CHAPTER 24

# Psychological treatments


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## Introduction

This chapter is concerned with various kinds of counselling, psychotherapy, behavioural and cognitive therapies, and some related techniques. The UK is almost unique in having a separate faculty and specialist training in psychotherapy for psychiatrists. In most countries, psychotherapy is considered a core aspect of a psychiatrist's role, fundamental to their professional identity. It is no longer routine for trainee psychiatrists to be trained fully in one or other form of psychotherapy, but rather they gain an overview. It will be obvious, however, that much of what follows below is inevitably woven into the daily practice of psychiatry. Expectations of this competence are likely to vary in the near future, but it is unlikely to disappear.

The subject is large, and some basic principles underly this chapter.

- Psychological treatment is not given in isolation, and this chapter complements the chapters on physical treatment and services.
- This chapter focuses on the general nature of the treatments; their use in specific disorders is covered in the relevant chapters.
- Psychological treatments are often combined with medication, considered in more detail with the relevant disorders.
- Many different techniques are considered here, so one will be described in detail.
- Supervised experience is essential before any of these treatments can be used with patients.

*Terminology*. The word psychotherapy is used in two ways. It can denote all forms of psychological treatment, including counselling and cognitive behaviour therapy (CBT). More traditionally it indicates established psychotherapies (usually broadly psychodynamic) that require a specific and elaborate training. These usually involve personal therapy, and exclude counselling and CBT. Psychological treatment is used for the broader sense and psychotherapy is used more precisely; for example, 'brief dynamic psychotherapy'.

## How psychological treatments developed

The use of psychological healing is as old as the practice of medicine—parallels have been drawn with the ceremonial healing in temples in ancient Greece. In psychiatry, psychological treatment evolved towards the end of the eighteenth century with developments in hypnosis. Anton Mesmer (1734–1815), physician, challenged the prevailing practice of 'casting out devils' in 1775. He proposed that the body could be influenced by magnetism, initially actual magnets, but more importantly the therapist's force of personality or 'animal magnetism' (Burns, 2013). 'Mesmerism' was renamed hypnosis by a Manchester doctor, James Braid, who believed it was related to sleep (Braid, 1843).

Treatment with hypnosis was revived in France by the eminent neurologist Jean-Martin Charcot (1825–1893). He treated many patients suffering from hysteria and recognized that it worked by suggestion. Freud visited Charcot to study hypnosis, and used it with his patients back in Vienna. He used hypnosis not to modify symptoms directly, but to release the emotions associated with repressed conflicts that he believed to be their cause. Freud's revolutionary advance was his recognition that patients could recall forgotten events and conflicts without hypnosis. Recall was achieved by the patient lying on a couch and being encouraged to let their mind wander with the therapist out of sight—'free association'. In time he attended to the intensity of the relationship with his patients—'transference'. These discoveries formed the basic technique of psychoanalysis and subsequently of the larger group of dynamic psychotherapies.

Freud published vivid accounts of his new treatment and elaborated his increasingly complex theories, collecting a group of followers. Some of these later broke away, forming their own 'schools' of dynamic psychotherapy. These developments will be described briefly. More detailed descriptions are widely available, and for a brief overview see Burns (2006) and Burns and Lundgren (2015).

### Early departures from Freud's original group

Alfred Adler left Freud's group in 1910; he stressed social factors in personal development and rejected the libido theory. He also stressed social factors in personal development, introducing the term 'inferiority complex'. His 'individual analysis' focused on current problems and solutions, and was highly influential with American analysts. Carl Jung emphasized the inner world of fantasy, and the interpretation of unconscious material, deduced from dreams, paintings, and other artistic productions. Jung believed that part of the content of the unconscious mind was common to all people (the '*collective unconscious*') and was expressed in universal images which he called *archetypes*. The Jungian relationship between therapist and patient is more equal, and the therapist is more active and reveals more about himself (Storr, 2000).

The neo-Freudians formed in the USA in the 1930s from predominantly Jewish refugees from Nazi Germany. While they accepted that the origins of neurosis were in childhood, they rejected Freud's emphasis on early infantile sexuality and considered family and social factors more important.

Melanie Klein in London adapted psychoanalytical techniques for use with very young children. She interpreted their play and originated the 'object relations' school of psychoanalysis. 'Object' is a confusing term here as it refers both to people (e.g. the mother), to parts of that person (e.g. the mother's breast), and, most importantly, to their internal psychological representation. Klein's language is excessively dramatic, emphasizing strong instinctual feelings of love and hate. She described emotional development, moving through a 'paranoid-schizoid position' to the 'depressive position'. Klein has been widely influential, particularly for therapists working with severely ill patients (see Segal, 1963).

*Attachment theory* originated in the work of John Bowlby, a British analyst. The theory is that infants need a secure relationship with their parents in reality—not just in fantasy. Insecure attachments can lead to difficulty in establishing relationships, and emotional problems later. Bowlby's ideas had a considerable effect on the care of children, such as the need to maintain contact with the parents when a child is admitted to hospital. For a review of the historical development of attachment theory, see Holmes (2000).

*Brief psychodynamic psychotherapy*. Ferenczi saw the need to develop treatments shorter than psychoanalysis. He did this by setting time limits, making the role of the therapist less passive, and planning the main themes of treatment. These innovations have found their way into the brief dynamic psychotherapy that is used today.

The trend has continued towards briefer treatment that attends more to the patient's current problems than to those in the past. *Interpersonal therapy* (see page 687), directed to current interpersonal problems in depressed patients, and *cognitive analytic therapy* (see page 698), using cognitive therapy techniques within a framework of psychodynamic understanding, are two current forms.

## The development of cognitive behaviour therapy

*Behaviour therapy*. Interest in a treatment based on scientific psychology arose in the early twentieth century. Watson and Rayner (1920) in the USA used learning principles in the treatment of children's fears, and aversion therapy for alcoholism. Maudsley psychologists in the 1930s used learning principles in treatments for phobic disorders. Joseph Wolpe in South Africa published *Psychotherapy by Reciprocal Inhibition* (Wolpe, 1958), describing a treatment for neurotic disorders, based on learning theory and making use of relaxation. In the USA, Skinner (1953) proposed operant conditioning in the treatment of psychiatric disorders. Wolpe's ideas were adopted in the UK, and Skinner's ideas were initially more influential in the USA. These approaches converged, and practice in the two countries is now similar.

There has always been an emphasis on evaluation for these new methods. The first clinical trial was reported in 1978 (Gelder *et al.*, 1978), followed by several trials establishing a strong evidence base for behavioural methods.

*Cognitive therapy* began with the work of A. T. Beck, a US psychiatrist who was dissatisfied with psychoanalytical psychotherapy for depressive disorders. Beck noted recurring themes in the thinking of depressed patients, and he concluded that these themes were an essential part of the disorder and had to be changed by challenging them in specific ways (see Box 24.8.). US psychologists were also dissatisfied with operant conditioning and its 'black-box' approach. They proposed that the recurrent thoughts played a part in maintaining distress, with suggestions of how these thoughts might be controlled (Meichenbaum, 1977).

*Cognitive behaviour therapy*. These cognitive approaches were integrated with behaviour therapy to produce CBT. The strong evidence base, clearly described procedures, and relatively brief treatment time of CBTs have made them the preferred psychological treatment for many disorders.

# Classification of psychological treatments

Several simple classifications of psychological treatments have been proposed. Two are given here, with a further classification given below, with hints to identify their use in most healthcare systems.

1. Classification by *technique*:
   - *Eclectic*
   - *Psychodynamic*
   - *Cognitive behavioural*
   - *Other* (e.g. systems theory).
2. Classification by *number* of patients taking part:
   - *Individual therapy*
   - *Couple therapy*
   - *Family therapy*
   - *Small and large group therapy*

These two classifications can be combined—for example, *individual cognitive behavioural* or *psychodynamic group* therapy.

## Psychotherapy in public services

Psychological treatment is the principal treatment for some psychiatric disorders, alone or with medication. Counselling, crisis intervention, and CBTs are used in this way when they have been shown to be effective in clinical trials. Dynamic psychotherapy, because there is limited evidence of its efficacy and because training is long and expensive, is less available. This is especially so of long-term psychodynamic therapy. 'Subthreshold' conditions are now generally offered counselling, and psychodynamic treatment for them now occurs mainly in private practice.

Planning their uses within a public health service has generated a third classification:

A *Simple psychological aspects of all health care*. This refers to skills and techniques to help individuals to adjust to stressful situations or confront difficult decisions. These are often considered aspects of a good doctor–patient relationship.

**B** *Moderately complex and provided by most mental health professionals*. This includes simpler CBT and brief dynamic psychotherapies. These treatments are usually an identified part of the management plan that includes medication and social measures.

**C** *Highly complex and provided by formally trained therapists*. This group includes the more complex psychodynamic and CBTs. These are used to treat more severe or complex disorders, alone or as part of a wider plan of management.

## Common factors in psychological treatment

Different psychological treatment methods achieve results that are broadly equal and are greater than placebo. The features that psychotherapies share may be more important than their differences. Jerome Frank (1967) identified them and they are listed in Box 24.1.

### Transference and countertransference

Therapeutic relationships are inevitably emotional but they can sometimes become very intense. These powerful emotions were labelled 'transference' and 'countertransference' by Freud because he believed their force derived from earlier, key relationships that had been 'transferred' to them. Transference and countertransference features mark all psychological treatments, and therapists overlook them at their peril.

*Transference* often becomes increasingly intense as treatment progresses, and is especially strong when patients reveal intimate personal problems. Transference can be positive, with warm feelings, or negative, with critical or hostile feelings. What is characteristic of them is their excess. Initially considered an impediment, transference, and its resolution, is now seen as an essential part of successful treatment.

*Countertransference* refers to intense feelings in the therapist towards the patient. Analysts debate whether the term countertransference should be restricted to 'neurotic' or distorted responses, or whether it can include all emotional responses. *Transference problems* may arise from excessive dependency on or idealization of the therapist and make it difficult to end treatment, with a resurgence of symptoms. However, dependency is a normal feature of much therapy and does not necessarily cause difficulties.

### Box 24.1 Common factors in psychotherapy

**The therapeutic relationship.** The most important of the common factors in psychotherapy but can become too intense.

**Listening.** Listening attentively shows concern for the patient's problems and develops the helping relationship in which the patient feels understood.

**Release of emotion.** Helpful early in treatment, but repeated release is seldom useful. Intense and rapid emotional release is called *abreaction*.

**Restoration of morale.** Many patients have suffered repeated failures, and may feel helpless. Improved morale enables the patient to begin to help himself or herself.

**Providing information.** Patients may remember little of what they have been told about their condition because of poor concentration. Information should be as simple as possible, expressed clearly, repeated, and perhaps written down.

**Providing a rationale.** All psychotherapies provide some explanation for the current problem, which improves the patient's confidence. It may be by direct explanation (as in short-term psychotherapy), or fostered indirectly (as in much long-term psychotherapy).

**Advice and guidance.** These are part of all psychotherapy, whether direct as in brief therapies or indirect as in long-term therapies.

**Suggestion.** All psychological treatment contains an element of suggestion, which is powerful during the early stages.

