Neurotic repetition has three essential patterns: • ‘Traps’: negative assumptions generate acts that produce consequences, which, in turn, reinforce assumptions. • ‘Dilemmas’: a person acts as if available actions or possible roles are limited and polarized (called ‘false dichotomy’) and so resists change. • ‘Snags’: appropriate goals or roles are abandoned either because others would oppose them or they are thought to be ‘forbidden’ or ‘dangerous’ in light of personal beliefs. Techniques The ‘three Rs’ of CAT are recognition of maladaptive behaviour and beliefs, reformulation of these (the main ‘work’ of therapy), and revision. The refor mulation is agreed between the therapist and patient and documented in a ‘psychotherapy file’. This reformulation is expressed in narrative and dia grammatic forms and considers both the past history and current problems. It is used throughout therapy to guide the active focus, to set homework, and to enable recognition of transference/countertransference. Phases of treatment Therapy involves active participation from both parties. • Assessment—explanation of rationale of method of therapy. Planning of number and timing of sessions (8–24 sessions, normally 12). • Early sessions (1–3)—patient asked to begin ‘psychotherapy file’, exploring common traps, dilemmas, and snags. Diary keeping to monitor moods and behaviours. Recapitulation of early experiences and narrative of current relationships.

Cognitive analytic therapy • Middle sessions (4–8)—agreement on reformulation of problems, with written and diagrammatic descriptions of ‘target problem procedures’. Exploration of methods of change (called ‘exits’) via work in sessions and in homework. • Ending sessions (9–12)—identification and recapitulation of key themes which emerged during therapy. Both therapist and patient write ‘goodbye’ letters summarizing progress and formally closing the relationship. There may be a planned 3-mth review appointment. Indications and contraindications As for other cognitive therapies. Efficacy Ongoing RCTs examining effectiveness in personality disorders and com paring CAT with other methods.

920 Chapter 19 Psychotherapy Solution-focused therapy This therapy, developed by de Shazer,10 aims to empower patients to rec ognize and make use of their own strengths. It is a brief intervention which may be delivered in a single session. Rationale The patient is more than the sum of their problems and already has a range of skills for coping with adversity. The best way for

the patient to achieve their goals is for them to discover and harness those capabilities and re sources which are already helpful and to make even better use of them. The solution-focused therapist facilitates this process. How illness is viewed Solution-focused therapy avoids viewing problems or symptoms as goals for therapy. Rather, it prompts the patient to visualize a future without the problem and to plan the stages necessary to achieve this. In-depth consider ation of the development of current difficulties is avoided, as this may imply that the problems are inevitable and unchangeable. Techniques (See Box 19.5.) • Problem-free talk—discussion of other areas of the patient's life—this helps the therapist to understand the 'patient behind the problems' and may elicit areas of strength or competence. If the patient discusses their problems, the therapist listens actively, reflects on the coping strategies described by the patient, and highlights the possibility of change. • Preferred future—the patient identifies future goals, shifting focus away from the current complaints. • Exception finding—the patient identifies situations when the preferred future seemed more attainable. Rather than seeing them as 'the exception which proves the rule', these situations are examined to determine which skills the patient used to help bring about a favourable outcome. • Scales—rating their preferred future as 10, the patient rates their current position numerically between 0 and 10. They are invited to discuss the difference between 0 and where they are now, and the resources responsible for this, and to identify the steps or signs of progress between points on the scale. Phases of treatment First session—establishes the patient's goals or best hopes from therapy, recognizes what the patient already does or has done which helps them to cope or moves them towards this preferred future, and identifies what the next signs of progress may be. Subsequent sessions—explore what the patient has done since the pre vious session which has been helpful, place this in the context of the patient's goals for therapy, and identify what may be further evidence of progress. 10 De Shazer S (1985) Keys to Solution in Brief Therapy. New York, NY: Norton.