# Counselling and crisis intervention

## Counselling

There is no distinct boundary between psychotherapy and counselling. Broadly speaking, counselling is less formal and less extensive (fewer sessions) than psychotherapy. Counsellors have shorter training than psychotherapists and are more open and equal in their relationships. Often counselling is focused on a specific problem (bereavement, drug abuse) rather than an attempt to permanently alter personality or uncover obscure conflicts.

Counselling is more widespread than formal psychotherapy, and counselling skills are a valued part of the professional identity of nurses and social workers. It is widely provided by voluntary bodies, often by unpaid staff. These voluntary bodies, such as the Samaritans, Cruise, and Relate in the UK, maintain a high profile and are easily accessible.

Counselling incorporates the non-specific factors shared by psychotherapies (see Box 24.1). The relationship between the counsellor and the person who is being counselled is believed to be the primary therapeutic agent in all counselling, but the relative importance of giving information, allowing the release of emotion, and exploring the situation, vary. Counselling developed from Carl Rogers' *client-centred approach*. In this the counsellor largely restricts his interventions to helping the client understand their feelings better by reflections back to the emotional content of the client's utterances, often simply repeating the last statement with an interrogative tone. They rarely seek clarification of facts nor offer explanations. The approach is optimistic in tone and actively encouraging but focused on increasing self-awareness, 'That seems to make you angry' (*reflection of feelings*) or 'You were disappointed' (*repeating for clarification the last statement*). Rogerian, or client-centred, counselling is widely available in primary care and voluntary agencies but has been largely replaced in secondary mental health care by the more structured and focused procedures.

## Approaches to counselling

*Problem-solving counselling* is highly structured, particularly suitable for problems related to stressful circumstances or when life problems are exacerbating or maintaining other disorders. Basic counselling is combined with a systematic approach to the resolution of problems. The patient is helped to:

- *identify and list* problems causing distress
- *consider courses of action* to solve or reduce problems
- *select a problem and course of action* that appear feasible and likely to succeed
- *review the results* and select another problem if successful, or another course of action if not.

*Interpersonal counselling* was developed by Klerman *et al.* (1987) from interpersonal therapy (described on page 687), and has many similarities to the problem-solving approach. Attention is focused on current problems in personal relationships within the family, at work, and elsewhere. These problems are considered under four headings—*loss, interpersonal disputes, role transitions*, and *interpersonal deficits*. Using a problem-solving approach, the therapist encourages patients to consider alternative ways of coping with these difficulties, and to try these out between sessions. For a review see Blanco *et al.* (2009).

*Psychodynamic counselling* places more emphasis on unconscious processes by which previous relationships influence current feelings and relationships. The patient's emotional reactions (transference) are used to understand problems in other relationships. Its developmental approach fits well in student health centres.

## Counselling for specific purposes

### Debriefing

Debriefing for survivors of disasters has become a worldwide phenomenon. Surviors are encouraged to recall the distressing events, with emphasis on emotional release, and responses to the immediate problems. Evidence from clinical trials is discouraging, suggesting that this approach may prolong ruminations (Mayou *et al.*, 2000) and distract from essential social supports and the traditional advice to 'get back on the horse as soon as possible'. NICE guidance (National Institute for Health and Clinical Excellence, 2013a) specifically advises against its routine use.

### Counselling for relationship problems

Couples are encouraged to talk constructively about problems in their relationship. The focus is on the need for each partner to understand the point of view, needs, and feelings of the other, and also to identify positive aspects of the relationship and potential strategies to move forward. A 'safe space' to explore can prevent a spiral down into mutual recrimination.

### Bereavement counselling

Bereavement counselling draws heavily on following the identified stages of normal grief (see page 155, Box 7.9.). It combines an opportunity for emotional release (including anger), information about the normal course of grieving, and sensitive encouragement about viewing the body and disposing of clothing. It also involves advice on practical problems of living without the deceased person.

### Counselling about health risks

Genetic counselling and counselling about the risks of sexually transmitted disease are probably not counselling as we generally understand it. These focus on giving information and providing an opportunity for reflection. However, to be effective counselling skills such as sensitivity and respect are essential.

## Counselling in primary care

In primary care, many patients are referred to practice counsellors and IAPT (Improving Access to Psychological Therapies) workers who have received a relatively limited training but often have no background in health or social care professions. GP counsellors use various methods of brief treatment, although most often they employ non-directive Rogerian approaches, usually 4–6 sessions. Although very popular, the effectiveness of counselling in primary care is modest (Bower *et al.*, 2003). IAPT workers are trained in basic CBT.

## Crisis intervention

Crisis intervention was originally conceived to use the crisis as an entry to longer-term problems but now is used mainly to cope with current crises. It originated in dealing with disasters (Lindemann, 1944); Caplan, 1961), and draws on Caplan's four stages of coping:

1. Emotional arousal with efforts to solve the problem.
2. Increasing arousal leading to a disorganization of behaviour.
3. Trials of alternative ways of coping.
4. Exhaustion and decompensation.

Crisis intervention seeks to limit the reaction to the first stage, or to avoid the fourth stage.

### Problems leading to crisis

Common problems include:

- *Loss and separation*, such as bereavement or divorce, but also during severe illness.
- *Role changes*, such as marriage, parenthood, or even a new job.
- *Relationship problems*, such as those between sexual partners, or between parent and child.
- *Conflicts*, arising from pressing but impossible choices.

### Crisis intervention methods

The methods used in crisis intervention (see Box 24.2) resemble interpersonal counselling and problem-solving counselling, but with a greater emphasis on reducing arousal. Treatment starts as soon as possible after the crisis and consists of a few sessions over a period of days or, at most, a few weeks. The focus is on current problems, although relevant past events can be considered. High levels of emotional arousal interfere with problem-solving, and the first aim of treatment is to reduce arousal. Reassurance and ventilation of emotions are usually effective, but anxiolytic medication is often used.

# Supportive psychotherapy

Supportive psychotherapy is one of the most difficult but also one of the most important skills that any psychiatrist must acquire. It is used to help a person to cope with enduring difficulties such as chronic mental or physical illness, and in the care of the dying (page 152). Supportive therapy is based on the common factors of psychological treatment (see Box 24.1). Its basic elements, listed in Box 24.3, are:

- *The therapeutic relationship*. A trusting and supportive relationship is central in sustaining patients with long-term difficulties. The most common anxiety voiced by staff is the risk of excessive dependence. An effective relationship is most often achieved by an acceptance of the realistic need for dependence. After all, the patient is seeing you because they 'need' you. We, after all, have achieved our independence through the successful resolution of our own dependence.
- *Listening*. As in all forms of psychological treatment, the patient must feel that they have their doctor's full attention and sympathy while he is with them, and that their concerns are being taken seriously.

**Box 24.2 Crisis intervention**

Treatment is immediate, brief, and collaborative

**Stage 1**

Reduce arousal
Focus on current problems
Encourage self-help

**Stage 2**

Assess problems
Consider solutions
Test solutions

**Stage 3**

Consider future coping methods

- *Information and advice* are important, but their timing should be considered carefully. Information should be accurate, but it is not necessary to explain everything during the first session. Indeed, the patient may need to receive information gradually, giving time to absorb it. Most patients indicate, directly or indirectly, how much detail they wish.
- *Emotional release* and its acceptance can be helpful.
- *Encouraging hope* is important, but unrealistic reassurance can destroy trust. Reassurance should always be specific, offered only when the patient's concerns have been fully understood. A positive approach builds on encouraging the patient to exploit their assets and opportunities.
- *Persuasion*. Doctors can use their powers of persuasion to help patients to take difficult but necessary decisions and actions.

Self-help groups can give valuable support to some patients and to relatives, more effective because it comes from others who have struggled with the same problems. Support groups vary enormously, and it is important have some familiarity with a particular group before recommending it. For an account of supportive treatment, see Bloch (2006).

## Interpersonal psychotherapy

Interpersonal psychotherapy (IPT) was developed as a structured psychological treatment for the interpersonal problems of depressed patients (Klerman *et al.*, 1984). IPT fully embraces the medical model, encouraging the patient to recognize that depression is an illness and that they are suffering from it. The treatment is highly structured. The number and content of treatment sessions are planned carefully. The initial assessment period lasts from one to three sessions. Interpersonal problems are considered under the following four headings:

1. bereavement and other loss
2. role disputes
3. role transitions
4. 'interpersonal deficits' such as loneliness.

**Box 24.3 Basic procedures of supportive treatment**

Develop a therapeutic relationship
Listen to the patient's concerns
Inform, explain, and advise
Allow the expression of emotion
Encourage hope
Review and develop assets
Encourage self-help

Each problem is considered using specific situations, and alternative ways of coping are evaluated. Clear goals are set and progress towards them is monitored, with new coping strategies tried out in homework assignments. In the middle phase of treatment, specific methods are used for each of the four kinds of problem listed above. For grief and loss, the methods resemble grief counselling (page 156). For interpersonal disputes and role transitions, patients are helped to identify clearly the issues in the dispute, as well as any differences between their own values and those of the relevant others. They are helped to recognize their own contributions to problems that they ascribe

to that person. Interpersonal deficits are addressed by analysing present relationship problems and previous attempts to overcome them, and then discussing alternatives. In the final two or three sessions, future problems are anticipated and considered.

Several clinical trials have shown that IPT is effective for depressive disorders in adults and adolescents (Mufson *et al.*, 2004), dysthymia (Markowitz, 2003), and bulimia nervosa. For an account of IPT, see Blanco *et al.* (2009).

## Cognitive behaviour therapy

All psychiatric disorders have cognitive and behavioural components, and both have to change if the patient is to recover. With other treatments, change comes about indirectly—for example, as mood improves with antidepressant therapy, or as conflicts become resolved with psychotherapy. CBT aims to change cognitions and behaviour directly. Unlike dynamic psychotherapy, it is not concerned with the origins of the disorder, but what is maintaining it now.

*Behaviour therapy* focuses on what provokes symptoms or abnormal behaviour. *Avoidance* is particularly important in phobic and anxiety disorders, as it prevents the normal extinction of the anxiety response. Many behaviours are *maintained by their consequences*. For example, the reduction in anxiety following escape from stressful situations reinforces the phobic avoidance. *Reinforcement* also entrenches symptoms, such as when parents pay more attention to a child's noisy and unruly behaviour.

*Cognitive therapy* generally focuses on two kinds of abnormal thinking—*automatic thoughts* and *dysfunctional beliefs and attitudes*. Automatic thoughts are often stereotyped and exaggerated responses to stressors such as 'everybody despises me' after mild criticism. They provoke an immediate emotional reaction, usually of anxiety or depression, and undermine self-esteem. Dysfunctional beliefs and attitudes determine the way in which situations are perceived and interpreted.

Three factors are thought to maintain dysfunctional beliefs and attitudes.

1. *Attending selectively* to evidence that confirms them, and ignoring or discounting evidence that contradicts them. For example, patients with social phobias attend more to the critical behaviour of others than to signs of approval.
2. *Thinking illogically* in stereotyped ways (Box 24.4).
3. *Safety-seeking behaviour*, believed to reduce an immediate threat, but perpetuates the fear.

### General features of cognitive behaviour therapy

Core features of CBT.

- *The patient is an active partner.* The patient takes an active part in treatment, with the therapist acting as an expert adviser who asks questions, and offers information and guidance.
- *Socratic questioning.* Automatic thoughts are challenged by questioning them—are there other ways of understanding what is happening? What are the implications of thinking this way?
- *Attention to provoking and maintaining factors.* The patient keeps daily records to identify factors that precede or follow the disorder and which may be provoking or maintaining it. This kind of assessment is sometimes called the *ABC approach*, the initials referring to **A**ntecedents, **B**ehaviour, and **C**onsequences.
- *Attention to ways of thinking*, revealed by recording thoughts associated with the behavioural or emotional disturbances.

#### Box 24.4 Examples of illogical thinking

**Overgeneralization.** Drawing general conclusions from single instances (e.g. 'He does not love me, so no one will ever love me').

**Selective abstraction.** Focusing on a single unfavourable aspect of a situation and ignoring favourable aspects.

**Personalization.** Blaming themselves for the actions of other people.

**All-or-nothing thinking.** Viewing people or situations as 'black-and-white'.

- *Treatment as investigation ('collaborative empiricism')*. Therapeutic procedures are usually presented as experiments which, even if they fail, help reveal more about the condition.
- *Homework assignments and behavioural experiments*. Patients practise new behaviours between sessions with the therapist, or carry out experiments to test explanations suggested by the therapist (Box 24.5).
- *Highly structured sessions*. At each session, an agenda is agreed, and progress since the last session is reviewed, including any homework. New topics are considered, the following week's homework is planned, and the main points of the session are summarized.
- *Monitoring*. Assessment includes checking daily records kept by the patient, and often includes rating scales.
- *Treatment manuals* describe procedures and how they are applied. Manuals ensure that therapists stick to effective procedures.

**Box 24.5 An agoraphobic patient's record of a behavioural experiment**

**Situation:** Shopping in a crowded supermarket.

**My predictions:** I shall panic and feel dizzy. Unless I tense my stomach muscles and breathe deeply, I shall faint.

**Experiment:** When anxious, do not tense stomach muscles or breathe deeply.

**Outcome:** I did panic quite badly. I felt dizzy, but less so than usual. I did not faint.

**What I learned:** I did not faint despite a severe panic, and without actions to prevent fainting. I may be wrong thinking I shall faint whenever I panic; tensing and deep breathing may not help. My therapist could be right in thinking that deep breathing makes me feel more dizzy.

**What I should do next:** Repeat the experiment next time I go shopping.

**Box 24.6 Topics to be considered during assessment for cognitive behaviour therapy**

1. **A description of each problem, including behaviour, thoughts, and emotions associated with it**
   - Where it occurs most often
   - Common prior events
   - Response to these events
   - What follows the problem
2. **Factors that alleviate or worsen the problem**
3. **Maintaining factors**
   - Avoidance
   - Safety behaviours
   - Selective attention
   - Ways of thinking
   - The responses of others

## Assessment for cognitive behaviour therapy

### Topics to be covered

As well as a full psychiatric history, certain additional topics are addressed (see Box 24.6). For each of the presenting problems, the therapist enquires about antecedents, behaviour, and consequences (the ABC approach). *The term 'behaviour' is used to include thinking and emotion, as well as actions*. By considering the sequence ABC on several occasions, regular patterns of thinking and responding are identified. The therapist focuses on the patient's reasons for their beliefs, which is essential for planning experiences that will change them.

### Sources of information

*Self-monitoring*: records of thoughts, behaviours, and experiences over days or weeks, made in real time. The record sheet usually has columns for symptoms, thoughts, emotions, and actions, plus the day and time at which they occurred. Events immediately preceding the problem are noted, as well as those occurring at the time and afterwards.

*Observations during treatment sessions*: the patient may be asked to imagine situations in which problems arise, and to report accompanying thoughts and emotions. Symptoms resembling the disorder may be induced (e.g. panic-like symptoms produced by hyperventilation), and accompanying thoughts and emotions noted.

*Special interviewing*: some patients need help to become aware of their maladaptive beliefs. *Laddering* involves a series of questions, each about the answer to the previous question. For example, a patient with an eating disorder might be asked what would happen if she were to gain weight, and she answers that she would

lose her friends. To the question 'Why?' she might reply that she would be unlikeable. To a further question 'Why?' she might say that only thin people are attractive and popular.

### The formulation

The information obtained in these various ways is combined with the usual psychiatric history in a formulation consisting of:

- the type of *events that provoke symptoms*
- any *special features of these events*
- *background factors*
- *maintaining factors*, including avoidance, safety behaviours, and ways of thinking.

The formulation is guided by a cognitive model of the disorder. The therapist discusses the formulation with the patient and may build it up, step by step, perhaps using a diagram on paper or whiteboard. The formulation is modified in light of the discussion.

## Behavioural techniques

There are many behavioural techniques, some for a single disorder (such as the enuresis alarm; see page 692), and others such as exposure that can be used for a variety of disorders. Here we describe the more commonly used methods. Evidence for them is considered in the relevant chapters for the particular disorders.

### Relaxation training

This is the simplest behavioural technique, and is mainly useful for subthreshold states of anxiety, for stress-related disorders such as initial insomnia (Viens *et al.*, 2003), and for mild hypertension (Yung and Keltner, 1996). In 'progressive relaxation', patients are trained to relax individual muscle groups one by one, and to regulate their breathing (Jacobson, 1938). Relaxation is used in anxiety disorders with good effects (Öst and Breitholtz, 2000) and can be learned in part from pre-recorded instructions or in a group. However, it has to be practised regularly, and many patients lack the motivation to do this.

### Exposure

Exposure is used to reduce avoidance behaviour, especially in the treatment of phobic disorders. For simple phobias it is often sufficient to use exposure alone, but for complex phobic disorders exposure is usually combined with cognitive procedures (page 000). Exposure can be carried out *in practice* by confronting the actual situations that provoke anxiety or *in imagination* by imagining the phobic situations vividly enough to induce anxiety. Exposure can be gradual, progressing through a series of increasingly difficult situations (*desensitization*), or abrupt and intensive (*flooding*). In practice, exposure is usually paced between these two extremes, preferably in practice rather than in imagination.

#### Desensitization

In desensitization the patient is helped to:

1. *Construct a hierarchy* of situations that provoke increasing degrees of anxiety. About 10 items are chosen with an equal increment of anxiety between them. Sometimes two or more hierarchies can be constructed if no obvoius theme links the stressful situations.
2. *Enter or imagine entering the situations* on each step of the hierarchy until achieved without anxiety.
3. *Use relaxation* while entering or imagining the situation to reduce the anxiety response, and enhance the imagery.

#### Flooding

In flooding, the patient enters the most feared situation from the start, and remains there until the anxiety has diminished. The process is repeated with other near-maximal stimuli. The experience is distressing and the results are no better than those obtained with desensitization, so flooding is seldom used.

#### Exposure in routine practice

Sessions last for about 45 minutes of entering a feared situation every day, either alone or with a relative or friend. Usually anxiety diminishes with each exposure. Sometimes, if the anxiety becomes overwhelming, the treatment has to restart from a less stressful situation. Disengagement from anxiety-provoking situations by thinking of other things is a commonly encountered defence.

### Exposure with response prevention

This is a treatment for obsessional rituals. The pressure for rituals decreases if they can be resisted for periods of about an hour.

1. The therapist *explains the rationale for treatment and agrees targets* for exposure, such as to touch a 'contaminated' object such as a door handle and not to wash their hands for the next hour. A more advanced target might be to do all the household cleaning without washing their hands until the task is completed. Patients need to feel confident that every task will be agreed in advance and that they will never be faced with the unexpected.

2. The therapist may demonstrate the necessary exposure, a procedure known as *modelling*.
3. Initially the therapist accompanies and supports the patient during prevention, but later the patient does this on their own.
4. With progress the patient practises entering previously avoided situations that normally provoke rituals. This is called *exposure*.

The obsessional thoughts that accompany rituals usually improve as the rituals are brought under control. Obsessional thoughts that occur without rituals are more difficult to treat. *Habituation training* is a form of mental exposure treatment in which patients dwell on the obsessional thoughts for long periods or listen repeatedly to a recording of the thoughts spoken aloud for an hour or more. Alternatively, *thought stopping*, is used (see distraction techniques on page 692).

## Social skills training

Some aspects of social behaviour include skills that can be learned—for example, making eye contact, or starting a conversation. These skills can be improved through modelling, guided practice, role-play and video feedback. The training is mainly useful for socially anxious people to improve self-confidence and in the management of adolescents with autism and Asperger's syndrome. It was also, for a time in the 1970s and 1980s, intensively pursued within rehabilitation for people with psychoses (Leff *et al.*, 1982). Although it failed to deliver the expected reductions in relapse, the techniques were adapted successfully with families to reduce high expressed emotion.

### Assertiveness training

Assertiveness training is a form of social skills training in which patients practise appropriate self-assertion. By a combination of coaching, modelling, and role reversal, patients are encouraged to practise appropriate verbal and non-verbal behaviour, and to judge the level of self-assertion that is appropriate to various situations. Assertiveness training has, surprisingly, been found helpful not just with timid people but also with aggressive individuals, as it teaches a more appropriate way of channelling anger.

### Anger management

In this form of social skills training, patients are helped to:

- identify situations that lead to anger
- identify attitudes that lead to anger that is out of proportion
- identify factors that reduce restraints on anger, especially the use of alcohol
- discover and practise alternative ways of dealing with situations that provoke anger—for example, delaying their response until anger can be brought under control ('count to 10').

## Self-control techniques

All behavioural treatments aim to increase patients' control over their own behaviour. Self-control techniques attempt to do this directly without the intermediate step of changing thoughts or emotions as in cognitive therapy. Self-control techniques are based on operant conditioning principles, and on the studies by Bandura (1969) of the role of self-reward in social behaviour. Overeating and excessive smoking are examples of target behaviours. Self-control training is usually part of a wider cognitive behaviour programme.

Self-control treatment has three stages:

1. *Self-monitoring*. Daily records are kept of the problem behaviour and the circumstances in which it arises. Keeping a record enhances motivation by demonstrating the severity of the problem. These records are subsequently used to assess progress.
2. *Self-evaluation*. Achievements to be rewarded are agreed with the patient, and progress is monitored by the patient.
3. *Self-reward*. A system of reward points that can be accumulated to earn a material reward such as a week without smoking may be rewarded by going out for dinner.

## Contingency management

Contingency management, like self-control techniques, provides rewards for desired behaviour and removes reinforcement from undesired behaviour. However, instead of relying on self-monitoring and self-reinforcement, in contingency management another person monitors the behaviour and provides the reinforcers. The latter are usually social reinforcers, such as indications of approval or disapproval, or enjoyable activities earned by accumulating points. Contingency management in the form of *token economies* was used mainly in the treatment of children and people with learning disability in residential settings, but is now seldom used because of its limited effect and generalizability. More recently, direct financial rewards have been given for changes in behaviour in various public health initiatives (Marteau *et al.*, 2009), including in mental health (Burton *et al.*, 2010). Direct payments have been

shown to increase adherence to antipsychotic maintenance management (Priebe *et al.*, 2013), but this approach meets stern resistance.