Solution-focused therapy Indications Depression, substance misuse, interpersonal relationship difficulties, pres entation in crisis or after self-harm. May be used with children and adoles cents and people with learning disability. Efficacy Few controlled trials, but some evidence of effectiveness for adults with de pression and for children and adolescents with emotional and behavioural problems. Box 19.5 Solution-focused questions* Problem-free talk How do you spend your time? What do you enjoy? What are you good at? How would your friends describe you? Preferred future (the miracle question) Imagine that tonight, while you are asleep, a miracle happens and your hopes from coming here are realized (or the problems that bring you here are resolved), but because you are asleep, you don't realize this mir acle has happened. What are you going to notice different about your life when you wake up that begins to tell you that this miracle has happened? Exceptions When doesn't the problem happen? When doesn't it last as long? When does it feel less intense? When do you feel less upset by it? When do you manage to resist the urge to . . . ? What are the signs that the miracle has already started to happen? Scales On a scale of 0–10, where 0 is the worst things have ever been and 10 represents your best hopes, where are you today? Where on that scale would be good enough, the point that you would settle for? What are you doing that means you are at 2, and not at 0? If you are at 2 now, what will you be doing that will tell us that you have reached 3? Locating resources It sounds as if things are very stressful; how do you cope? What helps you to keep going? How did you manage to get here? What have you been doing that has stopped things from getting even worse? When you've faced this sort of problem before, how did you resolve it?

- Source: data from BRIEF (2007) BRIEFER: A solution-focused manual. London: BRIEF.

922 Chapter 19 Psychotherapy Counselling methods Counselling may be thought of as a method of relieving distress undertaken by means of a dialogue between two people. The aim is to help the client or patient find their own solutions to problems, while being supported to do so and being guided by appropriate advice. In Western countries, over the last 50yrs, counselling has emerged as a profession in its own right, and individual forms of specific counselling have been developed. In its more general sense—helping others by the provision of advice, non-judgemental reflection, and emotional support—counselling takes place all over the world in the guise of family members, priests, tutors, teachers, etc. Counselling skills are integral to the practice of medicine, particularly in primary care and psychiatry, where counselling techniques are useful in history-taking, assessing and ensuring compliance, etc. Counselling should not be thought of as 'cut-down' or 'half-price' psychotherapy. There is clearly an overlap in the methods and skills of a psychotherapist and a coun sellor. However, the decision to use counselling as a specific treatment (e.g. for postnatal depression) should be made after considering both the dis order and the patient. There are a variety of counselling services in the voluntary and private sectors, some directed towards specific problems and some more general. Rationale Behaviour and emotional life are shaped by previous experience, the current environment, and the relationships the individual has. Many life problems can be viewed as arising from resolvable difficulties in one of these three areas, rather than as an 'illness'. People have a tendency towards positive change and fulfilment, which can be retarded by 'life problems'. A collab orative relationship with a counsellor (however defined) is one method of addressing these issues. This relationship will proceed according to agreed rules, towards a goal, and will be based on developing the client's strengths. Techniques • Information giving—key to all psychiatric treatment and psychotherapeutic work. Information should be provided in a form the patient can understand, and information giving should not be a 'one-off' but should continue throughout counselling. • Client-focused discussion—the client should 'lead' the sessions, particularly beyond the early information-gathering sessions. Time constraints may hinder this. • Problem-solving—a variety of techniques, particularly those borrowed from CBT, are employed here. The basic goal is to use the session time to explore current and potential future problems and to help the client consider the optimum solution. Different types of counselling • Information sharing/discussion—in some contexts, is also called psychoeducation. The aim is to properly inform a client prior to them making their own decision. Techniques of guided learning, providing verbal and written information, collaborative enquiry (compare with CBT).

Counselling methods • Crisis management—views crisis as a stressor, providing both risk and opportunity to change/learn/develop. Short-term, immediately follows trauma (first few weeks). Facilitates adaptive and normal emotional responses, discourages maladaptive responses. Focus on end point of intervention. Alternative to hospital admission in some cases. Should have access to alternative treatments, if necessary. • Problem-based counselling—directed towards a specific primary problem (e.g. drug misuse, CSA). Counsellor may or may not have had similar experiences themselves. • Risk counselling—used to guide an informed decision (e.g. prenatal interventions, genetic counselling). Differentiated from other forms of counselling by the fact that the counsellor is clearly 'the expert' and has access to specialist information. Nonetheless, the basic goal of enabling the patient to come to their own decision, with appropriate information and support, remains the same. Indications Absolute advice limited by lack of comparative trials and tendency for local availability of services to be the main factor in the decision to use counsel ling methods.