Contingency management involves four stages.

1. *Define and record the behaviour*. The behaviour to be changed is defined and another person (usually a nurse or a parent) is trained to record it.
2. *Identify the stimuli and reinforcements*. The events that regularly precede the behaviour are identified. Similarly, the events that immediately follow the behaviour, *reinforcers*. Those involved may be quite unaware of their role in stimulating or reinforcing such behaviours.
3. *Change the reinforcement*. Reinforcement is directed away from the problem behaviours and towards desired behaviours. For example, parents are helped to attend less when their child shouts and more when he is quiet—always a difficult thing to keep up.
4. *Monitor progress*. Records are kept of the frequency of the problem and desired behaviours.

### Enuresis alarms

This behavioural treatment is based on classical conditioning and was developed specifically for nocturnal enuresis (page 469). The original 'pad and bell' comprised two metal plates under the sheets attached to a battery and a buzzer, activated if the child passed urine. Nowadays a small sensor is attached to the pyjamas. The noise of the alarm wakes the child, who must then rise to empty his bladder and, if necessary, change the bed sheet. With repetitions the child begins to wake before his bladder empties involuntarily.

## Complex behavioural techniques

### Habit reversal

Habit reversal is a complex procedure that is generally used to treat tics, Tourette's syndrome, and stuttering. The classical treatment has five components—training in becoming aware of the onset of the behaviour, monitoring the behaviour, training in initiating competing responses that are incompatible with the behaviour, relaxation, and social support.

## Eye movement desensitization and reprocessing

This treatment was developed for post-traumatic stress disorder (PTSD). It has three components:

- *exposure* using imagined scenes of the traumatic events
- *a cognitive component* in which the patient attempts to replace negative thoughts associated with the images with positive ones
- *saccadic eye movements* induced by asking the patient to follow rapid side-to-side movements of the therapist's finger.

Eye movement desensitization and reprocessing (EMDR) remains controversial, particularly with regard to whether the eye movements contribute to its efficacy (Russell, 2008). A review (Silver *et al.*, 2008) suggests that it is effective, although the quality of the evidence is relatively poor.

## Behavioural techniques that are no longer in general use

*Biofeedback* has not been proved to add to the effects of relaxation alone. *Aversion therapy*, one of the earliest behavioural techniques, was developed in the 1930s as a treatment for alcohol dependence. Negative reinforcement was used to suppress unwanted behaviour. Its effects are temporary, and it was criticized as being more of a punishment than a treatment.

## Cognitive techniques

Four methods are commonly used to bring about cognitive restructuring (i.e. change in cognitions).

1. *Distraction*, or focusing attention away from distressing thoughts. This is done by attending to something in the immediate environment (e.g. the objects in a shop window), by engaging in a demanding mental activity (e.g. mental arithmetic), or by producing a sudden sensory stimulus (e.g. snapping a rubber band on the wrist), called 'thought stopping.'
2. *Neutralizing*. The emotional impact of anxiety-provoking thoughts can be reduced by rehearsing a reassuring response (e.g. 'My heart is beating fast because I feel anxious, not because I have heart disease'). Patients may carry a 'prompt card' on which the reassuring thoughts are written.
3. *Challenging beliefs*. The therapist produces evidence that contradicts the patient's beliefs. However, such beliefs persist and, for these, if they are severe, CBT is indicated. CBT therapists do this by asking questions, as in Box 24.7, and arranging behavioural experiments, as in Box 24.5.
4. *Reassessing the patient's responsibility*. We all overestimate our responsibility for events that have many determinants. Constructing a *pie chart* that shows all of the determinants can help reassess such responsibility. Allocating appropriately sized sectors to other identified factors before entering their own contribution demonstrates that there is less room for the patient's contribution than had been supposed.

**Box 24.7 Useful questions for challenging beliefs**

What is your evidence for this belief?
Is there an alternative way of looking at the situation?
How might other people think if they were in the same situation?
Are you focusing on what you felt rather than on what happened?
Are you forgetting relevant facts? Are you focusing on irrelevant matters?
Are you overestimating how likely this is?
Are you applying higher standards to yourself than you would to others?
Are you thinking in black-and-white terms when you should be considering shades of grey?
Are you overestimating your responsibility for the outcome?
What is the worst that could happen? How bad would this be?
What if the worst should happen? Could you cope?
Are you underestimating what you can do to deal with the situation?

Adapted from Clark DM, Cognitive–behaviour therapy for anxiety disorders. In: MG Gelder, NC Andreasen, JJ López-Ibor Jr, Geddes JR, (eds.), The New Oxford Textbook of Psychiatry, Copyright (2000), with permission from Oxford University Press.

## Cognitive behavioural treatments

CBT is now the most widely used psychological treatment internationally. It dominates UK provision for a range of disorders—mainly anxiety and depression, but also eating disorders, and it has even been used in psychosis. It has a coherent theory and a set of practices based on a collaborative approach between patient and therapist over a limited (often predetermined) number of sessions. The approaches are succinctly explained by Westbrook *et al.* (2011).

### Treatments for anxiety disorders

In anxiety disorders, cognitive techniques are combined with exposure. The importance of exposure relates to avoidance behaviour, more in the phobic disorders and less in generalized anxiety disorders.

Three kinds of cognition are considered in treatment:

1. *Fear of fear*: general concerns about the effects of being anxious (e.g. losing control).
2. *Fear of symptoms*: concerns about specific symptoms (e.g. fears that palpitations are a sign of heart disease).
3. *Fear of negative evaluation*: concerns that other people will react unfavourably to the patient.

The balance of these cognitions varies in different anxiety disorders. In generalized anxiety disorder, fear of fear and general worry predominate (page 167). In social phobia, fears of negative evaluation are particularly important, as are concerns about blushing and trembling. In agoraphobia, fear of fear (especially thoughts that the person will faint, die, or lose control) and fears about the symptoms of a panic attack are central. Treatment involves the techniques outlined above—giving information, questioning the logical basis of the fears, and arranging behavioural experiments.

*Information* about the physiology of anxiety helps patients to attribute symptoms such as dizziness and palpitations correctly, instead of to physical illness, often heart disease. The *illogical basis of the fears* is discovered by questioning the patient's own evidence for the beliefs. *Behavioural experiments* are devised to test the patient's beliefs and the alternative explanation suggested by the therapist.

*Anxiety management* is a general treatment for anxiety disorders. It has six stages:

1. *Assessment*. The patient keeps a diary record of:
   - the frequency and severity of symptoms
   - the situations in which they occur
   - avoidance behaviour.
2. *Information* about the physiology of anxiety and any other matters that will correct misconceptions.
3. *Explanation* of the various vicious circles of anxiety.
4. *Relaxation* training as a means of controlling anxiety.
5. *Exposure* to situations that provoke anxiety.
6. *Distraction* to reduce the impact of anxiety-provoking thoughts.

*Treatment for panic disorder* is focused on the belief that physical symptoms of anxiety are evidence of a serious physical condition, usually heart disease. These beliefs create a vicious circle in which anxiety symptoms such as tachycardia generate additional anxiety, and this further increases the physical symptoms. Treatment consists of:

1. *Explanation* of how physical symptoms are part of the normal response to stress, and how fear of these symptoms sets up a vicious circle of anxiety.
2. *Record keeping*. Patients record the anxious cognitions that precede and accompany their panic attacks.

3. *Demonstration*. The therapist demonstrates that:
   - physical symptoms can provoke anxious thoughts (e.g. by asking the patient to induce such symptoms by over-breathing or strenuous exercise and noting the accompanying thoughts and fears)
   - these thoughts can induce anxiety (e.g. by asking the patient to focus their mind on the cognitions and observe the effect).

This demonstration that physical symptoms lead to anxious thoughts, which in turn lead to anxiety, helps to *validate the vicious circle account* of the aetiology of panic attacks.

4. *Safety-seeking behaviours*. Attention is given to safety behaviours, and to any dysfunctional beliefs that make ordinary situations stressful.
5. *Behavioural experiments* to test the patient's ideas against those proposed by the therapist.
6. *Cognitive restructuring* follows the observation that symptom changes affect the severity of the panic attacks. Repeating the sequence gradually leads to control of the panic attacks.

*Treatment for PTSD* includes attention to the characteristic intrusive visual images in the condition. Patients repeatedly imagine the situations depicted in these images, as they would do in systematic desensitization. They try to change the content in small steps to images that are less distressing. Research into the use of imagery in CBT and in desensitization has become a focus for several treatment initiatives in PTSD and beyond (Hackmann *et al.*, 2011). Patients are also helped to integrate and process the fragmentary and distressing recollections of the traumatic events. (Treatment for PTSD is considered further on page 147.)

Overall, CBT is the psychological treatment of choice for anxiety disorders (Olatunji *et al.*, 2010). For a review of the current status and practice, see Clark and Beck (2011).

## Cognitive behaviour therapy for depressive disorders

Cognitive therapy for depressive disorders was developed by A. T. Beck (1976). It is a complex procedure intended to alter three aspects of the thinking of depressed patients—negative intrusive thoughts, beliefs and assumptions that render ordinary situations stressful, and errors of logic that allow these beliefs and assumptions to persist despite evidence to the contrary.

*Monitoring* is of three kinds.

1. Patients identify intrusive thoughts (e.g. 'I am a failure') by writing down their thoughts when their mood is low.
2. Therapists uncover dysfunctional beliefs and assumptions by asking questions such as those shown in Box 24.7. A typical belief of a depressed patient is 'Unless I always try to please other people, they will not like me.'
3. Patients record their activities and identify if it was pleasurable and if it was accompanied by a sense of mastery and achievement.

If the patient is severely depressed, the monitoring of thoughts is deferred and attention is focused on activities. The resulting 'activity schedule' is used to encourage activities that have been identified as leading to pleasure and mastery. The schedule also helps to bring a sense of order and purpose. At this stage the therapist helps the patient to reduce the need to make decisions, which are difficult for someone who is severely depressed.

If the patient is less severely depressed, treatment begins with an explanation of the cognitive model of depression, and an attempt is made to reduce intrusive thoughts. This is done through distraction and by rehearsing reassuring alternatives (e.g. 'Even though I think my work is bad, my boss praised me yesterday'). To help the patient to concentrate on the positive statement, the alternative can be written on a prompt card. As treatment proceeds, more time is spent in challenging depressive cognitions using the techniques outlined in Box 24.8 combined with behavioural experiments.

The following points are important in relation to cognitive therapy for depression.

- *Reviewing evidence*. Depressed patients are particularly prone to focus on evidence that supports their negative ideas, and to overlook evidence that contradicts them. The therapist should help the patient to give appropriate weight to the positive evidence.
- *Considering alternatives*. Depressed patients often reject positive alternatives to their thoughts and beliefs. The therapist can help the patient to consider alternatives by asking questions such as 'What do you think that another person would think about this situation?' or 'What would you think if another person had done what you have done?' (For additional questions, see Box 24.8.) Behavioural experiments are used to challenge beliefs and assumptions.
- *Considering consequences*. Patients should be helped to see the consequences of thinking negative thoughts. For example, the thought that everything

**Box 24.8 Logical errors in depressive disorders**

**Exaggeration:** magnifying small mistakes and thinking of them as major failures.

**Catastrophizing:** expecting serious consequences from minor problems (e.g. thinking that a relative who is late home has been involved in an accident).

**Overgeneralizing:** thinking that the bad outcome of one event will be repeated in every similar event in future (e.g. that having lost one partner, the person will never find a lasting relationship).

**Ignoring the positive:** dwelling on personal shortcomings or on the unfavourable aspects of a situation while overlooking the favourable aspects.

is hopeless may prevent them from attempting even small changes that could accumulate beneficially.

- *Considering errors of logic* (Box 24.8). The patient should be helped to ask questions such as 'Am I thinking in black-and-white terms?', 'Am I drawing too wide conclusions from this single event?', 'Am I blaming myself for something for which I am not responsible?', or 'Am I exaggerating the importance of events?' These questions are asked in relation to specific ideas, beliefs, and situations.
- *Considering beliefs*. As depression improves, more attention is given to the patient's beliefs, as abnormal beliefs can lead to relapse. Laddering (page 689) can uncover such beliefs. Useful questions include 'In what ways is this idea helpful?', 'In what ways is it unhelpful?' and 'What alternatives are there?'
- *'Mindfulness.'* People who are prone to depression may have a cognitive set in which thoughts and feelings are experienced as events rather than as aspects of the self. Modifying this set reduces the risk of relapse. Mindfulness-based cognitive therapy (MBCT) is an 8-week programme conducted in groups of 8–15 patients (Segal *et al.*, 2012), designed to modify these cognitive routines and reduce the risk of relapse. MBCT in addition to standard care significantly reduces the relapse rate in patients suffering from recurrent major depression (Chiesa and Serretti, 2010), and is recommended by the National Institute for Health and Clinical Excellence (2009a). The contribution of the specific 'mindfulness' component of treatment is unclear.

## Cognitive behaviour therapy for bulimia nervosa

Currently CBT therapists emphasize the applicability of their approach for all eating disorders and believe the strict distinction between bulimia nervosa and anorexia nervosa is unhelpful and the same approach (CBT-E) should be applied. Evidence for effectiveness is strong for bulimia nervosa but weaker for anorexia nervosa. See Chapter 13 for review of the evidence for, and contemporary approaches to, psychological treatment for eating disorders.

The treatment of bulimia nervosa with CBT is based on the idea that the central problems are excessive concern about shape and weight, and low self-esteem. This leads to extreme dieting, followed by binge eating and often by self-induced vomiting and abuse of laxatives and diuretics. This vicious circle can be interrupted by:

- restoring a regular pattern of eating three meals a day
- increasing restraint on binge eating
- discussing ideas about shape, weight, and self-esteem.

The therapist attends first to the disordered pattern of eating before attempting to modify cognitions. He *explains the cognitive model* and relates it to the patient's experience. He emphasizes the importance of regular meals, the causal role of long periods of fasting, and the adverse effects of repeated vomiting, and of repeatedly taking laxatives and diuretics. The patient *keeps a record* of what they eat, when they eat, and when they induce vomiting or take laxatives and diuretics. The situations that provoke binge eating are recorded. With this information, the patient is better able to control the urge to overeat and, subsequently, the bouts of vomiting. The patient takes a number of precautions to help them to control their eating:

- Meals are eaten in a place separate from that in which food is prepared or stored.
- A limited amount of food is available at each meal—for example, two slices of bread are put on the table, rather than a whole loaf.
- A small amount of food is left on the plate and then thrown away, to mark the end of the meal.
- When shopping for food, a list is made in advance and purchases are strictly limited to the items and quantities on the list.

The therapist strongly discourages frequent checking of weight and of appearance, as both habits maintain the disorder.

Because patients often binge when they are unhappy, lonely, or bored, they are helped to *find other ways of*

*dealing with unpleasant emotions*. For example, they might seek out friends, listen to music, or simply go out for a walk. Vomiting usually stops when the binges are under control. The dangers of abuse of laxatives and diuretics are emphasized once more, and the patient is strongly encouraged to dispose of all such drugs safely.

When eating is under better control, *attention turns to cognitions*. The patient records these together with the eating behaviour. Relevant cognitions are concerned not only with body shape and weight, but also with self-esteem. Examples of these cognitions include the following:

- to be fat is to be a failure
- dieting is a sign of strong will and self-control
- it is necessary to be thin if one is to be happy and successful.

Such beliefs persist because of the *illogical ways of thinking* (see Box 24.4). Identifying these illogical ways of thinking is not to deny that many of them receive strong social endorsement. The fact that many people agree with such cognitions does not mean that the thinking is not wrong. The questioning used to identify cognitions and illogical thinking resembles that described in Box 24.7.

Treatment also exists in a self-help format that can be effective with well-motivated patients (Box 24.9).

## Box 24.9 Self-help for bulimia nervosa

### Monitoring
- A daily record of eating, binges, and vomiting
- Weighing no more than once a week

### Regular planned meals
- Three normal-sized meals a day
- Three small between-meal snacks

### Stop binges
- Eat only the planned amount
- Keep other food out of sight
- Keep limited stocks of food
- Take just enough money when buying food

### Control vomiting
- Urge to vomit declines as binges stop

### Control purging
- Reduce laxatives/diuretics, if necessary, in stages

### Find alternatives to binge eating
- List distracting activities
- Try them

### Reduce life problems
- Problem-solving counselling

For further information, see Fairburn (2013).

## Cognitive behaviour therapy for hypochondriasis

The approach is twofold—first, to identify behaviours that maintain the disorder and, second, to change hypochondriacal ideas directly. The relevant behaviours include:

- repeatedly seeking reassurance, which relieves anxiety briefly but reinforces the concerns in the longer term
- checking bodily functions (e.g. measuring the pulse rate)
- checking bodily structure (e.g. palpating for lumps).

Hypochondriacal ideas are treated in the same way as anxiety and depressive disorders, using questioning and behavioural experiments. CBT has been found to be moderately helpful and MBCT has also been tested (Williams *et al.*, 2011).

## Cognitive behaviour therapy for schizophrenia

Two approaches are used. The first aims to help the patient to *reduce and cope better with stressors* that may be exacerbating the disorder, and to *cope better with hallucinations*. The techniques for dealing with stressors are similar to those described above—namely, identifying and finding ways of dealing with stressful situations. Patients are helped to cope with hallucinations by distancing themselves and repeating statements that neutralize their effects.

The aim of the second approach is to *challenge delusions*. This approach is directed to secondary delusions, especially those that seem to have developed to explain hallucinations. The therapist encourages the patient to regard the delusions as beliefs rather than facts, and to discuss alternatives. To do this effectively requires a detailed formulation of each patient's delusions and other beliefs. When questioning the basis of the delusions, the therapist should avoid challenging them directly. Instead, he should try to persuade the patient to consider the consequences of holding the delusion and what would be the consequences of thinking in another way. The therapist then tries to reformulate the delusion as a way of making sense of certain experiences, which can be understood in terms of the knowledge the patient had at the time, but should now be reconsidered.

Turkington *et al.* (2005) have taught the approach to nurses with considerable success, and it is a module in several postgraduate mental health nursing courses (www.thorn-initiative.org.uk).

CBT is included as an integral component of treatment in current schizophrenia treatment guidelines. For details, see Chapter 11.

### Cognitive therapy for personality disorder

Beck suggested that the techniques he had developed for the treatment of depressive disorders could be adapted for personality disorders. He described beliefs and ways of thinking that characterize each type of personality disorder in terms of self-view, the views of others, general beliefs, perceived threats, main strategies for coping, and primary affective responses. Beck also suggested a 'schema' characteristic of each type of personality disorder and consisting of statements that can be challenged in treatment. For example, the schema for histrionic personality disorder includes the following statements:

- 'Unless I captivate people, I am nothing'
- 'To be happy, I need other people to admire me'
- 'I must show people that they have hurt me.'

Schemas are challenged using the general techniques of cognitive therapy (see Box 24.7). There is some weak evidence for the value of schema-based CBT in borderline personality disorder (Blum *et al.*, 2008) and they are widely used in forensic settings.

### Dialectic behaviour therapy for borderline personality disorder

Marsha Linehan (Linehan *et al.*, 1994) developed this treatment for patients with borderline personality disorder who repeatedly harmed themselves. Despite the name, it uses cognitive as well as behavioural techniques. The treatment is highly structured and described in a manual. Therapy is intensive, with individual sessions, skills training in a group, and access by telephone to the therapist between sessions. It is delivered by a small team of therapists and lasts for up to a year.

Individual sessions have four elements:

1. *Cognitive behavioural techniques*, including self-monitoring, and a collaborative style of working with the patient.
2. *Dialectical ways of thinking about problems*, such as seeing causality in terms of 'both/and' rather than 'either/or', and the possibility of reconciling opposites. This approach is particularly valuable to avoid unhelpful confrontations.
3. *'Mindfulness'*—the practice of detachment from experience.
4. *Aphorisms*—that is, phrases that encapsulate the approach (e.g. 'Although I may not have caused all my problems, I still have to solve them').

During the sessions, treatment goals are prioritized, dealing first with life-threatening situations, then with matters that could reduce collaboration with treatment, and after that with behaviours that impair quality of life.

*Skills training sessions* are usually provided in weekly groups lasting for 2 hours or more. Patients learn how to control anger and other strong emotions, how to tolerate distress, how to develop interpersonal skills, and mindfulness. The procedures for teaching these skills are described in a manual.

*Telephone contact* is designed to help patients get through crises by using the skills that have been learned in the sessions. The hours at which contact will be available are agreed in advance between patient and therapist.

Dialectic behaviour therapy has been claimed to give good results with borderline personality disorder, and has become widely available, although providing the full programme can be difficult. The beneficial effects are primarily on behaviour (i.e. reducing self-harming and suicide attempts) rather than on mood and self-esteem, and the degree of prescription in its provision may be a barrier to better understanding of what is effective within it.

## Individual dynamic psychotherapies

### Brief insight-oriented psychotherapy

This kind of psychotherapy seeks to uncover the origins of a psychiatric disorder in early life experience, identifying unconscious factors that account for abnormal thinking, emotions, and behaviour. In its usual form, it aims to produce change, with weekly sessions over 6–9 months. The treatment is focused upon specific problems—hence an alternative term *focal psychotherapy*. The procedures can be summarized as follows.

### Starting treatment

The initial assessment is considered very important and is not hurried. It assesses suitability for brief treatment and selects the problems that will be the focus of treatment. This focus and the length of treatment are agreed with the patient, and that not all problems will be resolved is acknowledged. The therapist explains the general aim of linking past and present behaviour patterns, and that the therapist's role is to help the patient to find their own solutions. An atmosphere is created in which the patient feels involved and listened to, and one that is safe to explore ideas and fantasies that were previously hidden.