Clinical usefulness in: • Adjustment disorder. • Mild depressive illness. • Normal and pathological grief. • Sequelae of CSA. • After other forms of trauma (e.g. rape, accidents). • Postnatal depression. • Pregnancy loss and stillbirth. • Drug and alcohol problems. • Reaction to chronic medical conditions. • Prior to decision such as undergoing genetic testing or HIV testing.

924 Chapter 19 Psychotherapy Other therapeutic approaches 1 Mindfulness-based cognitive therapy Mindfulness-based cognitive therapy (MBCT) has been specifically de signed as a manualized group skills training programme to address vulner ability between episodes of recurrent major depression11 and, as such, is recommended by NICE (CG90)12 for people who are currently well but have a history of three or more depressive episodes (as a group-based 8- wk course, with four follow-up sessions over the year). MBCT combines cognitive therapy principles with mindfulness meditation where attention is paid to the present moment, allowing thoughts, feelings, and body sen sations to be noted with an attitude of curiosity and non-judgement. This creates a situation in which emotions, such as a sense of loss, sadness, fear, and worry, can be worked with to help prevent future depressive episodes. Acceptance and commitment therapy Arising from ‘comprehensive distancing’, in the early 1980s, acceptance and commitment therapy (ACT) developed into its modern form through the late 1980s and 1990s. It is based on functional contextualism and is derived as a clinical application of the relational frame rheory (RFT), a behavioural account of the development of human thought and cognition. Therapists aim to transform the relationship between the experience of symptoms and difficult thoughts/feelings, so that symptoms no longer need to be avoided and become just uncomfortable transient psychological events. In this way, symptom reduction becomes a by-product of treatment.13 ACT uses six core principles to help clients develop psychological flexibility—outlined by Steven C Hayes in 1999:14 (1) cognitive defusion (perceiving thoughts, images, emotions, and memories as what they are, rather than what they appear to be); (2) acceptance (allowing these to come and go without strug gling with them); (3) contact with the present moment (awareness of, and receptiveness to, the here and now); (4) use of the observing self (accessing a transcendent sense of self); (5) personal values (discovering what is most im portant to one’s true self); and (6) committed action (setting goals according to values and carrying them out responsibly). In terms of committed action, ACT utilizes similar methods to traditional behaviour therapy such as ex posure, skills acquisition, and goal setting. Provisional low-quality evidence has found that ACT may be at least as effective in treating anxiety disorders, 11 Williams JM, Russell I, Russell D (2008) Mindfulness-based cognitive therapy: further issues in current evidence and future research. J Consult Clin Psychol 76:524–9. 12 National Institute for Health and Care Excellence (2009) Depression in adults: recognition and management. Clinical guideline [CG90]. M https://www.nice.org.uk/guidance/cg90 [accessed 11 July 2018]. 13 Harris R (2006) Embracing your demons: an overview of acceptance and commitment therapy. Psychotherapy in Australia 12:2–8. 14 Hayes SC, Strosahl KD, Wilson KG (1999) Acceptance and Commitment Therapy: An Experiential Approach to Behavior Change. New York, NY: Guilford Press.

Other therapeutic approaches 1 depression, addiction, and somatic health problems as established psycho logical interventions.15 However, further methodologically robust trials are required. Compassion-focused therapy/compassionate mind training Compassion-focused therapy (CFT) is described as ‘an integrated and multimodal approach that draws from evolutionary, social, developmental and Buddhist psychology, and neuroscience.’16 Compassionate mind training (CMT) refers to specific activities designed to develop compassionate attributes and skills, particularly