### Subsequent sessions

In subsequent sessions the patient is encouraged to:

- give specific examples of the selected problems, and consider how they thought, felt, and acted at the time
- talk freely about these emotionally painful subjects
- express ideas and feelings even if they seem illogical or shameful
- review their own part in difficulties they usually ascribe to other people
- look for common themes in their problems and their responses
- consider how their present patterns of behaviour began, their original function, and why they persist
- consider alternative ways of thinking and behaving in distressing situations
- try out new responses to their emotions.

*The therapist's role* is to respond to the emotional as well as the intellectual content of the patient's descriptions (e.g. 'It sounds as though you felt angry when this happened'). He helps the patient to examine feelings previously denied, and to consider past situations in which similar feelings were experienced. Non-verbal behaviour can point to problems that are not being expressed directly. He maintains the agreed focus—avoiding problem areas too complex to address.

*Interpretations* are key features of dynamic therapy. These are essentially hypotheses linking present to past events and behaviours. They can include observations of defence mechanisms, such as blocks in recall during the sessions.

*Transference and countertransference*. The therapist has to be alert to intense emotions arising in sessions—transference and countertransference. *Transference* feelings about the therapist are a key to how the patient responded to key figures in childhood. In brief therapy, *countertransference* is usually taken to include all the therapist's emotional responses to the patient. Insight into countertransference can be difficult so therapists have their own regular supervision.

*Ending treatment*. The difficulty, and inevitability, of termination is discussed from an early stage. As it approaches, the patient should have a better understanding of their problems and be more confident about dealing with them. Endings often involve a 'flare up' of symptoms, allowing their understanding to be refreshed. It is common to arrange a couple of follow-up appointments spaced over 2 or 3 months.

### Indications

The indications for short-term dynamic psychotherapy are based predominantly on clinical experience. It is chosen when the problem:

- can be conceptualized in psychodynamic terms
- is emotional or interpersonal (rather than a specific psychiatric disorder)
- involves low self-esteem, and recurrent problems in forming intimate relationships.

In addition, treatment is more effective when the patient:

- has adequate social support while treatment continues
- is willing to attempt change through their own efforts
- can look honestly at their own motives
- is capable of ceasing self-exploration when the sessions end.

*Contraindications* include obsessional or hypochondriacal disorders, severe mood disorder, psychoses, and some personality disorders, especially those characterized by acting out. For a review of the theories and methods of brief individual dynamic psychotherapy, see Hobbs (2005).

## Cognitive analytic therapy

Cognitive analytic therapy is a brief therapy developed by a GP, Tony Ryle. Treatment is based on a 'procedural sequence model'. This proposes that behaviour follows a set sequence. Procedural sequences can be faulty in three ways.

- *Traps* are repetitive cycles of behaviour in which the consequences of behaviour perpetuate it. For example, depressed people think in ways that lead to failure, making further depression more likely.

- *Dilemmas* are false choices or unduly narrowed options. For example, people who fear angry feelings may think that the only alternative to aggression is excessive submission. This allows others to take advantage of them, making them even more angry.
- *Snags* are the anticipation of highly negative consequences of actions such that the action is never carried out and therefore never subjected to a reality check.

The *theory of reciprocal roles* was developed when cognitive analytic therapy was used with borderline personality disorder patients. Ryle proposed that people develop internalized 'templates' of social roles which consist of a role for the self, a role for the other person, and a paradigm of the relationship. Such roles include teacher/pupil, bully/victim, and abuser/abused. When one person adopts one of the roles, the other person feels under pressure to adopt the reciprocal role. These 'templates' can become narrow and inflexible.

### Outline of the treatment

Following assessment and an explanation of the treatment, the patient is helped to construct a list of problems, moods, and behaviours, and records them in a diary. Recurrent maladaptive behaviours, role problems, and faulty procedural sequences are identified and formulated, often using diagrams to explain the procedural sequences. Specific examples of general procedures are sought in the diaries, and homework is arranged to try out alternative procedures—for example, asserting oneself appropriately. The origins of maladaptive procedures are also considered from a psychodynamic perspective—present maladaptive behaviour may have arisen from behaviour that was adaptive when the person was younger.

The formulation is summarized in the form of a letter to the patient. The therapist helps the patient become aware of and change their behaviours, procedural sequences, and role problems. Transference and countertransference problems are anticipated, identified, and discussed. Treatment usually lasts either 16 or 24 sessions. When it ends, the therapist writes another letter to the patient summarizing their progress, prognosis, and future action, and the patient is asked to write to the therapist summarizing their experience. Patients often need help to become aware of their problems ('develop an observing I'). This is achieved by modelling the evaluation and analysis of problems using diagrams. There is some early evidence of its value in young patients and those with borderline personality disorder (Chanen *et al.*, 2008). For further information about cognitive analytic therapy, see Ryle and Kerr (2016).

## Long-term individual dynamic psychotherapy

Long-term dynamic psychotherapy is a general term for most individual psychotherapy that lasts for longer than 9 months. The best known is psychoanalysis, and most methods are derived from it. Long-term dynamic psychotherapy is costly, and because it has not been shown to be superior to shorter forms, it is rarely available in public health services. It is reserved for patients judged too difficult for short-term psychotherapy and is still used in training for psychotherapists.

Long-term dynamic psychotherapy aims to increase insight—that is 'the conscious recognition of the role of unconscious factors on current experience and behaviour' (Fonagy and Kächele, 2009). It also involves integrating these insights into current functioning, called 'working through'. Insight is achieved by bringing feelings and ideas previously outside consciousness into conscious awareness, and then interpreting their significance and linking past experiences to present ones.

The basic tools are free association, and examining the content of fantasies and dreams. Analysis of transference provides further information about unconscious processes, as does analysis of the countertransference. Recognizing countertransference is a key goal of personal psychotherapy during training.

*Resistance* to accessing unconscious material takes three forms:

1. *Repression:* active blocking access to unconscious material.
2. *Transference resistance:* restricting the intensity of the therapeutic relationship.
3. *Negative therapeutic reactions:* such as new symptoms that retard progress.

Analysis of resistance, as with analysis of transference, can often markedly increase insight.

*Interpretations* are considered the hallmark of this treatment. Interpretations link together seemingly unrelated mental phenomena and involve defences, unconscious processes, transference, or the links between past experience and present patterns. Transference interpretations are particularly emphasized in long-term therapy.

Long-term psychodynamic psychotherapy also differs from brief dynamic psychotherapy in that:

- *It is less structured*—the patient is encouraged to talk and associate ideas freely without a specific focus.
- *The therapist is less active* and guides the patient less.
- *Patients may be seen twice a week* (up to five times a week in vanishingly rare classical analysis).

# Treatment in groups

## Small-group psychotherapy

This is psychotherapy carried out with a group of usually about eight patients. Small-group psychotherapy is used most often to modify interpersonal problems, as a form of supportive treatment, or to encourage adjustment to the effects of physical or mental illness.

### The origins of group psychotherapy

Group therapy's early origins were in American physician Joseph Pratt's supportive and educational groups for patients with pulmonary tuberculosis (Pratt, 1908). Modern group therapy originated in the treatment of war neuroses in the UK. Group analysis (Foulkes and Lewis, 1944) was based on psychoanalysis with a rather passive group leader using analytical interpretations. Bion, a Kleinian analyst, focused specifically on the unconscious defences of the group as a whole rather than on the problems of individual members (Bion, 1961). In the USA, so-called 'action groups' in the 1960s and early 1970s provided a more intense experience. Group techniques are legion, but what they have in common seems more important than the differences.

### Classification of small-group therapies

One classification of groups is by their goals (specific versus non-specific) and the activity of the leader (high versus low) (Schlapobersky and Pines, 2009):

1. *Specific goals—high leader activity*: such as structured alcohol and drug programmes and CBT in groups.
2. *Specific goals—low leader activity*: includes problem-solving groups.
3. *Non-specific goals—high leader activity*: includes the many short-term group therapies, including psychodrama.
4. *Non-specific goals—low leader activity*: includes various psychodynamic groups.

### Terminology

Groups can be described in terms of their structure, process, and content.

- *Structure* describes the enduring reciprocal relationships between each member of the group and the therapist, and between the members.
- *Process* describes the short-term changes in emotions, behaviours, relationships, and other experiences of the group.
- *Content* refers to the observable events in the group meetings—the themes, responses, discussions, and silences.

### Therapeutic factors in group therapy

Group treatments share the therapeutic factors common to all kinds of psychological treatment, including restoring hope, releasing emotion, giving information, providing a rationale, and suggestion (see Box 24.1). Group treatment also shares additional factors, such as shared experience, support for and from group members, socialization, imitation, and interpersonal learning (Yalom and Leszcz, 2005), summarized in Box 24.10.

### General indications for group therapy

#### Group or individual therapy?

There is no strong evidence that the results of group therapy differ from those of equivalent individual psychotherapy. Nor is there evidence of differing results for forms of group therapy. Clinical experience suggests that they are somewhat less effective than individual therapies unless they build on shared clinical features.

#### What problems are suitable?

Group therapy appears most appropriate for patients whose problems are mainly in relationships. Contraindications are similar to those for individual psychotherapy.

## Types of small-group psychotherapy

### Supportive groups

Many of the therapeutic factors in a group (Box 24.10) work in supportive treatment. In supportive groups, the therapist encourages self-help and ensures that the experiences are used positively. He should also ensure that relationships do not become too intense, protect vulnerable patients when necessary, and ensure that each member is supported by and gives support to other members.

#### Self-help ('mutual-help') groups

Self-help groups are organized and led by patients or former patients who have learned ways of overcoming

### Box 24.10 Therapeutic factors in group therapy

**Universality (shared experience).** This helps the patient to realize that they are not alone and that others have similar experiences and problems. Hearing about others' experiences is often more convincing and helpful than reassurance from a therapist.

**Altruism.** Supporting others increases self-esteem of the giver, as well as helping the receiver. Mutual support leads to a sense of belonging to the group.

**Group cohesion.** Belonging to a group is especially valuable for those who have previously felt isolated. Group cohesion sustains the group through difficult patches.

**Socialization.** Social skills are acquired in the group from the comments and reactions of members in response to one another's behaviour. Members can try out new behaviours within the safety of the group.

**Imitation.** This involves learning from observing and adopting the behaviours of other group members. Patients imitate adaptive behaviours, although there is a risk that maladaptive behaviours can also be learnt.

**Interpersonal learning.** This involves learning from the interactions within the group and from practising new ways of interacting. Interpersonal learning is an important component of group therapy.

**Recapitulation of the family group.** Interactions can become over time increasingly based on past relationships between patients and their parents and siblings. This group transference is encouraged and used in analytical groups.

or adjusting to their difficulties. Group members benefit from the opportunity to talk about their own problems and express their feelings, and from mutual support. Group processes develop very strongly in these groups. Some such groups, such as Alcoholics Anonymous, have strict rules of procedure.

There are countless self-help groups for people who suffer from a wide range of different problems. These include Alcoholics Anonymous (page 584), Weight Watchers, groups for patients with chronic physical conditions, and groups for the bereaved (CRUSE Clubs). Few self-help groups (now often referred to as 'mutual-help groups') have been evaluated.

## Therapeutic groups

### Interpersonal group therapy

Interpersonal group therapy developed in particular from the work of Yalom and Leszcz (2005), and characterizes most group therapy. Treatment is focused on problems in current relationships, and examines the ways in which these problems are reflected in the group. The past is discussed only in so far as it helps to make sense of present problems.

Patients are prepared for their experience in a group by emphasizing:

- *Confidentiality*: the proceedings of the group are confidential.
- *Reliability*: members must attend regularly and on time, and not leave early.
- *Disclosure*: members are required to disclose their problems.
- *Concern*: members must show concern for the problems of others.
- *Disappointment*: at first members may be disappointed by the lack of rapid change, or frustrated by the need to share the time available for speaking.
- *Keeping apart*: The group members should not meet outside the group, and if they do so this should be reported at the next meeting.
- *Duration*: the length of the group is explained (e.g. '10 weeks' or '2 years'), together with the need to remain until the end.

#### Setting up the group

*General considerations*. About eight members are chosen. They should have some problems in common, and no member should have exclusive problems that set them apart from the rest. Meetings need a room of adequate size, with the chairs in a circle so that all members can see one another.

Meetings usually last for 60–90 minutes to allow adequate time for every member to take part; they are usually held once a week, and generally continue for 12–18 months. Most groups are '*slow open*', with new members joining only to replace those who leave. Totally *closed* groups are very difficult to maintain, and

rare outside residential settings. Groups that accept new members frequently, known as *open* groups, are usually supportive or psychoeducational.

*One or two therapists?* Most groups are run by one therapist, but many have cotherapists. The advantage of having two therapists is both practical and theoretical. It ensures continuity if one of the therapists has to be away, and it also provides an excellent training opportunity. Theoretically it can also help with countertransference problems. A risk is that cotherapists may compete with or behave defensively towards one another. However, in general if differences are discussed as they arise, they can provide further insight into the group process and offer healthy modelling of problem exploration and resolution.

### Some problems in group therapy

However skilful the therapist, certain problems commonly arise.

- *Formation of subgroups*. Some members may form a coalition based on age, social class, shared values, or other characteristics. The therapist should discourage such groupings, encouraging the group to discuss the reasons for their formation.
- *Members who talk too much*. The therapist needs to address this at an early stage, before the group rejects the talkative member. He may ask the group why they allow one person to absolve the rest from the need to speak about themselves.
- *Members who talk too little*. The therapist should assist silent members to speak and should therefore understand the reasons for silence.
- *Conflict between members*. The therapist should not take sides in conflicts but should encourage the whole group to discuss the issue in ways that lead to understanding of its arising, perhaps a hostile transference.
- *Avoidance of the present*. Members may talk excessively about the past to avoid present conflicts. The therapist can ask questions or use interpretations to bring the discussion back to the present, or actively relate it to current group process.
- *Potentially embarrassing revelations*. Common sense and judgement have to be used to protect vulnerable patients from blurting out potentially devastating information (e.g. about sexual or even criminal activity) early in the group.

## Group analysis

This technique has been widely used within the UK health service. It differs from the interpersonal method described above in the greater use of interpretations about transference and unconscious mechanisms and in encouraging 'free-floating discussion' rather than a specific focus. Particular attention is given to transferences to the therapist and between members generating hypotheses about previous relationships to understand current problems.

## Encounter groups and psychodrama (action techniques)

In *encounter groups* the interaction between members is actively intensified to provoke change. The encounter can be verbal, using challenging language, but it can also include touching or hugging between the participants. Sessions can last several hours. These groups are attractive to volatile individuals and undoubtedly carry some risks of things getting worse. *Psychodrama* groups enact events from the life of one member, in scenes reflecting either current relationships or those of their family of origin. Such enactments often provoke strong feelings reflecting the problems of other group members. Members often swap roles to understand the other person's perspective. The drama is followed by a group discussion. Psychodrama is found useful with less educated and verbal patients, and is favoured in some prison settings.

## Ward groups

Group meetings, often called 'community meetings', are part of the daily programme of many psychiatric wards. The approach originated in therapeutic communities. These are large groups, usually including all of the patients in a treatment unit together with some or all of the staff. At the simplest level, large groups allow patients to examine and deal with the problems of living together. They can confront individual patients about disordered or disruptive behaviour, and provide opportunities for social learning. Care needs to be exercised to avoid bullying, and a predominantly supportive atmosphere is needed for these groups to work. The group is sometimes used as a kind of governing body that formulates rules and seeks to enforce them.

## Therapeutic communities

In a therapeutic community, every shared activity is viewed as a potential source of learning and change. Members live, work, and play together, and learn about themselves through the reactions of other members in the course of these activities. Within the safe environment of the community, they are encouraged to experiment with new behaviours and appreciate points of view other than their own. Members take part in frequent group meetings. Maxwell Jones, its founder, called it a *living-learning*

**Box 24.11 Principal features of a therapeutic community**

**Informality.** There are few rules, and staff dress and behave informally.

**Mutual help.** Members support each other and help others to change.

**Permissiveness.** Members tolerate behaviour that they might not accept elsewhere.

**Directness and honesty.** Members respond directly to distortions of reality and other kinds of self-deception.

**Shared decisions.** Members and staff join in the day-to-day decisions about the running of the unit, the behaviour of its members, and often about the admission of new members.

**Shared activities.** Members provide some of the 'hotel' services in the community, so that each has a job involving responsibilities to other people.

*situation* (Jones, 1968), others a culture of enquiry. The underlying principles of the regimen have been summarized as *democracy, reality confrontation, permissiveness*, and *communality* (Rapoport, 1960). These translate into the features shown in Box 24.11. Residential therapeutic communities are no longer available in the NHS but the approach is still predominant in day units and in drug rehabilitation and some offender institutions.

### Therapeutic day hospitals

Therapeutic day units are increasingly widespread for the treatment of personality disorder (Bateman and Fonagy, 2008). They have a similar structure to therapeutic communities, with a culture of enquiry, but emphasize 'mentalization'. They are informed by psychoanalytical theory, but emphasize group work and a supportive environment. Using nurse therapists, the aim is to help patients to become aware of their strong emotions and reflect and learn to tolerate them, rather than act them out impulsively. There is no emphasis on understanding past experiences as long as the patient can begin to manage their intense emotions.

## Psychotherapy with couples and families

### Couple therapy

Couple therapy is usually proposed either because conflict in a relationship appears to be the cause of emotional disorder in one of the partners or to save a threatened relationship. The problem is conceived in terms of how the couple interact, and treatment is directed to this interaction. Couples are required themselves to identify the difficulties that they would like to put right.

Several techniques of therapy have developed, based on psychodynamic, behavioural, and systems theory approaches, and on a combination of techniques drawn from these latter two.

### Family therapy

Several, sometimes all, members of a family take part in this treatment. Usually both parents are involved, often together with the child whose problems have led the family to seek help. They may be joined by other members of the extended family. The aim of treatment is to improve family communication and functioning, and consequently to help the identified patient. Since success depends on the collaboration of several people, dropout rates are high. Whatever their method, family therapists have the following goals for the family:

- improved communication
- improved autonomy for each member
- improved agreement about roles
- reduced conflict
- reduced distress in the member who is the patient.

The systems approach is very influential, and was developed in the USA by Salvador Minuchin, who in his structural family therapy, advocated a practical approach to resolving problems. In Italy, the Milan school used hypotheses about the family system to suggest ways of promoting change. These approaches are described briefly below, together with an eclectic approach. The reader will find more detailed accounts in the chapter by Bloch and Harari (2009). Family therapy is used in the treatment of some young people with anorexia nervosa after weight has been restored by other means. Special kinds of family treatment have

been developed to reduce relapses in schizophrenia (page 290).

## Systemic family therapy

Systemic family therapy is concerned with the present functioning of the family, rather than with members' past experiences. The therapist's task is to identify the family's unspoken rules, their disagreements about who makes these rules, and their distorted ways of communicating. The therapist helps the family to understand and modify the rules, and to improve communication.

The *Milan approach* (Palazzoli *et al.*, 1978) usually consists of 5–10 sessions, spaced at intervals of 1 month or more ('long brief therapy'). *Circular questioning* is often used to assess the family. In this technique, one person is asked to comment on the relationships of others—for example, the mother may be asked how her husband relates to their son, and others are asked to comment on her response. The purpose is to discover and clarify confused or conflicting views. A hypothesis is then constructed about the family functioning and presented to the family, who are asked to consider the hypothesis during and between sessions. The family may be asked to try to behave in new ways. Sometimes the therapist provokes change with *paradoxical injunctions* designed to provoke the family into making changes that they cannot make in other ways. Paradoxical injunctions are impossible or counterintuitive suggestions that force the family to confront their hidden or unacceptable motives. A review of 10 outcome studies of Milan therapy found symptomatic improvement in about two-thirds of patients, and improved functioning in about 50% of the families (Carr, 1991).

## Eclectic family therapy

In everyday clinical work, especially with adolescents, it is almost impossible to do without simple short-term interventions to bring about limited changes in the family. The present situation of the family and how the members communicate with one another is usually the focus.

### Assessment

Constructing a genogram using conventional symbols (Figure 24.1) is a particularly useful step in family therapy, leading to questions on current and past family life, and the roles of the members. The therapist tries to answer two questions: namely how the family functions and whether family factors are involved in the patient's problems. Bloch and Harari (2009) have proposed a helpful framework in which to consider these questions.

1. How does the family function?
   - *structure* recorded in the genogram (e.g. single parent, a step-parent, size and age spread of the sibship)
   - *changes and events* (e.g. births, deaths, departures, and financial problems)
   - *relationships* (e.g. close, distant, loving, conflictual, etc.)
   - *patterns of interaction* involving two or more people (e.g. a child who sides with one parent against the other).
2. Are family factors involved in the patient's problems? The family may be:
   - *reacting* to the patient's problems (note that there may be other, unrelated, problems)
   - *supporting* the patient
   - *contributing* to the patient's problems (e.g. the problems of a daughter who cannot leave her lonely mother).

### Intervention

Specific goals for change are agreed with the members of the family, who are asked to consider how any changes will affect themselves and others, and what has prevented the family from making the changes. Paradoxical injunctions may be included, but should be made only after the most careful consideration of the range of possible responses. The therapist should remember that interchanges in the sessions are likely to continue when the family return home, and should try to ensure that this does not lead to further problems.

# Psychotherapy for children

The kinds of psychotherapy discussed so far do not lend themselves to the treatment of young children, who lack the necessary verbal skills. In practice many emotional problems of younger children are secondary to those of their parents, and it is often appropriate to direct psychotherapy mainly to them.