those that influence affect regulation, with postulated positive neuroimmunological and prosocial benefits. Through compassion/ self-compassion meditation and imagery, clients develop and work with experiences of inner warmth, safeness, and self-soothing, become more sensitive to their own needs and distress, and learn to extend warmth and understanding towards themselves and other people. Currently, there are limited data on the value of this approach. Schema therapy Developed by Jeffrey E Young17 for the treatment of personality disorders, schema therapy (ST) combines theory and techniques from existing ap proaches, including CBT, object relations, attachment theory, Gestalt therapy, and psychodrama. It substantially elaborates the concept of schemata (early self-defeating patterns of perception, emotion, and be haviour), maladaptive coping styles (e.g. over-compensation, avoidance, or surrender), and modes (clusters of schemata and coping styles, e.g. child modes, dysfunctional coping modes, dysfunctional parent modes, and healthy adult mode), which are thought to arise when basic emotional needs are not met in childhood (e.g. connection, mutuality, reciprocity, flow, and autonomy). In therapy, the goal is to recognize dysfunctional modes of functioning and to have behaviour guided by the healthy adult mode. This is done through the use of a variety of methods, including standard cognitive techniques, schema diaries, flash cards, use of guided imagery, and 'chair work' (to enact dialogues between modes of behav iour, to reach closure with imagined 'significant others' through mono logue, and to practice normal assertiveness). Although the evidence base is far from robust, ST appears to be a cost-effective way of improving remission rates in BPD. 15 A-Tjak JG, Davis ML, Morina N, Powers MB, Smits JA, Emmelkamp PM (2015) A meta-analysis of the efficacy of acceptance and commitment therapy for clinically relevant mental and physical health problems. Psychother Psychosom 84:30–6. 16 Gilbert P (2009) Introducing compassion-focussed therapy. Adv Psychiatr Treat 15:199–208. 17 Young JE, Klosko JS, Weishaar ME (2003) Schema Therapy: A Practitioner's Guide. New York, NY: Guilford Press.

926 Chapter 19 Psychotherapy Metacognitive therapy Adrian Wells' metacognitive therapy (MCT) for depression18 takes the view that depression is maintained by problematic thinking patterns that are predominantly ruminative, along with excessively self-focused attention on thoughts and feelings. MCT uses attention training technique (ATT), a set of daily exercises that involve active listening and focused attention, as a means to increasing awareness of thinking and regaining flexible control of it. MCT also attempts to reduce rumination and other unhelpful coping behaviours through modification of metacognitive beliefs. 18 Wells A (2008) Metacognitive Therapy for Depression and Anxiety. New York, NY: Guilford Press.

Other therapeutic approaches 1 927

928 Chapter 19 Psychotherapy Other therapeutic approaches 2 Behavioural activation Originally manualized by Jacobson et al. in 1996,19 BA includes teaching re laxation skills, increasing pleasant events, and providing social and problem- solving skills training. The 'extended BA model' in 200120 added a contextual approach to depression regarding avoidant coping patterns, such as with drawal from situations and people, as the means by which depressed mood is maintained. Intervention involves functional analysis, in which a detailed assessment of how an individual maintains depressive behaviour is carried out; the individual is taught to formulate and accomplish behavioural goals and is encouraged to move attention away from prevailing negative thoughts towards direct, immediate experience. A variation called behavioural acti vation treatment for depression (BATD) proposes that depression is main tained through the use of positive reinforcers