Melanie Klein believed it was possible to use the child's play as equivalent to the words of the adult in

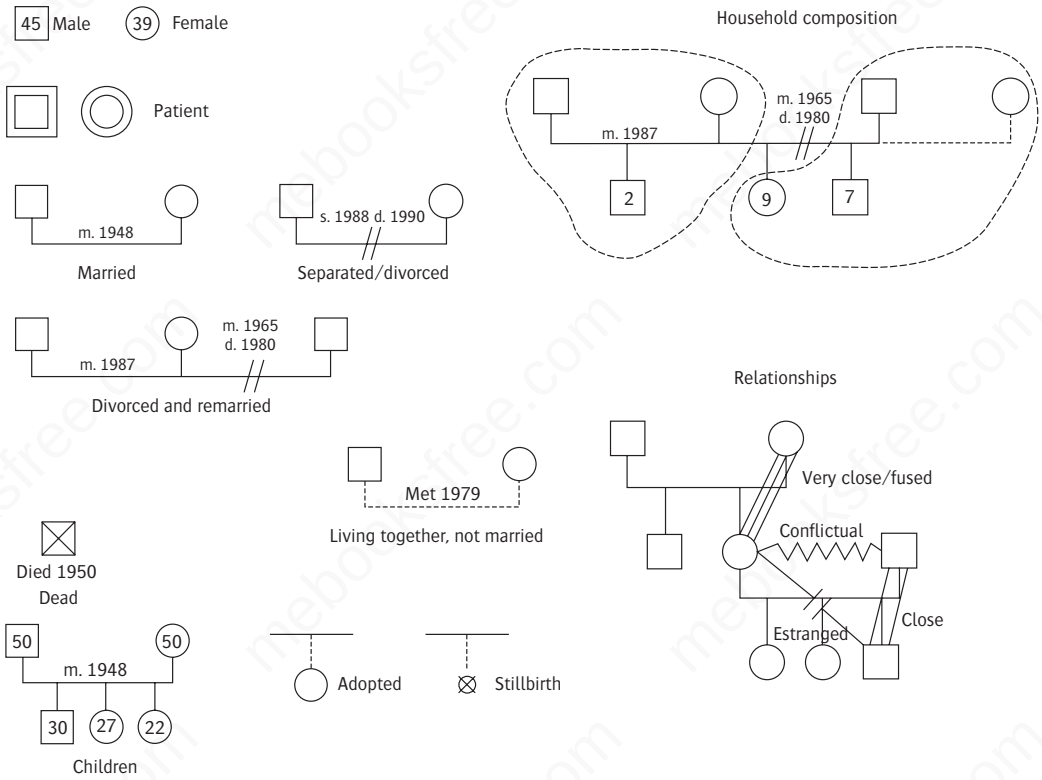


**Figure 24.1** Symbols used in the construction of a genogram.

Reproduced from Bloch and Harari, Family Therapy in the Adult Psychiatric Setting. In: MG Gelder, Andreasen NC, López-Ibor JJ Jr, Geddes JR (eds), The New Oxford Textbook of Psychiatry, Copyright (2009), with permission from Oxford University Press.

psychotherapy. Anna Freud developed child psychotherapy by a less extreme adaptation of her father's techniques to the needs of the child. She accepted that non-analytical techniques could be helpful, including reassurance, suggestion, the giving of advice, and acting as a role model (an 'auxiliary ego'). For many neurotic disorders, she advocated analytical techniques to identify the unconscious content and to interpret it to strengthen ego function.

In the UK, most psychotherapy for children is eclectic; the therapist tries to establish a good relationship with the child and to learn about their feelings and thoughts, partly through talking and listening, and partly through play. Older children can communicate verbally with adults, but younger children can communicate better through play. The therapist can help children to find words that express their thoughts and feelings, and can thus make it easier for them to control and modify them. Child psychotherapy is discussed further in Chapter 16. For a more detailed account, see Pearce (2009).

## Psychotherapy for older people

Increasing emphasis is being placed on the provision of psychological treatments as part of the care plan for elderly patients. Provided that they do not have cognitive impairment, elderly patients can take part in any of the treatments described for younger adults. When using cognitive therapy, it is important to be aware of minor cognitive impairment that, while insufficient to affect general functioning, may impair the patient's engagement in therapy. For a more detailed account see Cook *et al*. (2005).

## Treatments of mainly historical and cultural interest

In our evidence-based era it may seem inappropriate to list treatments that have fallen into disuse because of lack of effect. However, many of these treatments have entered our culture and have a strong hold on the public imagination. Psychiatrists are likely to be approached by patients who are keen to receive such treatments, and we need to be familiar with them in the same way as we are with outdated but influential concepts such as the 'schizophrenogenic' mother.

*Hypnosis* is a state in which the person is relaxed and drowsy, and more suggestible than usual. Hypnosis can be induced in many ways. The main requirements are that the subject should be willing to be hypnotized and convinced that hypnosis will occur. Most hypnotic procedures contain some combination of a task to focus attention (e.g. watching a moving object), rhythmic monotonous instructions, and the use of a graduated series of suggestions (e.g. that the person's arm will rise). The therapist uses the suggestible state either to implant direct suggestions of improvement, or to encourage recall of previously repressed memories.

Hypnosis is used infrequently in psychiatry but is used widely for stopping smoking, dieting, etc. A light trance is used occasionally as a form of relaxation. For this purpose hypnosis has not been shown to be generally superior to relaxation. A deeper trance is used occasionally to enhance suggestion to relieve symptoms, especially those of conversion disorder. Although sometimes effective in the short term, this method has not been shown to be superior to suggestion without hypnosis. The authors do not recommend the use of hypnosis in clinical psychiatry.

*Autogenic training* was described by Schultz in 1905 and was in use mainly in continental Europe as a treatment for physical symptoms caused by emotional disorder. Patients practise exercises to induce feelings of heaviness, warmth, or cooling in various parts of the body, and to slow their respiration. Repeated use of these exercises is supposed to induce changes in autonomic nervous activity, thereby alleviating physical symptoms in stress-related and anxiety disorders, including hypertension. Its results do not differ substantially from those achieved with simple relaxation, nor is there any good evidence that it has a specific therapeutic effect.

*Abreaction* (the unrestrained expression of emotion) has long been used to relieve mental distress and some psychiatric symptoms. Abreaction is part of many forms of religious healing (see below). It was used to great acclaim during the Second World War, using rapid-acting barbiturates to bring prompt relief from acute war neuroses (predominantly acute stress disorders), notably by Sargant and Slater. In civilian practice, abreaction is less effective, perhaps because fewer disorders are the result of discrete overwhelming stresses. For more information about the procedure, see Sargant and Slater (1963).

*Meditation and yoga* are increasingly used by people with minor psychiatric problems as an alternative or adjunct to psychiatric treatment. There are many approaches, each associated with different systems of belief, but sharing common features. They involve relaxation and the regulation of breathing, and directing attention away from the external world and from the stream of thoughts that would otherwise occupy the mind, often by repeating a word or phrase (a mantra). An important feature is setting time aside when calm can be restored. In addition, the espousal of a value system and association with similar-minded individuals (the activities are commonly group-based) may explain some of the reported successes of the methods. Aspects of meditation have been incorporated into MBCT.

*Traditional healing* still plays an important part in many individuals' lives, and is often a precursor to seeking professional help. It is not restricted, as is often assumed, to ethnic minority groups. Alternative medicines and treatments are ubiquitous in all strata of society. However, the use of traditional healers is generally restricted to minority groups. Traditional healers can be broadly divided into four groups (Jilek, 2000).

- *Herbalists* are concerned mainly with plant remedies, some of which are known to contain active ingredients, while others appear to be placebos.
- *Medicine men and women* use ritual methods of healing, sometimes combined with plant remedies. They are believed to have special powers, often of supernatural origin.
- *Shamans* use methods like those of medicine men and women, but also enter into altered states of consciousness in which they are believed to communicate with spirits or ancestors, and to recover the abducted souls of people made ill by this supposed loss.
- *Diviners* discover and name the cause of illness by interpreting oracles (in either clear or altered consciousness) from the content of dreams, or through some form of communication with ancestors or spirits.

Traditional healers use methods that incorporate the non-specific processes in western psychological treatment (Box 24.1). In addition, they are aware of the value of naming a condition and answering the questions 'Why am I (or my son) afflicted?' This ends uncertainty and relieves blame and guilt. Some traditional healers use therapeutic suggestion, and many involve the family both in the diagnostic process and in the rituals of treatment. Some employ cleansing or purification rituals to eliminate supposed polluting agents. A few healers use sacrificial rites to appease supernatural beings, sometimes combining these with confession and a promise of changed behaviour. They may involve the wider community to reinforce their message. Traditional healing is not necessarily incompatible with modern medicine, and may be running parallel with it more often than we think.

## Ethical problems in psychological treatment

### Autonomy

The need for informed consent is as great in psychological treatments as in any other medical procedure. To give such consent the patient must understand the nature of the treatment and its likely consequences. Such preparation is not only ethically desirable but also likely to improve the therapeutic alliance.

### Confidentiality

Group psychotherapy presents special problems of confidentiality. Patients should understand fully the requirement to talk of personal matters in the group, but they need to understand equally clearly the requirement to treat as confidential all they hear in the group. Family therapy presents similar problems, especially if the therapist agrees to see one member outside the family session, and is told of a family secret (e.g. an extramarital affair). Wherever possible the therapist should avoid such individual meetings and arrange for a colleague to see the family member if this is necessary (e.g. if one member is seriously depressed). Similar problems arise in couple therapy.

The answer to the question of when a therapist should reveal confidential material to a third party is the same as in other treatment situations, namely that it is justified when there is a substantial risk to a third party. Confidentiality is often confused with secrecy in psychotherapy (both by patients and by some therapists). Modern mental healthcare utilizes a model of shared responsibility, and often information must be shared. Only in exceptional cases should patients be promised that 'absolutely no one else will ever know of this'.

### Exploitation

Patients who are receiving psychological treatment are particularly vulnerable to exploitation. This arises from the experiences that cause them to seek psychotherapy, but also because of the intense and often dependent relationship with the therapist. As in other branches of medicine, exploitation may be financial or sexual. Financial exploitation is a potential problem in private practice, in which treatment may be prolonged for longer than is necessary. Occasionally the exploitation is sexual. In the medical and other caring professions, such exploitation is prohibited in professional codes of conduct. Several rogue therapists have defended inappropriate sexual contact as 'therapeutic' and, remarkably, in some cases have succeeded in this defence. However, it is never acceptable to form a sexual relationship with a current or previous patient. In some jurisdictions (e.g. some US states) there are evolving guidelines about the time that must elapse before such relationships can be considered acceptable.

Another form of exploitation is the imposition of the therapist's values on the patient. This may be open and direct (e.g. when a therapist imposes his view that termination of pregnancy is morally wrong) or it may be concealed and indirect (e.g. when a therapist expresses no opinion, but nevertheless gives more attention to the arguments against termination than to those for it). Similar problems may arise, for example, in couple therapy when the therapist's values may affect his approach to the question of whether the couple should separate. A controversial issue is that of 'implanting' erroneous explanations. This has been very contested in relation to 'recovered memory' syndrome, where the recall, after many years, of early familial sexual abuse has been attributed to therapists exploiting suggestibility. Although there has been no suggestion that this is deliberate, there is considerable professional doubt about its status, and the consequences are so potentially catastrophic that it requires very careful monitoring.

In group psychotherapy, one patient may be exploited by another. This is one of the reasons for proscribing contact outside the group. One patient may

bully or scapegoat another within the sessions, or may seek a sexual relationship outside. The therapist should try to protect vulnerable patients within the sessions. Clearly it is not possible to be as strict in this matter as in a professional relationship, but strongly emphasizing the purpose of the therapy rules is key to minimizing the problem.

## Further reading


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