such as i social attention and escape from aversive tasks. Depression is targeted by weakening reinforce ments, such as sympathy and escape from responsibility, and systematically activating healthy behaviour through the use of goal setting and i activity.21 Functional analytic psychotherapy Conceptualized in the 1980s by the psychologists Robert Kohlenberg and Mavis Tsai,22 functional analytic psychotherapy (FAP) is a form of radical behaviourism that utilizes behavioural principles, such as reinforcement and generalization, with a focus on the client–therapist relationship as a means of evoking problematic clinically relevant behaviours (CRB1s) and shaping improved behavioural responses (CRB2s) that can be generalized to everyday situations.23 FAP therapists focus on the function of a client's behaviour, instead of the form with cognition (thinking, planning, believing, and organizing) regarded as a form of covert behaviour. Together, the client and therapist work to form a unique clinical formulation of the client's therapeutic goals, rather than addressing a single therapeutic target. Cognitive–behavioural analysis system of psychotherapy Cognitive–behavioural analysis system of psychotherapy (CBASP) was spe cifically developed for the treatment of patients with chronic depression. It is a synthesis of interpersonal and cognitive and behavioural therapies devel oped (and patented) by James P McCullough Jr of Virginia Commonwealth 19 Jacobson NS, Dobson KS, Truax PA, et al. (1996) A component analysis of cognitive-behavioral treatment for depression. J Consult Clin Psychol 64:293–304. 20 Martell CR, Addis ME, Jacobson NS (2001) Depression in Context: Strategies for Guided Action. New York, NY: Norton. 21 Hopko DR, Lejuez CW, Ruggiero KJ, Eifert GH (2003) Contemporary behavioural activation treatments for depression: procedures, principles and progress. Clin Psychol Rev 23:699–717. 22 Kohlenberg RJ, Tsai M (1991) Functional Analytic Psychotherapy: A Guide for Creating Intense and Curative Therapeutic Relationships. New York, NY: Plenum. 23 Haworth K, Kanter JW, Tsai M, Kuczynski AM, Rae JR, Kohlenberg RJ (2015) Reinforcement matters: a preliminary, laboratory-based component-process analysis of functional analytic psychotherapy's model of social connection. J Contextual Behavioral Sci 4:281–91.

Other therapeutic approaches 2 University.24 It assumes that skills deficits in the area of operational thinking, arising from traumatic experiences or other adverse interpersonal experi ences, lead to a generalized fear of others and a lifetime history of failure of interpersonal behaviour (especially by avoidance) and subsequent de pression. There is some evidence that pre-operational thinking (the inability to use logic or transform, combine, or separate ideas) is more common in those with chronic depression (McCullough). By utilizing situational analysis, interpersonal discrimination exercises, and consequating strategies, the aim is to teach operational thinking and interpersonal behaviour that are in formed by empathy and personal values. Integrative behavioural couple therapy Integrative behavioural couple therapy (IBCT) was developed by Neil S Jacobson and Andrew Christensen25 and incorporates additional inter vention strategies, to promote acceptance and tolerance, into already well-established behavioural couples therapy techniques (e.g. behaviour ex change, communication training, and couple problem-solving). By using the concepts of functionality, rule-governed/contingency-shaped behaviour and acceptance IBCT may be better in dealing with particularly difficult problems in couples, such as infidelity and substance misuse, than other approaches. Third-wave therapies (See Box 19.6.) 24 McCullough JP (2000) Treatment for Chronic Depression: Cognitive Behavioural Analysis System of Psychotherapy (CBASP). New York, NY: Guilford. 25 Christensen A, Jacobson NS, Babcock JC (1995) Integrative behavioral couples therapy. In: Jacobson NS, Gurman AS (eds). Clinical Handbook for Couples Therapy, pp. 31–64. New York, NY: Guildford. Box 19.6 Third-wave therapies—revolution or evolution? 'Third -wave therapies' is a term used to describe a heterogenous mixture of

psychological interventions that have developed following behavioural approaches (E Behaviour therapy, p. 908) and cognitive approaches (E Cognitive behaviour therapy 1, p. 910). They are characterized by themes such as metacognition, mindfulness, acceptance, and dialectics. Whether they should be seen as entirely novel or revolutionary is debat able, as many of the techniques used either have their routes in Eastern mysticism or hark back to fundamental behaviourism. Indeed it is reported that Marsha Linehan does not consider DBT (E Dialectical behaviour therapy, p. 916) to be part of this ‘third wave’ but views DBT as a form of CBT that includes acceptance strategies. Similarly, Adrian Wells views MCT as an extension of CBT with a clear a priori scientific basis, disorder- specific empirically tested models, formulation-driven treatment, lack of any meditation techniques, and the aim to change psychological events dir ectly.1 Perhaps it is better to view these approaches as additional weapons in the psychological armamentarium that offer alternative emotional regu lation strategies and help identify maintaining factors of chronic problems. 1 Hofmann SG, Asmundson GJG (2008) Acceptance and mindfulness-based therapy: new wave or old hat?. Clin Psychol Rev 28:1–16.